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PSYNOPSIS

CANADA'S PSYCHOLOGY MAGAZINE

HEALTHCARE INNOVATION ISSUE

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PSYNOPSIS
CANADA'S PSYCHOLOGY MAGAZINE

THE OFFICIAL MAGAZINE OF THE CANADIAN PSYCHOLOGICAL ASSOCIATION

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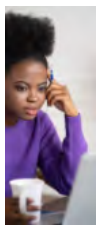

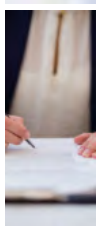

MESSAGE FROM THE GUEST EDITOR

DR. KIMBERLY CORACE

PHD, CPSYCH, VICE-PRESIDENT, INNOVATION & TRANSFORMATION, THE ROYAL OTTAWA MENTAL HEALTH CENTRE

What is "innovation"? The Council of Canadian Academies defines innovation as "new or better ways of doing valued things. An 'invention' is not an innovation until it has been implemented to a meaningful extent".[1] Thus, there is no innovation without implementation. But what does this mean for healthcare innovation? According to the World Health Organization, "Health innovation identifies new or improved health policies, systems, products and technologies, and services and delivery methods that improve people's health and wellbeing".[2]

The COVID-19 pandemic has impacted all that we do—from how we educate our students and trainees, to how we conduct our research and science, and to how we deliver care to our patients. COVID-19 made the ways in which we were accustomed to doing our work no longer viable. We had to pivot. We had to be nimble. People living in Canada are reporting increased stress, distress, substance use, and worsening mental health since the onset of the pandemic.[3,4] Access to care has been negatively impacted by COVID at a time when demand is increasing. Now, more than ever, healthcare needs innovation. This has the potential to transform our systems and, in turn, improve lives—and Canadian psychology is uniquely positioned to help drive this change. Collectively, we have a longstanding history of developing, implementing, and evaluating innovations as demonstrated in the Canadian Psychological Association's 3 pillars: education, science, and practice. In fact, innovation is a common thread that knits these pillars together. COVID-19 has most certainly propelled the field of psychology to innovate in response to the many challenges; however, our educators, scientists, and practitioners were already primed to do so. During times like these, one can either choose to sit down or stand up. I am humbled by what we did and what we continue to do. Canadian psychology not only stood up, but it continues to rise up.

This issue of *Psynopsis* highlights diverse and impactful healthcare innovations in the field of psychology. The articles underscore improvements in health policies, systems, technologies, services, and delivery methods, with the ultimate goals of improving access to quality healthcare, optimizing health outcomes, and fostering wellness and resilience. What are some of the "key ingredients" to these, and other, healthcare innovations?

1) Leadership: Psychology is ideally situated to provide leadership in healthcare innovation given their diverse expertise, unique skill set, and in-depth knowledge in integrating evidence-based approaches to care, psychological science, and education. Science drives the novel interventions and the interventions drive the science.

2) Collaboration and partnerships: We get nowhere unless we work together. Interprofessional teams and cross-sectoral partnerships are key to not only identifying gaps and generating innovative solutions, but also to facilitating successful implementation in complex systems. Silos and uncoordinated systems are often cited barriers to implementing novel models and interventions. With effective collaborations and partnerships, we can help foster integration to improve outcomes.

3) Engagement of stakeholders: No matter what the innovation, identifying and engaging stakeholders is imperative to success. If the innovation is *for* clients and families, then it needs to be done *with* clients and families.

4) Training and capacity building: Central to well-implemented innovations is a trained workforce with the necessary skills, abilities, and competencies to deliver the innovations. Innovations in capacity building and training can foster sustainability of the novel processes and models.

5) Empowering a culture of innovation: For innovations to thrive and have the most impact, they need to be widely adopted, scaled-up, and continually evaluated and monitored. We need to ensure our organizations and systems are ready, willing, and able to do so. We need to support and empower our stakeholders to innovate and implement.

The world around us is ripe for innovation. This issue highlights how Canadian psychology is prepared to answer this "call to action." By working collaboratively across systems, sectors and disciplines, we can push the innovation agenda forward and we can prepare our students to do the same. Our healthcare system needs our leadership, advocacy, and expertise. Our communities are counting on us. ■

Dr Kim Corace is the Vice President of Innovation and Transformation at The Royal Ottawa Mental Health Centre. She is an Associate Professor in the Department of Psychiatry at University of Ottawa, an Adjunct Research Professor at Carleton University, a Clinical Investigator with the Institute of Mental Health Research, and a Clinical Health Psychologist. Working at provincial, national, and international levels, her work focuses on improving treatment access and outcomes for people living with substance use and mental health co-morbidities, with a focus on developing collaborative care models. She contributes her expertise to numerous standards and guidelines committees as well as policy development initiatives to improve mental health and addictions care. Dr. Corace is currently the President of the Canadian Psychological Association (CPA). In 2015, Dr. Corace was the recipient of The Royal's 12th annual Inspiration Award in the young researcher category. In 2013, she and her colleague received the "Best Innovation in Mental Health Care Delivery" award from the Ontario Ministry of Health Innovation Fund for their Regional Opioid Intervention Service.

PSYNOPSIS
CANADA'S PSYCHOLOGY MAGAZINE

Psynopsis is the official magazine of the Canadian Psychological Association. Its purpose is to bring the practice, study and science of psychology to bear upon topics of concern and interest to the Canadian public. Each issue is themed and most often guest edited by a psychologist member of CPA with expertise in the issue's theme. The magazine's goal isn't so much the transfer of knowledge from one psychologist to another, but the mobilization of psychological knowledge to partners, stakeholders, funders, decision-makers and the public at large, all of whom have interest in the topical focus of the issue. Psychology is the study, practice and science of how people think, feel and behave. Be it human rights, health care innovation, climate change, or medical assistance in dying, how people think, feel and behave is directly relevant to almost any issue, policy, funding decision, or regulation facing individuals, families, workplaces and society. Through *Psynopsis*, our hope is to inform discussion, decisions and policies that affect the people of Canada. Each issue is shared openly with the public and specifically with government departments, funders, partners and decision-makers whose work and interests, in a particular issue's focus, might be informed by psychologists' work. CPA's organizational vision is a society where understanding of diverse human needs, behaviours and aspirations drive legislation, policies and programs for individuals, organizations and communities. *Psynopsis* is one important way that the CPA endeavours to realize this vision.

CANADIAN PSYCHOLOGICAL ASSOCIATION
SOCIÉTÉ CANADIENNE DE PSYCHOLOGIE

BECOMING A RESILIENT READY HEALTH CARE ORGANIZATION

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At The Ottawa Hospital (TOH), when we were asked to support physician health and wellness through the department of Medical Affairs, we selected an evaluated program that focused on decreasing stigma, working through culture change, and enhancing wellness; the military's road to mental readiness (R2MR). Lt Col Suzanne Bailey shared materials with us, and then served as mentor and coach as we worked through our adaptations for the health care environment. A decade into the wellness journey, we have learned several valuable lessons:

1. The number of professionals and administrators who work in health systems is vast and diverse. To change the wellness culture, you need collaborators across the organization. At TOH, they included Communications, Education, Ethics, Occupational Health & Wellness, HR, IT, Safety, and Medical Affairs.

2. This one wasn't surprising, but experiencing it is different than knowing it—true leadership support is invaluable. The wellness initiatives that were developed and offered through our organization were supported, endorsed, and sustained by the hospital's senior leadership.

3. The wellness needs of those in our organization mapped onto Maslow's Hierarchy of needs. It started with the physical needs, such as extended availability of food, broader food options, and access to family physicians. We had candid discussions about the systems barriers to health and wellness for those who worked in health care and understood that the primary goal was to create opportunities for our staff to engage in conversations about our own wellness: It's OK to be OK, and not to be OK.

4. The key is to make resources easily accessible for the moment they are needed, hence the importance of effective communication strategies.

The initial resiliency training program had several components (see Fikretoglu et al., 2019 for description and review of R2MR).[1]

1. The Mental Health Continuum Model, which provides a common and non-stigmatizing language for checking in with ourselves and with each other (see Figure 1).

2. Skills designed to promote preparation, coping, and recovery when faced with challenging or evocative situations (e.g., mental rehearsal, emotional preparation, sleep hygiene, tactical breathing, self-talk).

3. Crisis response training, specifically the ABC+ response strategy for challenging events (A = Ad hoc incident review; B = Back-to-basics; C = Coping and self-care; see Figure 2). Additional concepts of how to support ourselves and others in the initial 48 hours after events (B), and memory consolidation and recovery (C) were also included.

FIGURE 1: Mental Health Continuum Resiliency Reference

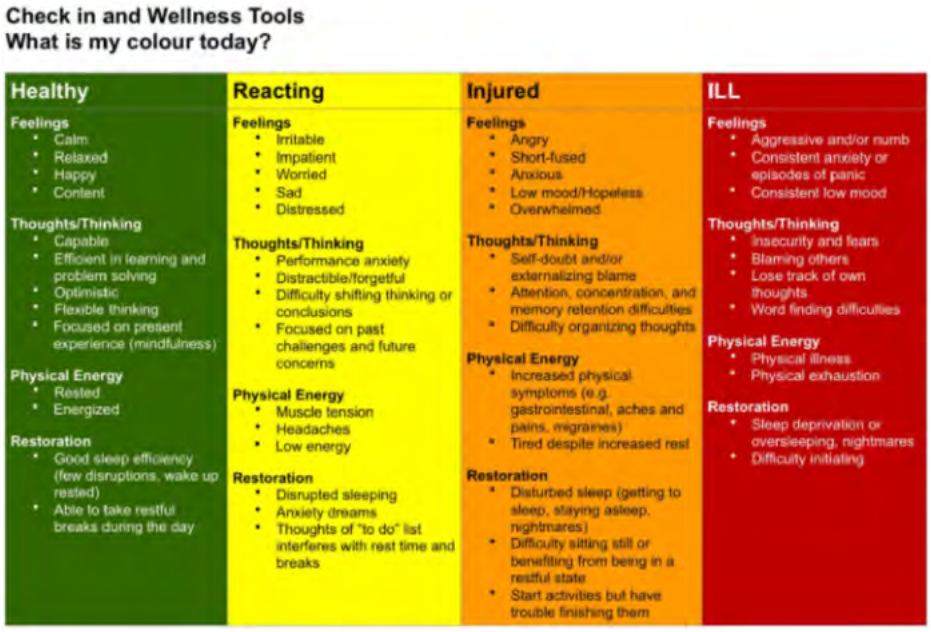

FIGURE 2: ABC+ Response to Challenging Situations Tool

ABC + Response Tool

A = Ad Hoc Incident Review (AIR)	B = Back to Basics	C = Coping and Self Care	
Stressful Event	First 2-3 days	First 4-6 weeks	Throughout
A = Acknowledge and listen	Rest, relax and sleep	Restore	Healthcare culture of:
I = Inform and colour check in	Nutrition	Sleep, exercise and motion	Safety
R = Respond and follow up	Identify energy makers and takers	Hobbies and passions	Accountability
* In private and can be brief		Engagement and support with others	Learning
			Support
Reach out to everyone involved	Get body back on line	Memory consolidation and integration	(Link to Just Culture)

We began with pilots for senior management, physician leaders, directors, and managers, across all areas of the hospital. Through grant funding (Mach-Gaensslen Foundation) we piloted the next iterations with physicians and residents, most of whom volunteered to participate in the evaluation component, and who provided feedback in focus groups. Over the next decade, as new practices, processes, and emergent situations occurred, our ever-growing team of collaborators came together to re-assess needs, tailor our wellness approach, and evaluate the offerings. Adaptations were created for the Medical Assistance in Dying team; after a large bus accident in Ottawa in 2019 that resulted in a Code Orange; during the implementation of our new hospital medical charting system; and during the COVID-19 pandemic.

Mike Kekewich, the Director of Organizational Ethics, broadened the wellness work, underscoring the importance of understanding, acknowledging, and supporting staff and physicians through moral distress. The communications department became an invaluable ally in supporting the distribution of the wellness materials and altering our language to a form that could be readily consumed. They brought us out of our offices and silos and taught us how to speak more broadly and succinctly, and to think about how to reach as many people as possible in an organization—to create materials and information that can be accessed when needed in multiple ways (e.g., hospital online newsletters, a monthly journal, a wellness site on our intranet, short video clips, social media, podcasts, and media interviews).

Overall, evaluations of the resiliency training indicated that staff felt better able to apply coping strategies, less stigma towards mental health, and increased belief in the ability to help team members deal with challenges. Over the decade, wellness of staff and physicians has become embedded within the operational decisions of the organization. For example, as the hospital prepared to roll out a new medical charting system in 2019, it concurrently integrated and introduced a 5-minute wellness survey that included the Mental Health Continuum questions, the Guarding Minds at Work (GMAW) Initial 6 Scan (a tool to evaluate psychological health and safety in the workplace). This survey was sent out to randomly selected staff and physicians every two months throughout 2019, and quarterly through 2020. The results provided feedback about staff experiences over time with the new charting system, and then COVID-19. It provided information on the impact of their health and the well-being of those at TOH, leading to focused resource development and offerings to all staff.

Health care systems are complex and therefore changes are complex, and take time. We can't necessarily change the health care demands or the crises that come our way. Individually and collectively, however, we can start the culture change by having these candid conversations about our health and wellbeing.

FOR A COMPLETE LIST OF REFERENCES, PLEASE GO TO CPA.CA/PSYNOPSIS

STEPPED CARE 2.0

An Open-Access Flexible Care System Designed by Psychologists

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Our current mental health system is organized to offer intensive psychiatric and psychological care. While effective for many people who require that level of care, the demand far exceeds the supply of such specialized programming. Stepped Care 2.0 (SC2.0) provides a framework for a system of care that integrates formal and informal care options, offered virtually and in-person, that span low to high intervention intensity.[1] Mental health concerns exist on a continuum of severity, and many people seeking to improve their well-being may not need psychiatric medication or intensive psychotherapy. While specialized care may be essential for people who require intensive services, referring a typical help seeker to a mental health specialist would be analogous to referring someone experiencing knee pain to an orthopedic surgeon before offering less intensive options such as ice, rest or physical therapy. Until recently there have been few equivalent less-intensive options for mental wellness within the care system. As a result, a person seeking support is in the same queue as people who may have very complex needs, delaying care in general and clogging the pathway to specialist care.

People are looking for less-intensive options. In two recent national polls we conducted in collaboration with Mental Health Research Canada, respondents were asked how interested they were in mental health resources (check all that apply) along the stepped care continuum. In the latest poll, most respondents indicated a preference for step 2 programming, or activities they could do on their own (46%). The next most common preference corresponded to step 1 information about mental health (40%), and a close third was one-to-one counselling (step 7), being of interest to 38% of those polled. Actual usage of resources on the Wellness Together Canada portal reflected a somewhat similar pattern. At the time of this publication, 51% of registered users chose self-guided tools (step 2), 33% sought counselling (step 7), and 16% were using coaching and peer support at step 3 (see Figure 1).

SC2.0 introduces a balanced and flexible approach to assessment and a range of care options that attend to people's capacities, level of readiness, and autonomy. Same-day, open-access to multiple levels of care, capitalizes on individuals' readiness and reduces delays in care.[2] A thorough intake assessment by a psychologist has been considered best practice owing to the perceived need to identify at-risk signs of suicide or potential harm to others. Although a reasonable presumption on the surface, we believe that the premise is flawed. First, risk of suicide or threat to others among those seeking care is low.[3,4] Second, our technical capacity to predict these threats is limited.[5] Finally, assessment in our current culture tends to focus on the identification of deficits as opposed to functional capacities which can lead to overprescription of expensive specialized remedies and lost opportunities for autonomy and self-management. Despite little evidence linking diagnoses to treatment outcomes,[6] we persist with lengthy intakes and screens that can delay care. Before letting go of risk assessment, we must acknowledge forces

underlying the risk paradigm that dominate our society and restrict creative solutions for supporting those in need. One such creative solution underpinning SC2.0 is to provide same-day access to care for anyone requesting mental health support (See Figure 2). This upstream rapid access to care, we propose, could become one of the most effective suicide prevention strategies.

SC2.0 integrates recovery principles and practice systematically within a range of traditional and emerging online mental health programs. Like most stepped care models, SC2.0 offers the lowest level of intervention intensity warranted by objective, continuous therapeutic measurement. SC20 also introduces more flexibility, more attention to client preference, and treatment matching based on readiness for change. It also includes the addition of strengths-based programming, thus extending the fit to more diverse populations and contexts. This deviation marks a shift from relying exclusively on evidence-based practices derived from controlled experimental conditions. Such a shift is possible with the introduction of practice-based evidence[7] using validated measures collected at every encounter with a client. Programming is adjusted based in part on clients' responses and preferences, rather than relying solely on symptom-based algorithms matched to one-size-fits-all manualized treatment protocols. This approach aligns well with the three-legged stool of clinical decision: making evidence-informed treatment, clinician expertise, and patient preference.[8] Through ongoing monitoring of therapeutic progress, practice innovations and culturally responsive approaches are encouraged.

As an upstream approach, SC2.0 may prevent mental health problems from escalating into more serious conditions by systematizing shared responsibility for accessing care options at the right time, with the right people, in the right context. SC2.0 provides a fulsome continuum of care with the potential to connect primary, secondary and tertiary care. The application of SC2.0 optimizes efficiency within the system and ensures that all providers, at every step, are able to focus on their areas of expertise (e.g., in-patient services, primary-care psychology) with fewer barriers to clients.

Psychologists have assumed the role of stepped care system consultants and architects in post-secondary counselling centres, provincial departments of health, and, most recently, nationally on the federally funded Wellness Together Canada portal. Psychologists can play important roles in mental health system building and transformation. But to do so, we will have to think about how our own practices could evolve. Psychotherapy will never be our exclusive domain. What roles do we see for ourselves in transforming the system? What roles can we assume in the context of SC2.0? Will we take on specialist functions at higher-step levels (e.g., step 8) or will we assume generalist and gatekeeping roles at first point of contact? The SC2.0 model offers a type of scaffolding for exploring such roles. For example, in addition to high-level system design work, psychologists could establish rapid access "one-at-a-time" single-session clinics and operate as behavioural health consultants in primary care settings. In addition to receiving warm hand-offs and providing immediate care, psychologists could advise physicians and patients on step level options should referrals be needed. Psychologists could advise on the development of evidence-based mental health literacy material and self-guided apps on mental health care portals for steps 1 and 2. They could also design training curricula for lived experience peers and coaches who provide support or guidance at steps 3-5. Psychologists could research and develop more effective, flexible, and efficient methods for delivering psychotherapy at steps 6 and 7. Finally, psychologists could assume more active specialty roles for complex cases at steps 8 and 9. SC2.0 offers diverse and innovative positions for psychologists in the mental health system. These are some of the many opportunities that exist right now for psychologists to have large-scale impact on policy and system-wide change.

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FIGURE 1: Percentage preference for population level Stepped Care 2.0 resources

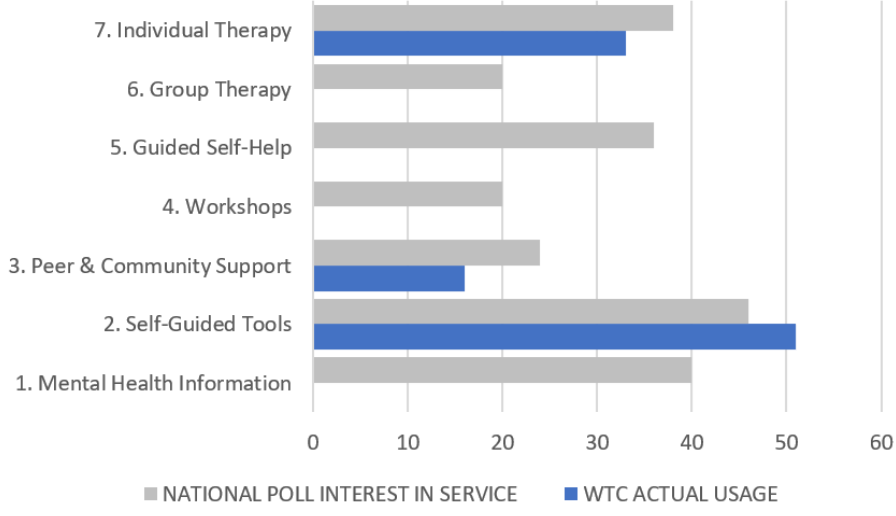
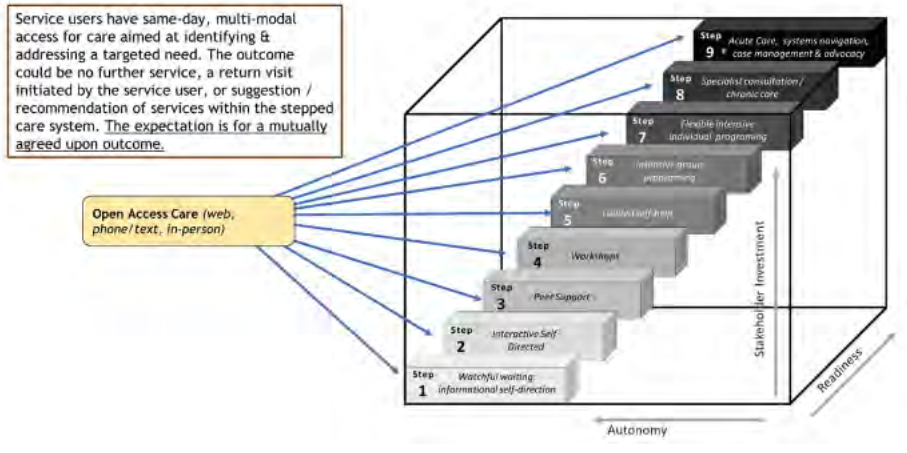


FIGURE 2: Open-access Stepped Care 2.0 model



ADVOCACY IN NEW BRUNSWICK

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New Brunswick is a unique province in many ways. As one of three Maritime provinces, we are the largest by land area. We are Canada's only official bilingual province—French is spoken by about one-third of our population. We are also unique in that we do not have a separate psychological association (i.e., a separate association that carries the sole function of advocating for the profession). Rather, the College of Psychologists of New Brunswick (CPNB) has a dual mandate:

1) To protect the public by regulating the professional practice of psychology; and

2) To advance the practice of psychology in New Brunswick.

Thus, it is a joint effort of the staff and the boards of the College to balance the regulatory functions such as licensing, discipline, etc., with professional affairs such as advocacy. This distinctiveness adds to the complexity of the advocacy activities we undertake. It requires unique considerations as we strive to balance the dual functions of the College.

We have enjoyed many successes in our efforts to advance the practice of psychology in New Brunswick. More recently, we have made significant advances with two notable projects—our *Increasing the Odds*[1] paper and our *Working Conditions Report*[2]. These projects have resulted in government initiatives that are very promising for the field of psychology in our province and for New Brunswickers.

Our *Increasing the Odds* paper was developed as a response to Federal Health Accord Funding. The Atlantic Provinces were the first to sign on and agree to the Federal Health Accord, and it provided us with an opportunity to initiate change. With the help of the Canadian Psychological Association and a joint effort with PEI, Nova Scotia, and Newfoundland, CPNB developed *Increasing the Odds*—a discussion paper that details the current and growing crisis in New Brunswick schools with respect to access to psychologists. The New Brunswick school system has seen a significant decline in psychologists over the past decade or more. As a result, children identified as having potential mental health and/or learning difficulties may not have access to a psychologist or face a significant wait. For example, we estimate that students may wait as long as three years for a psychoeducational assessment.

CPNB engaged the Health and Education Ministers, as well as various other stakeholders in the development and completion of this discussion paper. The result was a proposed multi-step solution that would put children first. CPNB recommended:

1. A short-term measure that includes a "hybrid model" using fee-for-service psychologists to address the current lack of resources in the system;

2. Working closely with stakeholders on an ongoing basis to improve retention of psychologists working in the public system; and

3. Establishing additional internships accredited by the Canadian Psychological Association.

We considered it a significant success when the Conservative leader, Blaine Higgs (now Premier of New Brunswick) used our discussion paper and recommendations in his platform commitments of how he will change the state of mental health for New Brunswickers.

Our second project, the *Working Conditions Report*, was developed in response to difficulties with recruitment and retention of psychologists in New Brunswick, particularly within the public sector. These difficulties result in substantial shortages of psychologists working within the public sector. CPNB conducted a survey of its members to identify factors that may be contributing to difficulties in recruitment and retention of psychologists. We undertook this survey with the purpose of understanding the demographic profile of our members, the type of work they do, and their satisfaction with their work environment. The survey results were summarized in the *Working Conditions Report*. The report identified several factors to improve working conditions for psychologists in New Brunswick, while also increasing recruitment and retention success.

The *Working Conditions Report* built the foundation for the next three years of projects, which included a communication and engagement plan to share the outcomes, as well as the means to advocate for measurable change. We engaged all levels of government and presented our report to the Minister of Health. Our efforts, as well as the Premier's platform commitments, prompted the development of a steering committee mandated with establishing a 5-year psychologists resource strategy for New Brunswick. Membership on the committee includes all departments of government, health authorities, unions, educational sectors and CPNB. We consider this a major success since it represents interest and initiative from all levels of government and across all sectors.

Members provide direction to appointed working groups in the development of an outlined strategy. Significant work has gone into developing a resource strategy that encompasses measures to address recruitment, retention and competencies and skills mix that will increase access to psychologists in New Brunswick. The result is a detailed action plan that will lead to measurable change. Components will inform a final report to be presented to government.

Our *Increasing the Odds* paper and *Working Conditions Report* have allowed us to advocate for change at the government level in New Brunswick. These initiatives have drawn attention to the common issues facing psychology not only in New Brunswick, but across Canada. We continue to work with government developing strategies and assisting implementation. CPNB continues to be a valuable resource to government as we maintain the strong relationships we have built through our advocacy efforts. We are extremely hopeful that New Brunswick psychologists see real change out of these activities, which create better access to services for all New Brunswickers.

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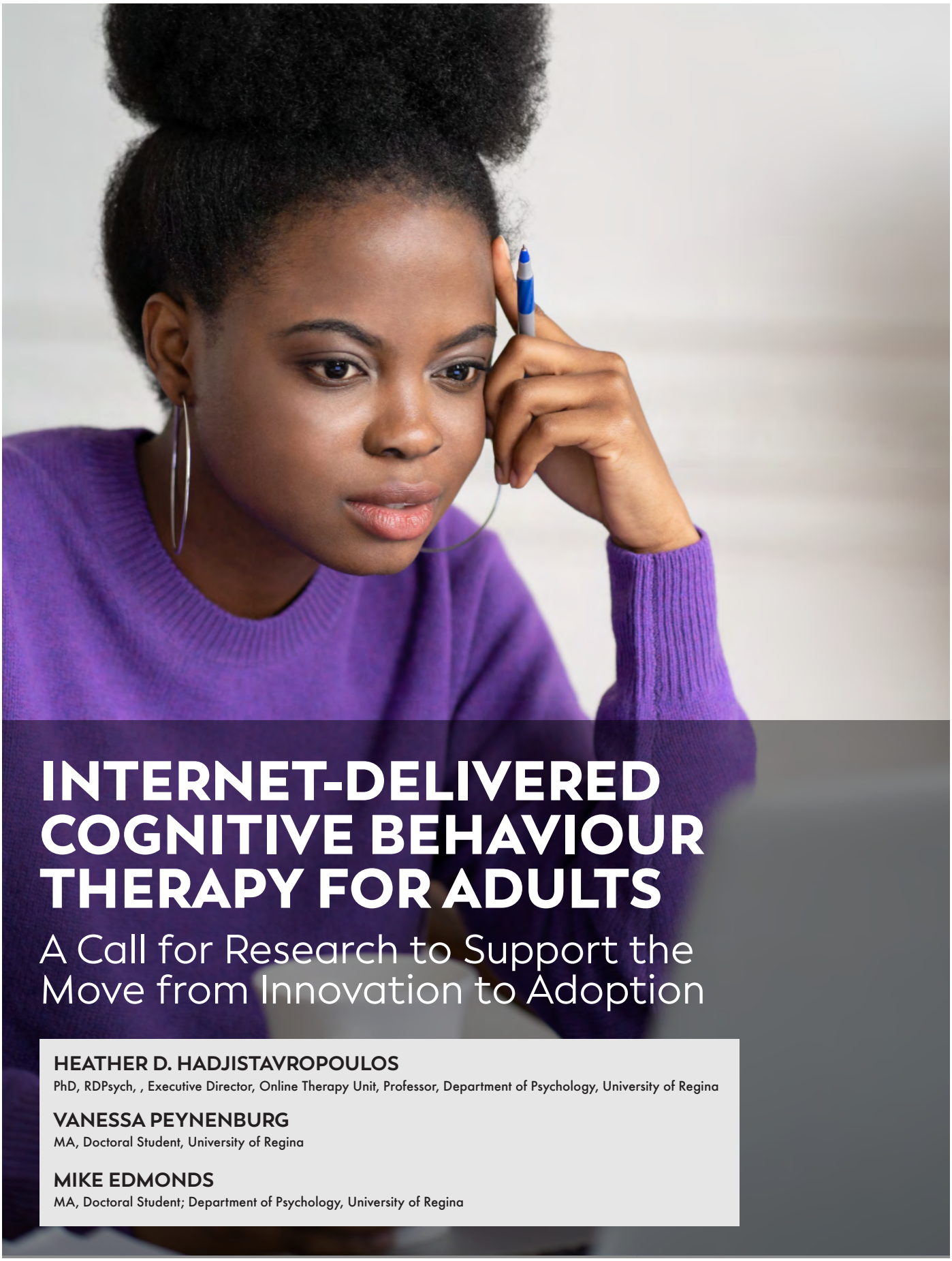

INTERNET-DELIVERED COGNITIVE BEHAVIOUR THERAPY FOR ADULTS

A Call for Research to Support the Move from Innovation to Adoption

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Internet-delivered cognitive behaviour therapy (iCBT) has been the subject of research for over two decades. The online delivery of therapeutic content in the form of lessons (e.g., text and multimedia) when first introduced represented a truly novel method of improving client access to mental health care. Since this initial pioneering research, iCBT has been examined for many different mental health conditions with a multitude of variations, such as with and without therapist support, with various modes of support (e.g., telephone, email, chat, blended delivery with face-to-face support), and in a diagnostic-specific versus transdiagnostic format.

There is now tremendous evidence for the efficacy of iCBT. There have been well over 300 trials of internet interventions,[1] most of which are iCBT, demonstrating moderate to large mean effect sizes when compared to control conditions for treating diverse conditions, such as depression, panic, social anxiety, generalized anxiety, and posttraumatic stress disorder. iCBT is also found to be efficacious when used to assist individuals with disparate chronic health conditions,[2] as well as individuals suffering from alcohol misuse.[3] Furthermore, a growing number of studies show that iCBT produces results comparable to face-to-face therapy.[4]

Consistent with the typical innovation-development process,[5] in Canada, as well as other parts of the world, there is now considerable energy being invested by various groups (e.g., researchers, government, non-profit organizations, private sector) on moving iCBT (or variants of it) from an innovative idea to routine care (for an environmental scan see CADTH, 2018).[6] While there is currently a move towards expanding patient access to iCBT, innovative research has enormous potential to improve the delivery of iCBT within the Canadian healthcare system. More specifically, research is required to understand what factors make iCBT more or less effective, acceptable as well as efficient in order to best meet the needs of patients within the context of our healthcare system.

Although we know that iCBT is efficacious, we also know that, similar to other forms of therapy, not all patients complete treatment and not all patients benefit from treatment. Continued research is needed to improve the core components of iCBT, including optimizing how/when core skills are taught, examining the value of adding components (e.g., motivational interviewing, booster sessions), as well as investigating how advances in technology (e.g., machine learning, sensors) can be applied to enhance adherence and outcomes. Moreover, while we know that therapist-assistance is associated with improved outcomes, there is much to be learned about how to best offer therapist support, and thus train therapists to achieve optimal outcomes, such as understanding the optimal length, frequency, duration and nature of therapist support in routine care. Although iCBT programs that include some degree of therapist support generally demonstrate larger effect sizes than self-directed iCBT, the scalability of self-directed iCBT makes this method of delivery of significant interest and importance.

We also know there is a need for additional research on how to improve patient understanding and acceptance of iCBT. Not all patients perceive iCBT to be an acceptable treatment, and lower expectations of treatment hamper outcomes. Interest in iCBT appears to be higher among those who report greater treatment need, difficulties accessing care, and greater computer self-efficacy.[7] What strategies work best for improving iCBT treatment acceptability? An innovative treatment is only beneficial if patients use it.

Research that seeks to examine the equity in delivery and outcomes of iCBT among diverse groups is also essential as iCBT moves from an innovation to implementation. When public funds are used to support iCBT, it is critical to examine the uptake and response of diverse cultural groups to iCBT, and work towards adapting treatment to meet the needs of diverse populations.

Research is also required to understand when it is most efficient to offer iCBT in the patients' mental health care journey. There are calls to offer iCBT to prevent mental health problems or when problems are mild as a first step in care, but is this best time to intervene?[8] More research is needed on the role of iCBT as an adjunct to care or step down in care or when face-to-face treatment has been unsuccessful. Furthermore, can it be assumed that results will be the same when patients are offered iCBT programs that have not been rigorously tested to ensure safety and quality?

In terms of safety, there is a tendency to exclude individuals with higher severity of symptoms from being offered iCBT, but clients with high symptom severity also seek iCBT due to challenges they face accessing face-to-face care. More research is needed on iCBT and screening practices with clients with higher symptom severity or suicidality,[9] as well as on whether concerns about client safety can be mitigated by coordination of iCBT with other forms of care.

The benefit of tailoring iCBT to meet the unique needs of patients also requires further research. To what extent does tailoring treatment to patient concerns and preferences impact iCBT engagement and outcomes, such as tailoring to populations with higher levels of mental health concerns (e.g., public safety personnel, post-secondary students)?

Given the length of time iCBT has been studied, as well as the volume of research on iCBT, it may be tempting to dismiss the need for additional innovative research on this form of care. We contend that significant incremental research is needed to advance this form of care and to ensure it fulfills its potential as a health care innovation.

FOR A COMPLETE LIST OF REFERENCES, PLEASE GO TO CPA.CA/PSYNOPSIS

INNOVATIVE INTERVENTIONS

Digital Peer Support for Youth with Chronic Illness

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Roughly one in four youth aged 17 or younger have at least one chronic illness,[1] defined as persisting health conditions that significantly impair daily activities, such as cancer, diabetes, cardiovascular disease, inflammatory bowel disease, and chronic respiratory disease.[2] Childhood and adolescence, now collectively referred to as youth, are critical periods of social, biological, and psychological development. Youths with chronic illness have the unique challenge of concurrently experiencing complex illness-related stressors in addition to 'normal' developmental stressors;[3] thus, they are at an increased risk of psychosocial maladjustment and the onset of psychopathology. Although public healthcare services have markedly reduced mortality rates for this population following medical advancements in life-saving treatments within the past decades,[4] The Canadian Academy of Health Sciences[5] and provincial healthcare ministries[6,7] report a gap in the long-term psychosocial care in public healthcare chronic care treatment models and services. In turn, these youths are vulnerable to poor long-term adjustment, health, and wellness. Evidently, we are in need of a solution that can readily be implemented without extensive policies or funding, and is efficacious, feasible, and self-sustaining. One that harbors the potential for future national adoption.

Fortunately, psychologists and researchers have recently been innovating a promising solution: Peer support, a psychosocial intervention whereby a person receives support from another that has experiential knowledge of a shared experience or stressor.[8,9] Humans have been each other's pillars of support as far back as history is recorded; however, what makes this 'new wave' of peer support innovative is its synthesis of evidence-based treatment processes and digital delivery (i.e., electronic devices). Modern peer support interventions have informational (e.g., problem-solving knowledge), emotional (e.g., empathy, validation, and acceptance), and appraisal (e.g., adaptive evaluations) components.[10] More specifically, peer support has been linked to psychological processes, such as social modeling, social comparison, and self-efficacy, and theoretical frameworks, such as social identity, self-categorization, and self-determination theory.[8,11] Following formal peer support programs, a select few of those receiving support that carry inherent supportive dispositions may be elected or chosen to pass on the tradition. Some programs have a healthcare professional oversee the intervention and train the new or elected peer supporters according to the program's mission, values, and best practices. For the most part, training aims to encourage authentic interaction and retain the 'likeness' of the peer supporter. In essence, peer support is founded on the principle that social support is a key ingredient to health, health behavior, and long-term outcomes for multiple dimensions of health-related quality of life for youth with chronic illness.[12]

Distinct from biomedical treatment processes and targets, peer support addresses the gap in psychosocial well-being, development, and adjustment in standard care. Youth with chronic illness have higher rates of school absenteeism, social isolation,[13,14,15] loneliness,[16] and achieve fewer developmental milestones[17,18] compared to healthy peers. Additionally, in the long term, they have higher anxiety and depression,[19,20] lower higher-educational attainment, greater unemployment rates, and lower income levels.[19,21] Loneliness, or the subjective experience/evaluation of feeling alone, is a predictive factor for greater anxiety, stress, depression and general mental health over time[22] that deserves more attention. Social isolation, or the objective circumstance of being alone, increases the likelihood of feeling lonely.[23] Youth are particularly vulnerable to feeling lonely when isolated.[24] Canadian COVID-19 surveys report that we are feeling more anxious and lonelier,[25] and our mental and physical health is diminishing.[26] Social support through peer support can mediate the effects of loneliness on health outcomes.[27,28]

In general, through peer support, increased exposure to social, emotional, and illness stressors combined with persisting engagement with supportive, relatable peer relationships, youth potentially adopt or experience a combination of self-management techniques and adherence practices, validation of their emotional and social experiences, development of emotion regulation and social skills, achieve developmental and educational milestones, adaptively appraise their illness, make meaning and develop their identities, establish and maintain ongoing social supports, and learn how to simultaneously balance work, life, and illness.[8,29]

The innovativeness of digital peer support interventions stands on its novel intersection of meeting psychosocial needs with relevant treatment components and utility of scalable (i.e., efficacious, feasible) technology[30] that addresses psychological, logistical, or systemic barriers to treatment.[31] With nearly all youth using the internet, owning smartphones,[32] seeking social support[33] and health information online[34], preferring online social support groups and self-management programs at times,[35,36,37] and recent major investments from the federal government to bring broadband to indigenous, rural, and remote communities,[38] now more than ever it is suitable for researchers and practitioners to work with the spirit of the times. Digital interventions have the added safety benefit of physical distancing during the ongoing pandemic. Further, digital peer support programs and communities specifically designed for youth with chronic illness circumvents problems, such as internalized stigma or prior invalidating responses[39] that may condition nondisclosures of their medical diagnosis online,[40] experienced on the general web. Formal digital peer support programs have thus far reported promising results for self-management, psychological distress, and participant satisfaction.[12,29,41,42,43] Peer support has the added benefit of relieving burden in caregivers and family units[44,45,46,47] and reducing acute care visits and hospitalizations.[5] Peer support researchers have suggested future studies consider demographic variables (e.g., cultural backgrounds), unique needs of a given chronic illness, regular patient feedback informing treatment, randomized-controlled trials, objective measures, longitudinal designs, and synthesis of best practices and components in the digital peer support literature (e.g., asynchronous support from healthcare professionals, ethical and secure data collection, user-friendly and accessible communication platforms).

Digital peer support, effective for self-management and psychosocial well-being,[29] is one promising, scalable interim answer in response to the current shortfalls of standard care in the psychosocial well-being, development, and adjustment for youth with chronic illness.

FOR A COMPLETE LIST OF REFERENCES, PLEASE GO TO CPA.CA/PSYNOPSIS

INNOVATION

Management of Multiple Chronic Illnesses

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Caring for multimorbidity in the community can be a challenge for the primary care physician. It is well known that anxiety, depression, and stress- and trauma-based symptoms accompany chronic disease. If unaddressed, this may lead to non-compliance, unneeded physician and emergency room visits, and hospital admissions. In response, a team of researchers including two family physicians and two psychologists are piloting a chronic disease management clinic (CDMC) within a family health team (FHT) in Ontario. This model of care acknowledges the particular role and contributions of psychologists in primary care.

The CDMC team is comprised of a psychologist, a family physician, a nurse practitioner, a pharmacist (all working in the same FHT) and a community Health Link nurse. The family physician refers their patient to the CDMC. The CDMC then follows a predetermined data collection form and each professional assesses the patient (by phone, teleconferencing or a home visit via Healthlink) to identify the various issues that impede the patient's disease self-management and quality of life. Thereafter, the team meets with the patient to confirm their goals and delineate a personalized treatment plan. For the next six weeks, the nurse practitioner monitors the patient every two weeks to explore adherence to the collaborative treatment plan; successes are celebrated, and difficulties or challenges are examined.

Results from a mid-point evaluation using semi-structured interviews with patients and CDMC team members revealed high levels of satisfaction for both patients and health professionals, especially regarding having a clear management plan. The CDMC team recommended continuing to find ways to optimize patient-centeredness and shift away from the traditional disease-centered paradigm. As such, several recommendations were made:

1) Multidisciplinary meetings should be led by the psychologist,

2) Team meetings with patients should be shorter in duration,

3) Closer follow-ups with the patients should be ensured, and

4) An ad hoc, interprofessional meeting with the patient should be considered to reassess or refine the suitability of the management plan if the need arises.

Regarding the first recommendation, the team agreed that having the psychologist lead the multidisciplinary team was a strategic and innovative way of optimizing patient-centeredness. This also addressed the objective of shifting away from a medical/disease-oriented approach where the physician traditionally assumes leadership, hence also promoting a shared leadership model of care. It was felt that the psychologist's advanced training and expertise in the psychological aspects of physical health problems was a valuable asset with potential to optimize and sustain the team's overall focus on integrating both medical and psychological interventions as seamlessly as possible per patients' identified needs, priorities, objectives, and values. We will continue to monitor the outcomes of this innovation to shed light on potential emerging roles for psychologists in primary care.

INNOVATION

Web-based CBT Intervention

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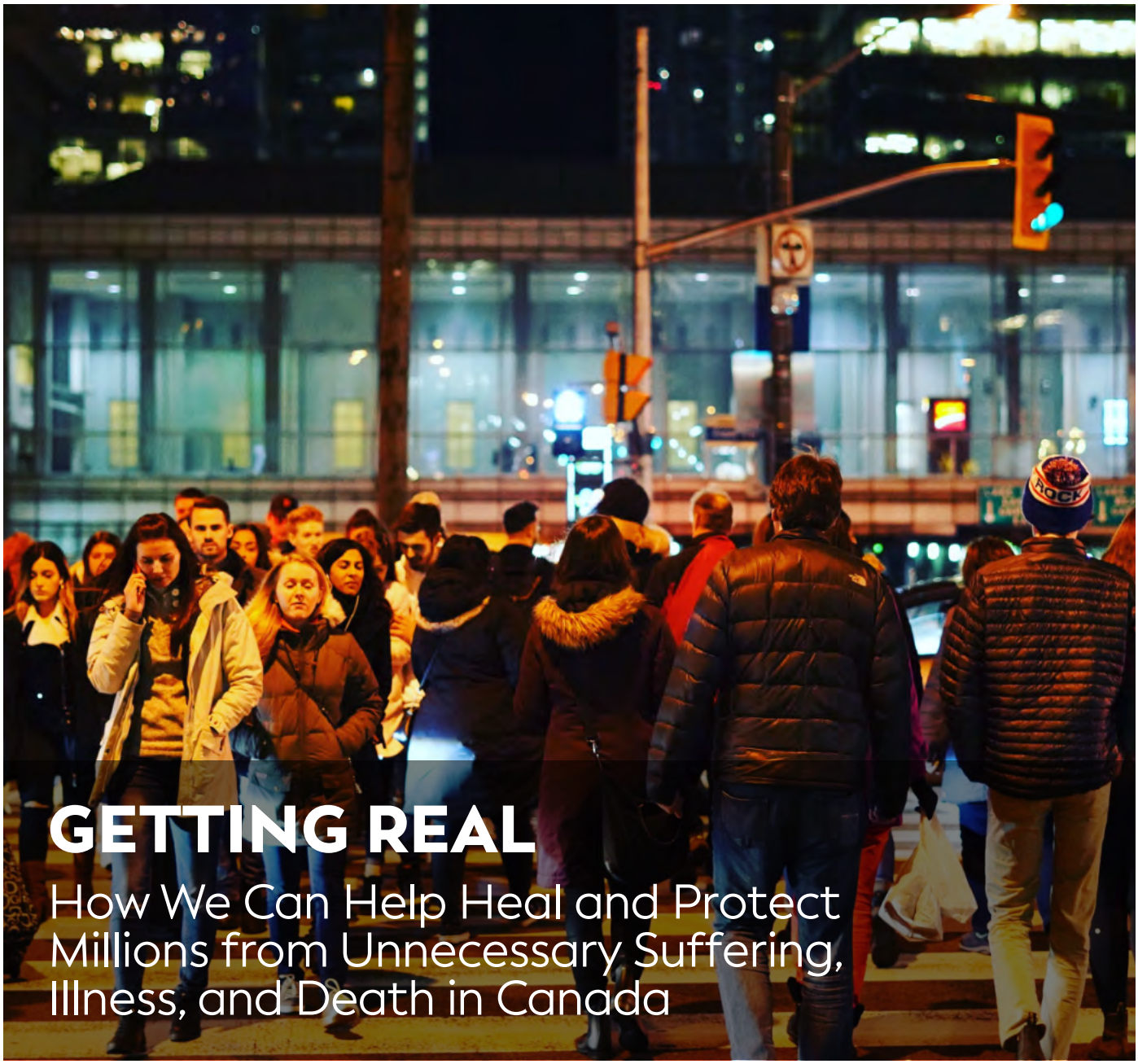
Anxiety and depressive disorders are common mental health disorders in primary care. Cognitive behaviour therapy (CBT) is one type of psychotherapy that has been proven effective for anxiety and depressive disorders. In order to improve access to psychotherapy, the health system is now turning to various online programs and intelligent applications. However, since only a few proven programs are available in French, this is a disadvantage for Francophone minority communities (FMC) for whom the provision of French-Language mental health services is essential and is recognized as an unmet need for these populations.

In collaboration with a larger multi-setting/multi-researcher project led by Dr. Pasquale Roberge, a researcher and psychologist from l'Université de Sherbrooke, we participated in the French translation of a mixed anxiety and depression module that is part of an internet-based CBT program that originates from Australia and has a demonstrated track record. With financial support from the « Consortium national de formation en santé », we are pilot testing this module among the Francophone population in the Ottawa region, and will report on the feasibility and acceptability of this type of intervention among Francophone physicians and patients in Ottawa. This pilot study uses mixed approaches with Francophone patients aged 18 or older, suffering from depressive and/or anxiety disorders, and their family physician. The family physician prescribes the program and patients have up to three months to complete it. The program consists of six weekly 20-30-minute courses with between-session homework and tasks.

The feasibility and acceptability of the program will be explored through semi-structured interviews and questionnaires. Quantitative data will also be gathered over the course of the program. We anticipate that this pilot project, and most certainly the larger project being led by Dr. Roberge, will lead to the development of additional evidence-informed, web-based services for Francophone—and eventually Anglophone—patients with mental health problems. This will improve access to efficient treatments in their language of choice and improve primary care access to evidence-based psychotherapies.



GETTING REAL

How We Can Help Heal and Protect Millions from Unnecessary Suffering, Illness, and Death in Canada

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World Mental Health Day took place on October 10, 2020, and it was amazing—so many people coming together, speaking out, and highlighting the importance of mental health! It is timely, since this year has chronicled unspeakable rates of loss of life, families torn apart, record job and business losses, and delayed/devestated plans and dreams, all while we manage uncertainty about the future. Suffering knows no boundaries. It does not discriminate by political leanings or religion. Mental health impacts how we think, how we feel, and what we do. Not just one day a year, but Every. Single. Day.

Let's be honest—for most Canadians, the only health care provider available with whom to share their suffering, pain, struggles, and hopelessness is their family doctor. Indeed, recent data suggest that up to 80% of Canadians rely on their primary health care physician for mental health services.[1] This is regardless of the fact that many primary care physicians self-report that they lack the appropriate training, resources, and time to provide adequate mental health care.[1] Family physicians work exceptionally hard to support their patients; some seek out additional training or connect with community partners. However, 6 out of the 10 current leading causes of death in Canada are non-communicable in nature (including suicide) and are not currently being addressed.

Primary care physicians cannot fill the gap left by the absence of mental health treatment within the primary care system. One result is that our province's health

care systems pay billions of dollars annually into anti-depressant, anxiolytic, and sleep medications. There are some specialized treatment programs available for those who meet criteria, and the rest of the population either suffers in silence or ends up in our emergency rooms and hospitals. They are acutely assessed for risk, and then usually discharged with the following reccomendation: "follow up with your primary care physician within a week."

MAKING THE CASE FOR INTEGRATED PRIMARY CARE

Integrated primary care (IPC) refers to the integration of mental health services, in particular regulated mental health professionals (i.e., those monitored by independent licensing boards such as psychologists), into the familiar primary care setting to provide a comprehensive, patient-centered approach to addressing mental health related concerns.[2,3] There has been extensive research highlighting the advantages of IPC, including improved access to mental health services, increased patient and clinician satisfaction, increased treatment and follow-up adherence, improved patient clinical outcomes, reduced feelings of stigmatization by patients, and reduced economic burden.[2,4,5] The data are clear. It works.

So what does IPC look like in Canada? We reviewed the literature and found 16 articles related to the role of psychology within a primary care setting in Canada. Within a primary care setting, psychology adopts a modified role that differs from what people traditionally think of when they imagine seeing a psychologist (a lovely boutique office, expensive couch, lots of books). Primary care psychologists differ in several important ways:

- Typically see patients in a medical office[6,7]
- Maintain larger case loads than traditional psychologists[8,9,10]
- Do brief, real-time assessments to help provide immediate same day care [11,12,13]
- Work with a more diverse population[8,9,12,14]
- Adopt a brief, current issue focus model of care[8,9,11,12,14,15]
- Provide "curbside consults" to their medical counterparts[16]
- Specialize in cognitive and behavioral factors impacting the management of chronic health conditions, and
- Are real-time educators and supervisors.[9,11,17]

What we also discovered, is almost no one is receiving this in Canada—the exceptions being visionary primary care physicians, practices, and divisions of health applying for grant funding to "innovate" primary care.

WHAT ARE THE NEXT STEPS?

Advocacy

It is apparent that the unique qualifications and potential roles for psychologists within IPC have been overlooked. Much of the literature often places psychologists in the same group as "mental health counsellors" (no longer ensuring training, oversight, competency, or qualifications). Psychologists' expertise in evidence-based treatments; their diagnostician qualifications; their knowledge of biopsychosocial processes; their expertise in consultation, supervision, and program evaluation; and their competencies for incorporating research into practice constitute some of the skills psychologists 'bring to the table' that would augment the delivery of patient-centered mental health care.[16] To fellow psychologists: we must judiciously highlight the unique contribution that we and our colleagues can make to the IPC team.

Training

Despite the unique skills and competencies needed to engage in effective practice, training programs do not often provide instruction or adequately prepare psychology students to practice integrated care.[18,19] Moreover, almost no training programs currently in Canada provide class or practicum training in IPC. Given that psychologists working within a primary care setting have a scope of practice and roles that are largely different from traditional service delivery, greater attention on training is needed. To the doctoral training programs and residency programs: continue being leaders in healthcare by offering training opportunities to foster the unique competencies practicing in IPC and other medical settings.

Legislation, Policy, and Incentivization

While there has been extensive research that highlights the advantages of including psychologists within primary care, essentially no government funding models (i.e., fee-for-service; blended capitation; MSP billing) cover outpatient services delivered by non-physician providers (i.e., psychologists).[20] This lack of funding inadvertently creates a barrier to the inclusion of psychologists because the specific salary ranges for non-physician providers can create financial incentives for primary care practices to recruit less-skilled, lower-salary staff over more extensively trained, yet higher-paid mental health professionals, like psychologists.[21] Moreover, these below-market salary ranges may not be sufficient to incentivize psychologists to pursue a career within IPC.[22,23] Despite recent recommendations for policy and legislation, reform may help to facilitate the appropriate compensation and recruitment of psychologists within primary care (wherein provincial and territorial governments could disperse funding directly integrated practices or indirectly to health authorities).[20] To the politicans, policy and decision-makers: keep listening to the science. We can do better. Let's make it happen.

I have recently likened the operation of our primary care system to an analogy of a plane. The government would never let a plane be cleared on the runway if it only had half an engine. Yet, we built our healthcare system, cleared it for operation, put it on the runway and fly millions of people with only half the engine. We would not even consider running the medical system without physicians—why do we think we can run healthcare without psychologists?

We don't need costly new buildings/wings/bricks and mortar solutions. We just need to have psychologists working alongside their medical colleagues in the existing primary care system. So, what are we waiting for?

With that, happy belated World Mental Health Day.

FOR A COMPLETE LIST OF REFERENCES, PLEASE GO TO CPA.CA/PSYNOPSIS

INNOVATION AND PSYCHOLOGY LEADERSHIP IN PUBLIC PRACTICE PSYCHOLOGY

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There is a new and exciting horizon in the professional psychology practice landscape in Ontario. Within the public mental health sector there is an increasing focus on using advanced data analysis, including leading-edge tools and technology, to design and deliver measurement-based care, evidence-based treatments, and to increase access to appropriate, quality care for Ontarians. Through this approach, we are increasing our capacity to provide effective, efficient, equitable, client-centered care that is accessible to individuals across the province. This approach helps to ensure that our health care dollars are more efficiently spent and that we can assure that people have access to the care they need, when and where they need it most.

The Ontario Structured Psychotherapy program is a provincial program that is designed, evaluated, and delivered within a structured framework. Specifically, the program aims to make evidence-based psychotherapy and related interventions available to people across Ontario with depression, anxiety, and anxiety-related problems. The program utilizes a stepped-care framework, which allows participants to be stepped-up or stepped-down between a suite of treatment options. Within this model, the intensity and focus of treatment is matched, in a dynamic and collaborative manner, to the client's needs. This program aims to decrease the wait to care, improve access to much needed resources, and to empower and engage clients in their mental health care.

As scientist-practitioners, psychologists are uniquely positioned to design, implement, and evaluate the programs and procedures within the OSP program; having psychologists involved in these undertakings facilitates the enactment of data-driven innovation and service excellence. The psychology program at the Canadian Mental Health Association – York Region and South Simcoe (CMHA-YRSS) is a demonstration of psychologists providing clinical, programmatic, and systemic leadership within the provincial program.

With unique insights into streamlining access to care, optimizing health systems and structures, and evaluating and enhancing programs, the psychology team at CMHA-YSS play an integral role in designing and implementing innovative services within the OSP program. One example that is proving to be particularly promising is the Bibliotherapy Centre of Excellence, a provincial resource operated by CMHA-YRSS. This Centre demonstrates service innovation through administration of two service arms: clinician-assisted bibliotherapy, and coach-assisted bibliotherapy (i.e., BounceBack). Our large, blended workforce (80 paraprofessional coaches and regulated health practitioners such as social workers and occupational therapists) provides remote-delivered services including screening, assessment and triage functions, as well as structured, evidence-based treatment and related interventions.

At our Centre, psychologists provide workforce oversight (i.e., no direct, patient-facing care), develop and deliver rigorous standardized training (initial and ongoing), and ensure fidelity to clinical protocols and operational procedures through continuous quality assurance and clinical consultation activities.

As program leaders, CMHA psychologists foster data-driven excellence by leveraging data measurement software embedded within a robust IMIT framework to evaluate program performance at the service, provider, and patient level.

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AN INNOVATIVE STEPPED-CARE COGNITIVE-BEHAVIOURAL THERAPY PROGRAM FOR DEPRESSION AND ANXIETY-RELATED DISORDERS IN ONTARIO

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Depression, anxiety disorders, and related problems are common conditions for which there are number of well-established, effective, psychological treatments.[1,2] Yet, many people with these problems often do not receive help, experience long waits for help, or receive treatments that are not supported by the best available evidence.[3]

The Ontario Structured Psychotherapy (OSP) Program was designed to increase access to effective treatments for depression and anxiety-related problems. OSP is funded by the Ontario Ministry of Health; the implementation process has begun, with plans to scale up across the province (https://www.ontario.ca/page/roadmap-wellness-plan-build-ontarios-mental-health-and-addictions-system).

OVERVIEW OF OSP

OSP provides access to evidence-based, publicly funded psychotherapy for depression and a range of anxiety-related problems, including generalized anxiety and worry, social anxiety, unexpected panic attacks and agoraphobia, phobias, health anxiety, post-traumatic stress, and obsessive-compulsive concerns. The program is based on the successful "Improving Access to Psychological Therapies" (IAPT) program in England, which treats over 600,000 per year in a stepped care framework.[4,5]

When fully implemented, the OSP program will have a number of core components:

- *Services Provided Within a Network Model* – Services will be delivered across Ontario through a "network model" consisting of a group of Network Lead Organizations and Satellite Delivery Sites.
- *Centralized Access* – Access to OSP services will be centralized within each network to facilitate efficient and equitable access.
- *Stepped-Care Model* – Similar to IAPT in England, clients will be matched to the appropriate level of service within a stepped-cared model. For example, clients may initially be matched to clinician- or coach-guided bibliotherapy or clinician-supported, internet-delivered cognitive-behavioural therapy (CBT), with the ability to step up to face-to-face individual or group CBT, depending on need.
- *Evidence-Based Interventions* – All interventions will be based on well-established interventions. Initially, interventions will be within a CBT framework, but over time other evidence-based approaches (e.g., mindfulness and acceptance-based approaches) may be incorporated.
- *Standardized Training* – Clinicians complete a standardized, blended training program with in-depth instruction in the fundamentals of CBT and the treatment of specific conditions. In addition to completing courses, all clinicians receive ongoing clinical consultation (usually from a psychologist) to ensure a high level of quality.
- *Measurement-Based Care, Performance, Assessment, and Accountability* – Standardized tools are completed throughout treatment, with data used to facilitate client progress. A standardized data system will be used to collect data to inform planning and quality improvement to achieve the goals of OSP.

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CPA HIG

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. NEW PSYCHOLOGY WORKS FACT SHEET – CLIMATE CHANGE AND ANXIETY

This new fact sheet was prepared by Dr. Lindsay J. McCunn, Vancouver Island University, Mr. Alexander Bjornson, Vancouver Island University, and Dr. Robert Gifford, University of Victoria. It deals with anxiety related to climate change in general, and anxiety before during and after climate events. It also discusses steps psychologists can take including advocacy and knowledge mobilization.

2. NEW PSYCHOLOGY WORKS FACT SHEET – PSYCHOLOGICAL INTERVENTIONS FOR ACUTE PAIN MANAGEMENT IN CHILDREN

This new fact sheet was prepared by Miranda Di Lorenzo, Shaylea Badovinac, and Dr. Rebecca Pillai Riddell, York University. It discusses the definition of acute pain, as well as assessment and prioritizing acute pain in children. It provides strategies for managing pain for infants and toddlers, younger children, and teens. It also discusses parental behaviours to avoid.

3. INDIGENOUS AWARENESS TRAINING ONLINE COURSES

Indigenous Awareness Canada (IAC) has created five Indigenous Awareness Training online courses and is providing discounts on those courses for CPA members. These courses are designed to help you and your organization, build positive, respectful, and effective relationships with Indigenous people in Canada.

4. QUANTITATIVE METHODS COURSES

Two Quantitative Methods courses that were offered during the 2020 CPA Virtual Series are now available as on-demand video. These non-credit courses are the first step in fulfilling the CPA's commitment to providing resources for students and researchers in the field of psychology. The courses, presented by Mark Adkins of York University, are 'Better (and Quicker) Data Cleaning using R and the Tidyverse' and 'Small Steps Towards Reproducible Data Analyses'.

HLIGHTS

5. PODCASTS

The CPA podcast *Mind Full* launched it's first season in December, featuring four guests who discussed COVID and the upcoming winter in detail, and later formed a panel to do a webinar on the same subject. *Mind Full* also featured Dr. Christine Korol of the Vancouver Anxiety Centre, and Dr. Stephen Shainbart, New York - Toronto psychologist and author of *I Actually Did It! Becoming Canadian Because of Trump*.

6. CPA WEBINAR: COVID AND THE CANADIAN WINTER

The CPA convened an expert panel to discuss four different facets of the pandemic and the cold Canadian winter. Drs. Ben Kuo, Heather Hadjistavropoulos, Yael Goldberg and Janine Hubbard gave short presentations and answered questions concerning racism, teletherapy, anxiety, isolation, and children. The webinar was recorded and is available on the CPA YouTube channel.

7. CAREER FAIR

On November 12, 2020, the CPA, in collaboration with the Canadian Society for Brain, Behaviour and Cognitive Science (CSBBCS), hosted its first ever Career Fair. Held virtually, the fair was a huge success, providing over 70 students and faculty, an opportunity to hear about the various career paths available to psychology graduates outside of academia and health practice. Many thanks to the various mentors who shared of their time and insights! Building on the success of this event, the CPA will be hosting more career-focussed events for our student affiliates and members throughout 2021 including sessions on preparing your CV, preparing for an interview, and financial wellness.

8. CAREER HUB

As part of the CPA's Inaugural Career Fair, the CPA was pleased to launch a Career Hub on our website. Visit this page regularly for career-development information; new information will be added regularly. It is available on the CPA website under the Resources tab.

9. NANOS RESEARCH PUBLIC OPINION SURVEY

On December 2, 2020, the CPA and the Council of Professional Associations of Psychologists (CPAP) issued a news release that summarized the findings of a recent public opinion survey of more than 3,000 Canadians undertaken by Nanos Research. The news release, 'COVID-19 Worsening Canadians' Access to Psychologists', and the survey results can be found on the CPA website.

10. HEAL RELEASES BEYOND COVID-19 DOCUMENT

CPA is a founding member of HEAL (Organizations for Health Action). On November 17, 2020, HEAL released their recommendations for a healthier nation, 'Beyond COVID-19'. Among the recommendations: "Working in partnership with the provinces and territories, and other key stakeholders, increase funding for sustainable, evidence-based mental health services and supports to meet the growing demand for timely access to mental health care."

CPA MEMBER SPOTLIGHT

R. NICHOLAS CARLETON

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ERIC BOLLMAN
Communications Specialist,
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"One of the things you might do as part of an assessment is hand somebody a list of potentially psychologically traumatic events, called the 'life events checklist'. I remember being a student going in with my checklist, focused on trying to do a good job with an assessment. It happened to be an RCMP officer I was interviewing, and I handed him the questionnaire. I said, 'you just check the box on how many of these things you've seen, or that you've experienced'. He looked down at the list, then back up at me and said, 'do you mean…this week?'"

It was at this point that Dr. R. Nicholas Carleton realized just how off the charts exposure rates really were for public safety personnel (PSP). Whenever one of us interact with a paramedic, firefighter, or a police officer, it is likely that the interaction takes place during a potentially psychologically traumatic event—one for which we might tick off one of the boxes on the questionnaire. It is also likely that for the PSP attending that event, it is one of several in that shift alone.

PSP include many other personnel—border security, correctional workers, communications officers and officials, operational intelligence personnel, search and rescue, dispatchers, and many more. Across the board, they screen for mental health disorders at about five times the rate of the general public. We know this thanks to a study done by Dr. Carleton and his colleagues that began in 2016.

Before that study, there were almost no Canadian data available when it came to, for example, the instance of PTSD in RCMP personnel. To address this paucity of data, Dr. Carleton proposed the creation of the Canadian Institute for Public Safety Research and Treatment (CIPSRT) in 2015. Shortly thereafter, he published the first CIPSRT-related study, which highlighted the lack of research that had been done on these subjects up to this

point. Thanks to that publication, the demand for research—including longitudinal studies into prevention programs for mental health disorders—grew, most notably among the PSP groups themselves.

And so began the first of many studies. The study Dr. Carleton and his team began in 2016 involved more than 9,000 PSP in an unprecedented national data collection effort. That study later became a research article in the *Canadian Journal of Psychiatry*, and that became the first research article in the history of Canada (we believe) to be cited in a Canadian federal budget. Thanks to that citation, and the work of this group, $30 million was allocated to the support of CIPSRT-related activities, including a consortium effort with the Canadian Institutes of Health Research.

This issue of *Psynopsis*, however, is about innovations in healthcare and not innovations in data collection. And that brings us to the next steps. A free and anonymous online tool was created to help PSP from across Canada assess their own mental health and seek support should they need it (you can go to the CIPSRT site and try it out right now—surveys will compare your mental health to that of frontline PSP in a variety of disciplines, and suggest the next steps you might want to take as a result.) Tens of thousands of PSP in Canada have used this tool, and it may only have increased in usefulness with the onset of the coronavirus pandemic.

Then there's the ongoing Longitudinal Study of Operational Stress Injuries (OSI) at the RCMP. What's that old cliché about the desirability of real estate? That the three most important things to consider are location, location, and location? The same might apply to Dr. Carleton's research, which happens to be taking place in the absolute best possible location—Regina. Dr. Carleton is one of those unicorns in the academic world where he started at the University of Regina as an undergrad, then returned to do his Master's and his PhD at the same institution, and is now a professor in the very same place. The same place that is just up the road from the RCMP Depot.

All RCMP cadets in Canada are trained at the Depot in Regina. As a result, Dr. Carleton and his team have direct access to every recruit the moment they set foot on the grounds of the academy and can follow them through training, all the way to deployment, and beyond. It is because of this that they can both conduct this study and provide those cadets with some of the tools that they can use to increase resilience and boost the effectiveness of treatment from the very beginning.

All cadets who graduate and are deployed will have knowledge that Dr. Carleton hopes will help them avoid the many exposures to potentially psychologically traumatic events and mitigate the effects of those events. And, worst case, be familiar enough with mental health practices by that time that they are better able to cope, and more likely to access mental health help, which in turn will be delivered more efficiently and more effectively thanks to their familiarity with the subject matter.

Those graduates will be followed over the next several years, with self-assessments and reports of event exposures creating a greater understanding of how, and where, the most help might be delivered. Dr. Carleton says he hopes that within 5-7 years, the picture created by this research will be complete enough to inform an even more concerted strategy going forward. One day, the hope is that the solutions coming out of this endeavour will be used by all PSP across Canada.

And finally, there's the internet-delivered Cognitive Behavioural Therapy (iCBT) program for PSP, called PSPNET. The project is designed to provide immediate and personal mental health treatments to the PSP across Canada who are, as Dr. Carleton says, under-served by the current mental health systems. This program rolled out in a big way by July of 2020, reaching PSP in Saskatchewan and Quebec. Already, other provinces are clamoring to be included, and it looks like only a matter of time until it is nationwide.

Here, Dr. Carleton credits his colleague Dr. Heather Hadjistavropoulos for being a huge driving force – something he does throughout our interview. He credits his graduate students for being the ones to collect what data was available for PTSD in PSP, and for identifying the enormous gaps in that research. He is very quick to recognize that while he is the face and the voice of much of this work, there is a big, brilliant, and highly engaged team alongside him that make these goals attainable.

In speaking with Dr. Carleton, it is very apparent why he has become the voice and face of these projects. He's a great communicator, able to explain complex ideas in a clear and thoughtful manner, such that I can see him comfortably describing biological measures of mental health injuries to a class of third graders. There is an ease about him, and a simplicity of message, that makes him the ideal vehicle for knowledge mobilization such as this.

That ease also makes those who speak with Dr. Carleton more likely, I think, to open up more than they otherwise would. By the end of our interview, I found myself confessing to him that I had completely ignored my deadline for *Psynopsis* and that this whole thing had snuck up on me, so I was reaching out, very last-minute, to learn more about his research. It was extremely kind, I think, for him to accommodate such a request, and I can't help but think that even back when he was a graduate student interviewing RCMP officers, that he was able to elicit from them a similar desire to share more of themselves than they would with most anyone else. It's a trait that I imagine led to Dr. Carleton's career in psychology, and eventually to these groundbreaking advancements in the mental health care of PSP.

Canadian Psychology
Psychologie canadienne

BUILDING A CUMULATIVE PSYCHOLOGICAL SCIENCE

AN UPDATE FROM CANADIAN PSYCHOLOGY / PSYCHOLOGIE CANADIENNE

The past decade has witnessed much debate and controversy in the psychology literature over the replication crisis or the failure to reproduce many of psychology's most prominent findings. The November 2020 special issue of *Canadian Psychology / Psychologie canadienne* features articles examining the causes for and responses to the replication crisis. The editors of the special issue, Vina Goghari from the University of Toronto, and Donald Sharpe from the University of Regina, noted that Canadian psychology journals have not focused much attention on the crisis, which is ironic given papers published in *Canadian Psychology / Psychologie canadienne* predicted the current crisis as far back as thirty years ago.

To call attention to this omission, the editors invited respondents drawn from various areas of psychology and from both Canada and the United States were asked to reflect on where the replication crisis stands and how researchers can build a more cumulative science. Respondents included Rex Kline, author of the multi-edition *Principles and Practices of Structural Equation Modeling*, Stephen Lindsay, former editor-in-chief of Psychological Science, and the late Scott Lilienfeld, editor-in-chief of *Clinical Psychological Science*.

Causes for and responses to the crisis that were highlighted by contributors include theory, measurement, preregistration, data analysis, questionable research practices, journal publication policies, research collaborations, and meta-analysis. Although there are no easy solutions to the replication crisis, no area of psychology is immune to the crisis, and there is no one cause for the replication crisis - the editors and contributors highlighted the need for more theory based confirmatory work in psychology, the need to intensify focus on measurement issues, the need to focus on preregistration of studies, and the need for journal editors as the gatekeepers of science to promote and reward best practices.

A number of the contributors spoke to the importance of graduate training to produce more replicable research. Through collaboration and conversation, the editors and contributors in the November 2020 special issue of *Canadian Psychology / Psychologie canadienne* share the hope that psychology will build a cumulative psychological science.

Read our open access Editorial here:

Sharpe, D., & Goghari, V. M. (2020). Building a cumulative psychological science [Editorial]. *Canadian Psychology/Psychologie canadienne*, 61(4), 269–272. https://doi.org/10.1037/cap0000252

Read our American Psychological Association Journals Article Spotlight here:

https://www.apa.org/pubs/highlights/spotlight/issue-202

PSYCHOLOGY IN THE SPOTLIGHT

THE DIAGNOSTIC ASSESSMENT RESEARCH TOOL (DART):

A NEW, OPEN-ACCESS PSYCHODIAGNOSTIC INTERVIEW

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The Diagnostic Assessment Research Tool (DART)[1] is an open-access, semi-structured diagnostic interview to assist with the assessment of DSM-5[2] diagnoses. The DART was developed in Canada by psychologists, primarily at St. Joseph's Healthcare Hamilton, to address several challenges with the existing psychodiagnostic interviews including the shift to pay-per-use model, limited disorder coverage, lengthy administrations, and low reliability for some disorders.

The DART consists of distinct modules allowing for flexible administration in clinical and research settings. Interviewers can choose to administer all modules or select only the relevant modules to inform their diagnostic questions and determine the order of administration. The complete DART consists of:

- *Diagnostic modules* that assess mood disorders, anxiety disorders, obsessive compulsive and related disorders, trauma and stressor-related disorders, feeding and eating-related disorders, substance-related and addictive disorders, somatic symptom and related disorders, insomnia, attention-deficit/hyperactivity disorder, and borderline personality disorder. Each DART module contains mandatory, criterion-based questions, as well as optional clarifying questions to ensure diagnostic accuracy and aid learners.
- *Screening modules* for psychosis and suicide, non-suicidal self-harm behaviour and homicide risk.
- *Summary modules* for background information, behavioural observations, and diagnostic impressions and treatment plan.
- *A self-report screening questionnaire module* that can be used independently or completed prior to the DART to identify which diagnostic modules to administer.

The DART was developed in stages. First, DSM-5 mental disorders were divided among expert clinicians to write interview questions for specific modules. Second, the modules were designed and reviewed for accuracy and to ensure consistency in the style of questions and response options to ensure ease of use. Third, the DART was piloted over a one-year period in private practice, hospital, and university research settings. Fourth, feedback from pilot users was incorporated and the modules were revised. The fifth phase, a comprehensive study of the psychometric properties of the DART, is currently ongoing and is funded by the Canadian Institutes of Health Research. For more information visit https://psychiatry.mcmaster.ca/research/dart, or to obtain a copy of the DART please contact Dr. Randi McCabe at rmccabe@stjosham.on.ca.

FOR A COMPLETE LIST OF REFERENCES, PLEASE GO TO CPA.CA/PSYNOPSIS

JESSICA D'ARCEY
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ETHICS AND EFFICACY

THE USE OF MOBILE APPLICATIONS IN AN INCREASINGLY DIGITAL HEALTHCARE SYSTEM

In the wake of the global shut-down in March, we saw an impressively rapid uptake of digital delivery of mental health services, or telepsychology, in order to continue to meet mental health demands, and potentially even increase access to services in our communities. However as an already overburdened system, we are now seeing the full effects of what public health has referred to as "the tertiary wave of COVID-19," which is the spike in mental health challenges stemming from social isolation, pandemic fatigue, and loss of typical coping mechanisms. In Toronto, for example, we are currently experiencing the peak of mental health referrals that is higher than previously recorded.[1]

A common proposed solution to such acute demand is to recommend self-directed, asynchronous digital tools, like smartphone applications. Owing to the tremendous popularity and growing ownership of smartphones, mobile applications directed at mental health challenges offer scalability that few other mental health services can, by overcoming traditional barriers to care and extending treatment opportunities beyond the clinic and into real life and real time. Despite the enormous promise of such healthcare innovations, there is also growing concern of the commercialization, and commodification of mental healthcare.

Mobile applications, even when marketed as mental healthcare tools, do not need to be registered with a regulatory body like FDA or Health Canada to be available to consumers on app stores. This means that the applications available for download are not required to be evidence-based, yet can be advertised and marked toward individuals with mental health concerns. In fact, if you look through your app store on your smart phone, most of the apps available have no academic or healthcare centre support and no available published research, which seriously calls into question the efficacy and effectiveness of these tools.

While well-meaning, the attitude of "it's better than nothing" is a dangerous one, because as we've seen with other mental health interventions, we really can't know if it is better than 'nothing' without adequate randomized control trials. Even if the program claims to follow evidence-based therapy, mobile applications may not be an effective delivery platform. Further, without rigorous testing, we also cannot quantify potential harm to ensure that the benefits of these digital programs, do in fact outweigh potential harms. In fact, even the majority of applications with published, peer-reviewed research, have only produced pilot trials, or trials within the general user-base and examine general stress and wellbeing, with varying effect sizes.[2] Without trials in clinical populations, we definitely cannot claim these tools as a replacement for guided mental health services.

Beyond questions of efficacy and effectiveness, there are also fundamental ethical concerns that require attention, such as user safety and privacy. Most mental health mobile applications do not include a feature to connect with a certified clinician, nor do they typically provide crisis resources, given difficulties providing geographically appropriate information in globally available applications. On top of this, many of the applications are not evidence-based practice-informed, meaning they do not necessarily follow evidence-based manuals or principles.

Additionally, as we've seen in popular examples such as Facebook, large tech companies, have the ability to share your data without explicit informed consent. Many mobile application privacy policies found on the app store are often vague, missing important information on data sharing, or have language that requires a high reading level (grade 13+) in order to understand.[3] Common data sharing purposes are to better understand user characteristics and the use of the app by internal or external evaluation teams; however, there is also the possibility of selling personal information, such as in the case of Facebook, in order to allow for targeted ads—which, if the content of the ads is related to mental health, could be a triggering experience.

Another ethical consideration comes from a health equity perspective. Often the most vulnerable individuals within clinical populations do not have access to smartphones, cellular data packages, or wireless internet; and further, may not have the digital literacy skills to effectively use the applications, even if provided with the device. So even when we can identify mobile applications that may be beneficial, we need to be mindful of such disparities in our system planning and healthcare recommendations.

It's not all bad news when it comes to mental health apps! There is promising research on blended therapies, which encompass professionally guided psychotherapy with the use of mobile applications as an adjunct tool to facilitate collaborative care. Two growing areas of use include the collection of ecological information about patients to help clinicians better understand their clients lives outside of session, as well as a behavioural support mechanism for collaborative goals determined in session to increase the generalizability of skills.[4]

With so many red herrings, however, it can seem daunting to even consider adding a mobile application into your therapeutic repertoire. Well, more good news! Despite a lack of regulatory oversight, other professional bodies, like the American Psychiatric Association (APA) with efforts led by Dr. John Torous[5], have been hard at work to create evaluation tools to help clinicians with such decisions. Recently, they have paired with an accessible website called "Bridging Apps"[6] which under their 'find an app' feature can help identify vetted and evidence-based options for adjunct digital therapeutics.

FOR A COMPLETE LIST OF REFERENCES, PLEASE GO TO CPA.CA/PSYNOPSIS

CAMPUS CORNER
YORKVILLE UNIVERSITY

SUMAN BANIK
Chair-Elect, CPA Student Section

Yorkville University's Master of Arts in Counselling Psychology (MACP) program is offered completely online. The virtual platform is what makes this program diverse and accessible, allowing students from all over Canada and abroad to engage. Despite being online, the platform does not interfere with student life since class sizes are small which allows students to connect on the platform and/or transition to meet in person. Students can benefit from other's support while navigating the complex world of counseling psychology. The staff are supportive of students with disabilities and created a platform with text-to-speech, as well as providing tailored accommodations when needed. Yorkville also offers free counselling sessions and academic support for its rigorous curriculum. Although the program is academically challenging, the professors are supportive and come from various counselling backgrounds throughout North America.

Unlike other universities, Yorkville is more theory-based for the purpose of practical application (versus programs that are heavily influenced within the scope of research); however, the program's flexibility can allow students to gain more experience or engage in research outside the curriculum. The program is flexible, allowing students to take breaks between courses, and coursework does not require students to participate in a set schedule. This allows students to work full-time while completing their degree. Also, unlike many counselling programs, there are more electives to help students streamline their interests within psychotherapy. Yorkville's courses explore counselling theoretical frameworks, but also include a Skills Learning Lab preparing students for practicum. The courses involve group work and practicing developing skills alongside other students and professors. These skills are essential for excelling in practicum. Like other counselling programs, obtaining practicum can be challenging; however, the large student network and faculty guidance provides students with connections and resources to find local placement opportunities. In addition to this expansive network, Yorkville provides various podcasts and occasionally has speakers assisting students in keeping up to date with counselling concepts that prepare them for their role as a registered psychotherapist (RP).

Yorkville is also part of eight professional designations for receiving RP accreditation, including the Canadian Counselling and Psychotherapy Association. These designations facilitate students to practice locally and between provinces. For students interested in continuing beyond their RP designation, Yorkville offers their new Doctorate of Counselling Psychology program. Additionally, students can apply to other doctoral programs outside the school.

HAVE YOUR SAY

FIONA CUNNINGHAM
MEd, C.C.C., Fielding Graduate University,
Clinical Psychology PhD Student (Class of 2024)

In reflection of the question posed by *Psynopsis* in a previous issue about how psychological practice, research, and academics might change as a result of COVID-19, I am brought back to a session I attended at the May 2019 CPA Annual Convention. In the session, Dr. Mikail reported on the 2019 Montreal National Summit on the Future of Professional Psychology Training. A statement he made is reflected in an article subsequently published sharing the overview and recommendations from the summit: "The Standards and Models working group recommended that…existing programs should establish satellite or distance programs aimed at serving northern, rural, and remote regions and practice".[1]

As a student at the only APA accredited PhD program in Clinical Psychology that is based on a distributed learning model, I know that the establishment of such satellite or distance hybrid models is not only feasible, but a model to do so already exists. Fielding Graduate University (FGU) has been both a distributed learning program and APA accredited since 1991. Diversity and Social Justice are two of the core values of the school that are enacted in the learning model. The distributed model creates accessibility to diverse learners along with an awareness of the social justice implicit in doing so. These values feel shared with the CPA in their desire to establish professional psychology programs that would serve northern, rural, and remote regions.

As we move through our COVID-19 experience, our concept of residency, professional socialization, and use of online learning in clinical psychology doctoral programs is adjusting accordingly. As Zoom fatigue is experienced by students who perhaps never before used video conferencing as a learning platform, it is acknowledged that the use of online learning as an aspect of training is in no way an easier modality for learning than classroom learning. Moving beyond classroom walls means students can be socialized to the profession in a way that goes beyond the current regionalized training with inherent restrictions of being tied to a physical location. Faculty can be recruited from across the country into such programs thus contributing to a theoretical, research-based, and clinical heterogeneity that benefits both university's community of students and faculty. Thus, more opportunities along with broader and more diverse professional socialization are created than can be afforded in traditionally structured training systems.

During the Montreal Summit, Dr. Bradley's message was that "in order to build mentally healthy people we need to build mentally healthy communities".[1] Building mentally healthy communities can be facilitated by training community members to become psychologists from within their communities. When prospective doctoral clinical psychology students have to leave their communities for five or more years to complete training the community suffers the loss of the individual and vice versa. This loss may be felt more profoundly in more culturally collectivistic communities. Providing better opportunities for healthcare professionals to be built from within that community may help to break the constraint of postal codes as determinants of health outcomes. A distributed learning model can help to do so.

I applaud the CPA's vision to deliver high quality training in professional psychology programs regardless of postal code and believe that our COVID-19 experience has launched us into an examination of the reality and feasibility of tele-health and tele-learning and our preconceived implications of them. I believe our COVID-19 experience has begun to show us that we are capable of creative thinking and problem solving to achieve a realization of Recommendation 13 of Breakout Group #1, as well as many other Summit recommendations.

FOR A COMPLETE LIST OF REFERENCES, PLEASE GO TO CPA.CA/PSYNOPSIS

THE INTERNATIONAL UNION OF PSYCHOLOGICAL SCIENCE

ROLE, FUNCTIONS, AND CURRENT ACTIVITIES

SABA SAFDAR
PhD, Psychology Professor, University of Guelph, Head of the Canadian National Panel for IUPsyS, Member of the International Relations Committee

The International Union of Psychological Science (the IUPsyS), which was established in 1889, represents more than one million psychologists worldwide through national member organizations. The IUPsyS has currently 82 national members and 20 affiliated organization members. The CPA, in partnership with the National Research Council of Canada, represents the interests of Canadian psychologists in the IUPsyS. Within the CPA, the work to maintain our membership falls to the newly formed Canadian National Panel for IUPsyS, which is part of the International Relations Committee. The Canadian delegates to the IUPsyS General Assembly are currently John Berry and Saba Safdar.

The main focus of the IUPsyS is developing and promoting psychology globally. This is done through sponsoring the flagship (ICP) every four years and co-sponsoring other regional conferences of psychology. The 32nd ICP was scheduled to be held in Prague, Czech Republic in July 2020 and is now rescheduled due to COVID-19 to July 18-23, 2021. The Congress theme remains the same, 'Open Minds, Societies and the World'. More information about the ICP 2020+ can be found at www.icp2020.com.

An important function of the IUPsyS is to participate in major global organizations such as UNESCO, the World Health Organization (WHO), and the International Council for Science. For example, the IUPsyS contributes to implementations of UNESCO's programs and participated in the revision of the International Classification of Disease by the WHO. The IUPsyS also contributes to psychological knowledge through publication. This includes the *International Journal of Psychology* and the IUPsyS monthly *Bulletin*. The *Bulletin* provides brief information and updates on the work and activities of the IUPsyS and related regional and international matters. It is circulated by email to its National Members, Affiliates and related organizations, and to others requesting to receive it. It is available free in PDF format at https://iupsys.net/publications/bulletin/index.html.

As reflected in the content of the last issue (2020, Vol. 12, No 03), the IUPsyS, as "psychology's global voice," recently expressed concerns over "blatant racism in the USA" and urged the country's leaders to end violence against its own citizens. The *Bulletin* also provided information on response to COVID-19. This included the World Health Organization (WHO) guidelines and reports concerning preventing the spread of COVID-19 and its effects on mental health (e.g., https://www.who.int/emergencies/diseases/novel-coronavirus-2019).

Visit the IUPsyS website https://www.iupsys.net/) for further information about the activities and publications of the International Union of Psychological Science.

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INFORMED.
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Innovation and Psychology Leadership in Public Practice Psychology

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Psychologists use this data to inform clinical consultation with our workforce and iterative adaptations to program design/operations. Psychologists also work closely with Master's-prepared data analysts on our team, and external academic research partners to consult in the design and implementation of rigorous research activities (e.g., economical evaluations). Outcomes of these activities inform clinical and operational work planning, and bolster communications with internal and external stakeholders.

At the provincial level, psychologists participate in interprofessional governance committees of the OSP program. Psychologists demonstrate thought-leadership in their expert presence at the clinical, training, and implementation tables. Psychologists help to determine the required services across treatment areas and design the programs, content, structure, resources, and measures to meet program needs and goals. Further, they help to deliver and evaluate the structured, program-wide training that all OSP providers undergo. Finally, psychologists then help to ensure the standardized and data-driven implementation and operation of the services of the OSP program across organizations. Psychologists' expertise naturally aligns with the required skills for leadership of initiatives, including communication with stakeholders involved in funding and promotion of programs. Our capabilities and deep knowledge of program design, evaluating service outcomes, workforce performance, and operational data, as well as the ability to measure, monitor, and iteratively enhance services and practices, are key to leadership within this space.

The current climate in public sector mental health care in Ontario is a cause for optimism: the potential of innovative, remote-delivered services to increase access and enhance the quality of mental health care is becoming clear. Extending the reach of evidence-based quality care while monitoring and enhancing services to ensure they are accessible and acceptable is a key piece of our work. So too, is the role of psychology leaders in the science-informed design, implementation, and evaluation of these services.

An Innovative Stepped-Care Cognitive-Behavioural Therapy Program for Depression and Anxiety-Related Disorders in Ontario

Continued from page 21

Increasing access to CBT is an important goal of OSP. This will require ensuring that our services are appropriate, acceptable, and adapted (as needed) for individuals from groups that are often under-represented or inadequately served in the mental health care system, including individuals without access to health care benefits, people with low incomes, people who identify as Black, Indigenous, and/or of colour, people who are Francophone, people who identify as LGBTQ2S+, people living with disabilities, and people living in remote areas.. The program will collaborate closely with individuals from these groups and communities to ensure that it meets their needs.

INTERPROFESSIONAL APPROACH

OSP is based on an interprofessional approach to care. Therapists include clinicians who are registered in professions that can provide psychotherapy, which is a "controlled act" in Ontario. A primary goal of the OSP initiative is to increase the overall capacity of regulated therapists within Ontario to provide high-quality and empirically supported treatments for depression, anxiety, and related disorders. In addition, the development of this program involves significant contributions from experts across different disciplines in the areas of program and systems development, operations and implementation, education, clinical training, evaluation, and research. This approach has led to the development of a highly robust and well-informed model for clinical care delivery.

Psychologists have played a significant role in the clinical management, consultation, operations, and research aspects of OSP, at both the provincial and regional levels. Psychologists within OSP have leveraged their training and clinical experience in the development of the clinical model for treatment delivery and the training and consultation framework that underlies the training of all the regulated therapists. In addition, the day-to-day operations across each of the four network lead organizations has often relied on the clinical leadership of psychologists. Psychologists have been tasked with assisting with implementing the regional programs, providing the core training and consultation to the therapists being trained in the delivery of CBT, and evaluating the effectiveness of the program using a standardized approach to outcome monitoring. Psychologists are uniquely suited to bridging the gap between science and implementation, and as such, have been able to significantly contribute to the success of this project.

CONCLUSION

The importance of the OSP program lies not only in the provision of high-quality, empirically supported treatments across the province, but also in the development of a robust infrastructure (including a high quality and standardized data system) that supports the continued development of a coordinated and organized service delivery model in Ontario. Such a model must be formed upon the principles of empiricism, competence in implementation, as well as accountability to our clients and stakeholders. Robust relationships must exist across academia, primary care, community, and hospital-based organizations to cement a coordinated response to the rising mental health needs of Ontarians. Any such system of care must also be flexible, responsive, include multiple treatment options of varying intensities, and be available in different formats. We believe that the OSP program has done this through the development of a centralized intake and stepped-care system of treatment, well-developed community and hospital-based partnerships, and with interprofessional expertise among staff and leadership. Through its innovative approach and infrastructure, we believe that the OSP program will be instrumental for the future of mental health treatment in Ontario, and potentially beyond.

FOR A COMPLETE LIST OF REFERENCES, PLEASE GO TO CPA.CA/PSYNOPSIS

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