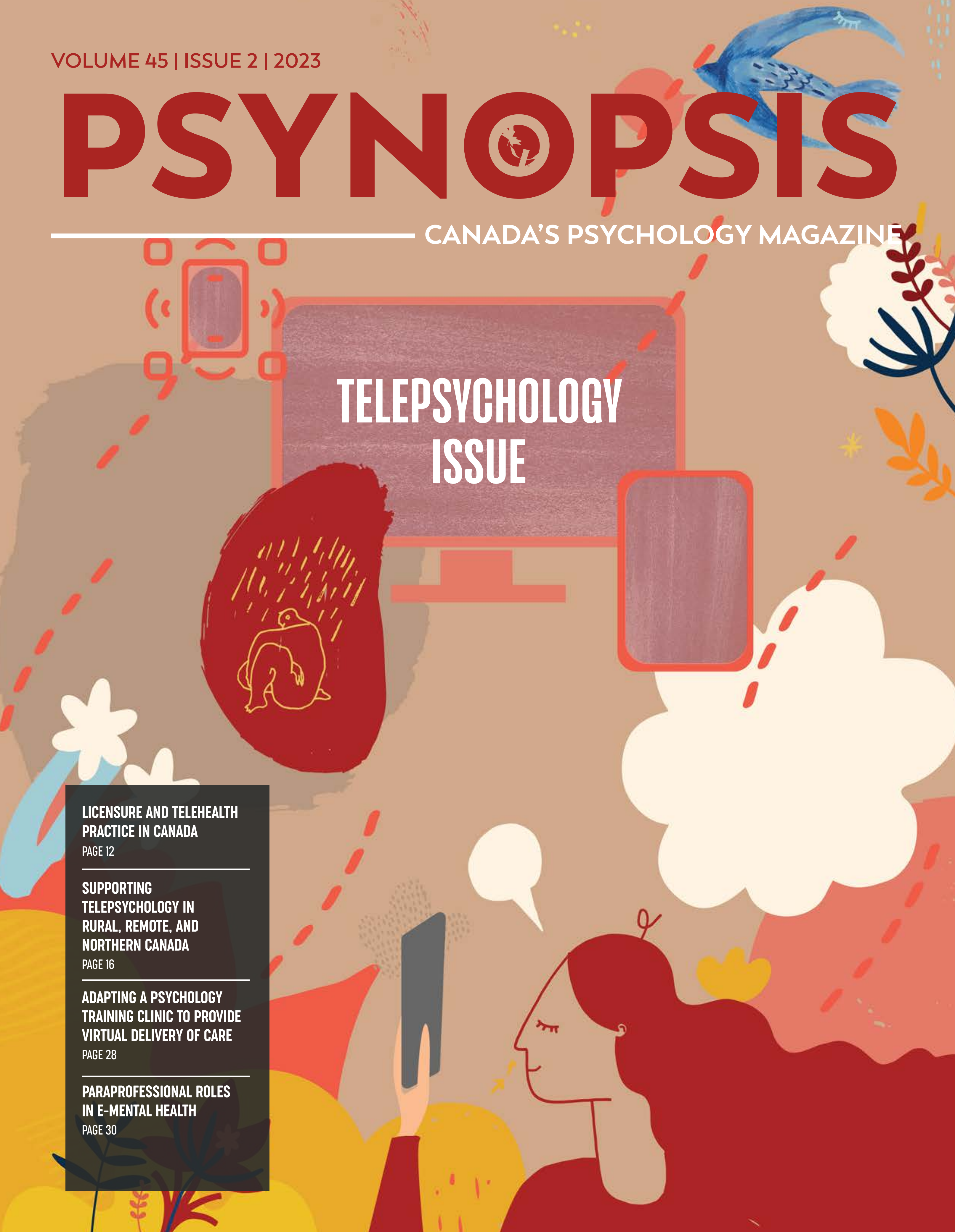
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PSYNOPSIS
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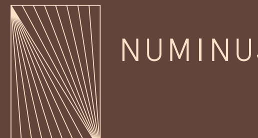

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CANADA'S PSYCHOLOGY MAGAZINE

THE OFFICIAL MAGAZINE OF THE CANADIAN PSYCHOLOGICAL ASSOCIATION

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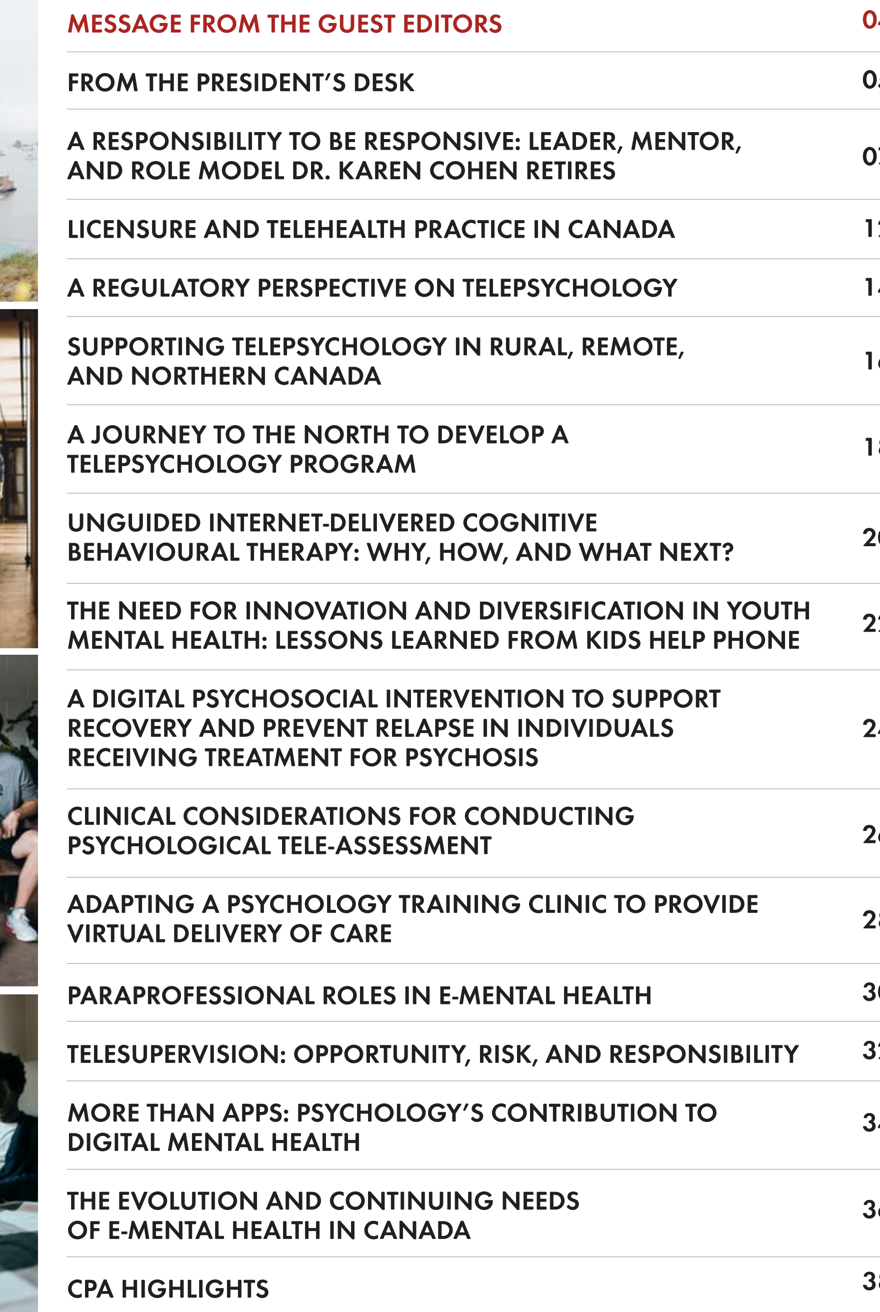

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MESSAGE FROM THE GUEST EDITORS

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The COVID-19 pandemic forced psychologists worldwide to modify how they offered their services. Most shifted to telepsychology, defined as the provision of psychological services using telecommunication technologies such as telephone, mobile devices, interactive videoconferencing, e-mail, chat, text, or self-help websites. Canada had already been a leader for decades in providing empirical evidence for the use of these technologies: clinical trials were conducted in Canada in the late 1990s,[1,2] with several contributors to this special issue being actively involved in research or policy development during that time.

In the early 2000s, telepsychology was conceived as an option to provide service to people located in rural or underserved communities. Several governing bodies and professional organizations had established basic guidelines and legislations, but most considered telepsychology as a solution to provide services to "people located far away." Very few considered telepsychology as a means to provide services "from anywhere" (e.g., a psychologist located in a rural community may provide services to a patient who lives in an urban area.)

Then COVID-19 struck, requiring professionals to adjust their practices, organizations to adapt their models of service delivery, and regulating bodies to revise their guidelines and rules. The Canadian Psychological Association (CPA) struck a Telepsychology working group in fall 2020, chaired by two Board members, Dr. Laurie Ford and Dr. Elizabeth Church, to identify actions CPA should take to support Canadian psychologists with their telepsychology practice. In November 2021, the Board approved 11 recommendations from the working group, including having a special issue of *Psynopsis* on telepsychology, advocating for equitable access to virtual care, and developing CPA guidelines on telepsychology.

The CPA *Guidelines on Telepsychology* were developed to highlight the needs and accountabilities of the practice environment in seven domains: ethics, standards, and legal considerations; technical issues, administrative and organizational considerations; assessment; intervention and consultation; equity and access; training; supervision. Draft guidelines were circulated for consultation in February 2023 to a wide range of stakeholders, including experts in telepsychology, CPA sections and committees, regulators, and provincial psychology associations.

The final CPA *Guidelines on Telepsychology* will be submitted to the CPA Board for approval in June. The objectives of the guidelines are to offer guidance to Canadian psychologists regarding telepsychology practice; identify advantages and benefits; alert psychologists to the risks, potential harms, and challenges; and provide a framework for psychologists to assess when telepsychology may – or may not – be appropriate and/or warranted.

The articles in this special issue of *Psynopsis* address central areas in relation to the practice of telepsychology, including the changing regulatory landscape, tele-assessment, innovative models of providing services electronically, the benefits and drawbacks of telepsychology for different populations and communities, telesupervision, and providing remote training.

FROM THE PRESIDENT'S DESK

KERRI RITCHIE Ph.D., C. Psych. (CPA President 2022/2023)

Timely access to mental healthcare services is something the profession continues to speak to and for which we advocate. What we mean by access changes with time, the pace of technological change, and our approach to integrating technology into our practices.

When I was an early career psychologist, I worked in high-risk pregnancy, and I quickly learned that the traditional model of coming in to see one's psychologist in an office could result in multiple barriers for accessing care. From obtaining childcare, transportation, cost of travel and parking, through to medical conditions that could severely restrict mobility, I discovered the effectiveness of telepsychology, which at that time was the landline telephone (!)

The COVID-19 global pandemic has accelerated on-the-ground innovations, and the speed with which organizations updated platforms, portals, and introduced secure charting systems was unparalleled. All of the sudden, offices could be contained within a computer and care could be accessed through smart phones, tablets, and computers. This broke down walls, as well as many of our preconceptions of how we could provide care; and the opportunities and challenges of working from home for many became the solution to work-life integration.

When the pandemic started, I was providing bed side care to individuals throughout the inpatient units in our hospital. Now, I am providing services to medical staff and employees at The Ottawa Hospital, both on-site and virtually. None of these are models in which I was originally trained, but each of them increases access and removes barriers to care.

In this issue of *Psynopsis*, telepsychology in rural and remote areas, partnerships with Indigenous communities, and the use of digital health innovations such as live chats and unguided internet therapy demonstrate that the possibilities of transforming our care models to focus on both quality and access are within our grasp. As we continue to advocate for funding parity for mental health in health care, we have the opportunity to shape and continue to evolve in the ways in which we meet the needs of our diverse communities.

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, healthcare 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.

A RESPONSIBILITY TO BE RESPONSIVE: LEADER, MENTOR, AND ROLE MODEL DR. KAREN COHEN RETIRES

Eric Bollman, CPA Communications Specialist

"I've always been impressed with Karen's tireless dedication to the profession of psychology and to the role of the CPA. She's not just an employee, she's a shareholder who represents the best of what the profession has to offer."

- Glenn Brimacombe, Interim CEO, CPA, former CEO of the Canadian Psychiatric Association

At the CPA, we strive to acknowledge, boost, and spotlight all the best of what psychology has to offer. This includes the more prominent aspects of the profession, like the mental health side of things where clinical psychologists can help people through difficult times by providing therapy, guidance, and support. It involves research, helping to understand human functioning and behaviour. It involves advocacy, like using research to help inform public policy where human behaviour is integral to success. Education is part of it too, teaching and informing people about mental health, substance use, critical thinking, and general well-being.

In all these aspects and more, Dr. Karen Cohen has been an exemplary role model. As the CEO of the CPA for the past 15 years, she has had to be. Trained in clinical psychology, and having worked as a clinician, Karen brought that knowledge and experience to her role as CEO.

"My Ph.D. was in clinical psychology, and I did a postdoc in neuropsych and rehabilitation. I worked as a clinician for the first third of my career, and also did some part-time work as the Registrar of Accreditation at the CPA. In those days, I worked one half day a week as Registrar, if you can imagine that now, given the number of accredited programs we have!"

Around 2001, the CPA decided to expand its staffing and created the position of Associate Executive Director. Karen moved seamlessly into that role from her work in accreditation, expanding her portfolio and helping to create a strong advocacy arm for psychology in Canada. When former Executive Director John Service stepped down, Karen threw her hat in the ring for the job.

"One of the things I feel the most proud about, from the time of my CPA presidency, is that the official letter appointing Karen as Executive Director of CPA bears my signature."

- Dr. Thomas Hadjistavropoulos, Professor of Psychology, Director of Centre on Aging and Health at University of Regina; CPA President 2008

So often, we hear stories about bosses that are less than ideal. Psychologists, in particular, have long studied the traits that make a boss good, those that make for a bad boss, and the areas that are most important when hiring for such a position. As an employee of the CPA, I can honestly say that Karen exemplifies many of the best traits one would want in a boss – not the least of which is trusting the people she hired to be good at their jobs without constant oversight or intrusive guidance.

When talking about the learning curve that was required upon first becoming Executive Director (a title that was changed shortly thereafter to CEO), Karen is quick to highlight the people around her. She had, as a practitioner, extensive knowledge of the mental health landscape (the healthcare system, mental disorders, treatments, services, interventions) and so she took on the mantle of practice advocacy. It was important that she surround herself with folks who had expertise in other areas. She points to current CPA Deputy CEO Dr. Lisa Votta-Bleeker who heads up the CPA's science portfolio, and to Glenn Brimacombe, CPA's Interim CEO, who has spent his career as a health economist.

The science and advocacy portfolios have not always existed at the CPA, and their current prominence in our office might have seemed like a pie-in-the-sky goal for CPA employees in 1990. While Karen took over at a time of growth for psychology in Canada, and has presided over a great deal of that growth, she herself has also been the catalyst for a lot of the expansion of psychology's influence in Canadian society.

"I worked with Karen during a time of substantial change for CPA and was always impressed with her consistent and total dedication to doing what was right for CPA and for Canadian psychology. Even when the discussions became heated, Karen stayed true to that ideal and, in doing so, demonstrated the highest form of leadership."

- Dr. Kevin Kelloway, Psychology Professor at St. Mary's University and CPA President 2016

I have had more than 80 Big Bosses over the course of my working life. In almost every case, when the boss wanted to speak with me, it created an uneasy feeling of dread – have I done something wrong? Is there a crisis of some sort I'm going to have to address? Are we going to end up talking about the upcoming Detroit Tigers season for hours while I itch to finish my work?

I can think of only two bosses whose presence in my office was not only welcome but also valuable. The first was Jeff Brown, then-Program Director at CHEZ 106 in Ottawa and current morning show host on Surge 105 in Halifax. Jeff never came to see me, or called me into his office, without an idea for an event or a segment that would make our morning show better. Even when I was in fact in trouble, his judicious reasoning made such meetings far less uncomfortable than they might otherwise be.

The second is Karen, who will pop by with a great idea or to discuss an ongoing project. Every time she does, I learn something – about psychology, or diplomacy, or the healthcare system itself. She has a clarity and objectiveness in her thoughts that not only expands my understanding of an issue but also distills difficult concepts in a way that enables me to approach my own advocacy with a greater command of the facts at hand.

It is this leadership that has made the CPA a leader in public advocacy. Going from maybe a few meetings per year on Parliament Hill with decision-makers when she became CEO, psychology has now become an integral part of many decision-making processes related to public policy, those involving health care in particular.

When Canada was debating same-sex marriage, the House of Commons struck a committee. Karen was the Associate Executive Director at the time, and at a meeting in Vancouver, when she received a call from head office saying the CPA had to present before that committee. There had been a view, advanced by some in the media, that parents of the same gender would do damage to the development of children. She and the team were able to quickly pull up the literature that looks at identity and development in children. It was easy to determine that no damage would be done to kids were they to have same-sex parents, and if those children had any challenge at all, it was in relation to how society treated them and their families.

Karen was able to go to this committee to put forward this view based on the literature. When she was finished her presentation, two MPs stood up and clapped. Karen says "that was one of my proudest moments. There were people presenting that day, with opposite views, who were trying to marshal science to confirm their opinions already held. I was using science to inform one. I think that embodied the best of what we can do as researchers and practitioners, which is to share what we know to make good public policy".

Same-sex marriage was legalized nationally in Canada in 2005 thanks in no small part to public health organizations and scientists advocating on behalf of the consensus in the community. By 2011, more than 20,000 same-sex marriages had been performed in Canada.

The CPA has changed legislation in other ways as well. When the Medical Assistance in Dying (MAiD) legislation was being proposed, the CPA again presented to a House of Commons committee and made a series of recommendations. One of them had to do with exempting health providers from prosecution under the Criminal Code of Canada if they participated in an end-of-life decision with a patient. Physicians and nurse practitioners need those exemptions for carrying out a person's decision, and Karen argued that psychologists needed that dispensation as well because an end-of-life decision is the kind of thing someone might discuss with a psychologist. Without an exemption, participating in those decisions could lead to criminal charges against the psychologist for aiding a suicide. Because of Karen's presentation, psychologists are named in the MAiD legislation, exempt from being charged under the Criminal Code.

For several years, across two different stretches, Karen has sat on the Disability Advisory Committee to the Minister of Revenue and earlier on a Technical Advisory Committee to the Ministers of Revenue and Finance. A lot of her work centred on how to equitably assess eligibility for the Disability Tax Credit (DTC), particularly for people with mental disorders. The DTC is a tax measure intended to compensate people for the extraordinary costs of living in a society where their disabilities are not accommodated. The work to which she contributed has resulted in changes to legislation governing the treatment of tax credits for persons with disability.

More recently, because of the expertise and leadership of members of the CPA's sections (e.g., Gender Identity and Sexual Orientation, Environmental Psychology), Karen's advocacy work has centred on how psychological science is critical to the development of good public policy. The CPA's position against conversion therapy, a practice or treatment designed to change a person's gender expression or reduce non-heterosexual attractions and behaviours, has been one of the CPA's most cited positions and contributed to the ban on conversion therapy in Canada. The CPA's positions and advocacy on the behavioural science of societal events and crises like climate change and the pandemic have helped legislators understand that how people think and behave is critical to the success of public health and well-being, especially during times of crisis (think wearing masks, making vaccination decisions, composting, or using public transit).

"Karen has been a leader in the field, a mentor to many, and an inspirational advocate for mental health in Canada. I have learned so much from her about what it means to be a psychologist, scientist practitioner, and supervisor. The field will miss her daily contributions, greatly, but there are so many of us who carry her wisdom in and around us that the profession has many of her "offspring" to carry the torch!"

- Dr. Heather B. MacIntosh, author of *Developmental Couple Therapy for Complex Trauma: A Manual for Therapists*

This is certainly true. So often I'll walk into Karen's office with an odd request – hey, do you happen to know of someone who could talk about the psychology of organ donation? Why people decide to do it, why they don't? She will more often than not know the exact person, or at the very least someone who can point me in the right direction. Sometimes that is a person Karen has personally supervised, someone she has mentored and tutored and taught to be the next generation of scientists, psychologists, and advocates.

It's this desire to disseminate knowledge as widely as possible and lift the voices of all those around her that led Karen to make significant changes to the CPA's magazine *Psynopsis*. Initially a member-facing publication with content by members for members, she saw an opportunity to share an extensive variety of voices, findings, and suggestions with a wider audience.

Today, member-facing content has been moved to a members-only online publication called *Psygnature*. *Psynopsis* is now an entirely external-facing publication, one that gets read by MPs, senators, healthcare leaders, and decision-makers across Canada.

Each issue of *Psynopsis* now has its own theme. In the past few years, there have been issues exploring climate change, autism, the COVID-19 pandemic, Missing and Murdered Indigenous Women and Girls, and other topics of interest to the Canadian public. Each issue has guest editors, experts in that particular field. Karen says "the way we theme [these issues] is that we look to the things that are keeping society up at night. Whether it's psychology in schools, aging, or healthcare system change, it's an opportunity for psychologists to write in an accessible way. Not just for each other but for the public, for government, for funders. What does the science of psychology have to say about these really important societal issues?"

Psychologists know how to talk to one another; they know how to talk to fellow scientists and health professionals and so on. But they do not get trained, at any stage of their careers, in how to speak to the public. This is something they have to learn for themselves if they want to do it, and more often than not they have to seek out that ability outside the confines of the profession.

In our search for a new CEO for the CPA to replace Karen, there are few personal attributes in a potential candidate less important than diplomacy and tact.

It's tough, as many of us know, to make decisions and develop policy that will meet the needs and views of every of the CPA's 7400 members and affiliates, as well as be ones that also resonate with psychology's partners and decision-makers in health and science. There is a delicate balance that must be struck when a member or section's laudable impulse might run up against bylaws or guidelines, or some political or stakeholder issue, that prevents them from carrying out their idea in the way they envisioned. This is a skill honed through time, through trial and error, and through a wealth of experience few others possess.

"I learned to really appreciate Karen's juggling skills; providing strong leadership while trusting others enough to delegate without need to micromanage; keeping current programs running while on the lookout for promising new initiatives, and all of that while behaving like a diplomat."

- Dr. Wolfgang Linden, Professor Emeritus, UBC and Past President of CPA

Even with all the hard-learned juggling skills in the world, no one person, even the most charismatic busker, can do everything they set out to do. Such is the case with Karen, who says there is still more left on the table in the wake of her departure. "Advocacy is both fast and slow. Things can turn on a dime depending on who is in a decision-making role, and sometimes you find yourself plodding away at the same message. To some extent we have – in terms of funding for psychological services – we've been very consistently talking about that for 15 years. Same goes for science funding. I think we're on the brink of achieving parity for mental and physical health coverage, but we're not there yet. While Canadians and people around the world recognize the importance of mental health to a much greater extent than they did 15 years ago, we still don't have parity and we still don't really recognize, in science funding, the importance of psychosocial aspects of health. I had hoped we'd be further along."

While Karen has been very glad to support the CPA Board's more recent initiatives around equity, diversity and

inclusion, and human rights and social justice, she notes that we have a ways to go in becoming a more inclusive discipline and profession. "It is the identities we celebrate, the voices we elevate, the consensus we create from what we have in common that will help us be better and do better for psychology and as psychologists for communities".

She has always been concerned about new graduates – whether they're looking for academic careers or wrestling with contract positions that don't give them the incentives and supports they need. She also mentions concerns around the move toward private practice and the impact that has on the public sector where recruitment and retention of psychologists is a challenge. This movement impacts access to psychological services and it impacts psychologists' abilities to shape public policy. She says "an important part of advocacy is getting to the table and to keep showing up. It always means compromise – balancing what is good for the profession, other stakeholders, and most importantly, the public."

"I have had the good fortune to work with Karen when she was part-time as the Registrar for the Accreditation Panel and what has struck me over these many years is her ongoing and deep concerns for how our training affects the future of our profession, wanting to ensure that the future is as strong as possible as the demands will be so great on us."

- Dr. Ian Nicholson, Manager of the Psychology and Audiology Departments at London Health Sciences Centre, Past President of CPA

As Karen moves on, her legacy is both entrenched and ongoing. The things she has accomplished as the leader of the primary association representing psychologists in Canada are evident, and impactful. The accomplishments of those stepping into her role and those who have learned from her will move the profession forward. And, in the spirit of Karen's overarching goal, will move society forward as well.

"I really think we have a responsibility, whether we're educators or researchers or

practitioners, to address the problems people in society face," says Karen. "The impacts of climate change, the needs of an aging population, how to cope with the pandemic, redressing discrimination. These are all things that need to, in some way, be part of our training. Of course, graduate school would take 20 years if we graduated being experts in all these areas. But I do think psychologists have a responsibility to look to the needs of students, the public, and patients and to try to align those to what we train psychologists to do."

"[My take on this] is that we're talking about societal issues as harbingers of mental health issues," she continues. "There are many factors that affect mental health. Traumatic incidents, difficult upbringings, and genetic predispositions can all create mental health issues – but so too can poverty, discrimination, and marginalization. To truly address the issues that cause mental health problems in Canada and elsewhere, it is not enough for psychologists to simply treat or research the mental health symptoms that arise from inequality. Psychologists, and psychology as a profession, must lend its expertise to the root causes of inequality, shaping public policy and helping our populace as a whole live in an environment where the impact of inequality is lessened or eradicated because inequality is lessened or eradicated. As with most activism, this often begins at home (think globally, act locally)."

"Mom has always been 'the fixer'. If we've got a problem, Mom is always the first person we talk to."

- Madison Cohen-McFarlane, Signal Processing/ Data Science Consultant and Karen's daughter

It is evident, in speaking with Karen's two daughters, the love and connection between them as well as the high esteem in which they hold their Mom. Madison says that her parents are the inspiration that led her to graduate school and the career path she has chosen for herself. Sydney agrees, saying that having Karen as a Mom was "intimidating, but a constant reminder of what success looks like. With her and my Dad as parents, there was no other option but success."

Tragically, Karen lost her husband Dr. Keith McFarlane suddenly in 2020, just as the pandemic started. This meant the girls lost their father as well. The pain from this event is still palpable in all three Cohen-McFarlane women, though enough time has passed that happy memories are now some of the first that come to mind when reminiscing. Says Sydney, "Dad was always Mom's biggest cheerleader, and the first person to let us know that she's the smartest person in the room."

"Psychology isn't the easiest concept to grasp when you're a little kid. But I do remember when Mom took over as CEO, and I thought that was really cool, like she was some kind of big boss lady. I used to call her the Big Poncho, because that's what I thought the job title was."

- Sydney Cohen-McFarlane, Computer Security Developer and Karen's daughter

In our office at the CPA, Karen and the rest of the senior staff talk a lot about work-life balance, and do their level best to ensure that the rest of us in the office are achieving that. To the point where I feel a little guilty, and conscious of this, while I type this article after 8 pm on a Wednesday. Even as the CEO of an

important organization, Karen has managed to maintain that balance pretty well throughout her children's lives, as Sydney and Madison remember Mom always being there.

Of course, the demands of the job in the pre-work-from-home era did mean that sometimes Mom wasn't there. Both Madison and Sydney recall attending just about every summer camp Ottawa had to offer. Madison talks about a robotics camp that she loved – but where she felt awkward being the only girl. Karen adjusted her schedule so that on days when the robotics camp went swimming Madison could stay home and avoid that uncomfortable situation.

Sydney remembers absolutely hating clown camp (yes, it is actually possible for someone to hate clown camp) and not even making it to lunch on the first day before Karen came to get her and bring her home. To this day she is incapable of making balloon animals, a veritable misfortune that undoubtedly plagues her in her everyday life.

Though both girls are well on their way to their own very successful lives and careers, they remain very close to their Mom, brought even closer by the passing of their Dad and the subsequent three years of pandemic. There is no telling what retirement holds for Karen, though the opportunities for a post-CPA life are vast. What is certain is that her daughters will be an integral part of what comes next. Their future involves Mom, and Karen's future involves Madison and Sydney.

For those of us at the CPA though, it's incredibly hard to imagine a future without Karen. We will miss the measured and careful yet incisive intellect that powered our organization for the past 15 years. It will be a different office without Karen in the corner, popping out to suggest a brilliant new initiative. Or just being there to explain all about disability insurance or direct us toward Canada's expert in suicide prevention should the need arise. Or bringing a beautiful box of scones to a staff meeting. But thanks to a long and astonishingly impactful tenure as CEO, we will carry her message, her passion, and her goals forward in the coming years.

Whenever the CPA puts a psychologist forward to do a media interview, we remind the reporters that the honorific 'Dr.' must accompany the person's title. It's a way to remind journalists, and the public, that a great deal of education and training goes into becoming a psychologist, and that the weight given their voices should be commensurate with that scientific acumen.

When our CEO does an interview, she is always 'Dr. Cohen' for this reason. But I've rarely heard that phrase used around the office. Here in our workplace in downtown Ottawa she has always been 'Karen' to all of us. A boss, yes, but also a mentor and friend to most of us. The kind of friend to whom we turn for guidance, for reassurance, and to work out problems that might be too big for each of us on our own. We wish her all the best in her next chapter, spending even more time with her girls who just call her 'Mom'. Or maybe something else.

"Whether a researcher, educator, or practitioner, we have a responsibility to be responsive to the needs of the people our work ultimately serves. And sometimes, we need to remind ourselves of that."

- Dr. Karen Cohen, Past Big Poncho of the CPA

LICENSURE AND TELEHEALTH PRACTICE IN CANADA

KAREN.R. COHEN, Ph.D., Past CEO, CPA
GLENN BRIMACOMBE, M.A., Interim CEO, CPA

A survey undertaken by the CPA at the end of 2017 showed that only 8% of psychologists delivered digital services independently of in-person contact with their clients.[1] Yet, with the arrival of the COVID-19 pandemic, psychologists, along with all health providers, had no choice but to abruptly change the way they delivered service. To maintain continuity of care, they had to quickly transition to digital delivery, quicker than many thought possible. In addition to shifting how they met the needs of their rostered patients, psychologists and other mental health providers faced increased demands for service from populations for whom the pandemic took a considerable mental health toll.[2]

One of the great challenges to digital delivery of services, especially during the pandemic, were the jurisdictional barriers to the delivery of regulated care. Health professionals in Canada are regulated provincially and territorially. However, with the pandemic, students studying in one province returned home to another, people who lost jobs in one province returned to live with families in others, and people worked from home at physical or jurisdictional distances from their workplaces.

The Canadian Free Trade Agreement (CFTA) (and the Agreement on Internal Trade – AIT before it)[3] mandated mobility of all provincially and territorially regulated professionals in Canada. However, the process of mobility under CFTA involves onerous and duplicative applications for registration, as well as review and approval of requirements. Further, CFTA (and the AIT before it) requires the provincial and territorial regulatory bodies to support mobility but gives them no authority to set common regulatory requirements. This is especially problematic for professions like psychology where the entry-to-practice requirements differ considerably from province/territory to province/territory.

While psychology regulators in the Atlantic provinces have a Memorandum of Understanding permitting interjurisdictional practice,[4] the same is not true for the rest of Canada's jurisdictions. While some maintain provisions for short-term or pandemic-related practice, there is commonly the requirement that a psychologist must have regulatory permission to practice in the jurisdiction from where they are delivering service as well as in the jurisdiction where the service is being received. Given the pandemic-related shift to digital delivery of health service, we find ourselves in a situation where regulatory authorities enforce physical boundaries to practice that may no longer be necessary or practical.

The Canadian Medical Association (CMA) has recently been very public in its call for a single, pan-Canadian licensing system that they state would support "virtual care across provincial and territorial borders, providing greater continuity and more timely access".[5] Pan-Canadian licensure as conceived by the CMA would allow physicians licensed in one province or territory to practice unrestrictedly in any other without having to obtain an additional license or pay additional fees.

In January 2023, the CPA convened a meeting of national health professional associations to discuss the issue, understand where each stood in relation to national licensure, and see if there was opportunity for Canada's health professions to take a common position on the issue. While these discussions are ongoing, national licensure continues to be high on the national policy agenda, not just for health professionals but for governments. In February 2023, the federal government released its plan[6] for health transfers to the provincial and territorial governments. Twenty-five billion dollars of the $46.2 billion in new federal funding will be provided over the next 10 years through bilateral agreements between the federal government and each provincial/territorial government. One of the bilateral transfer requirements is that provinces/territories develop action plans around specific shared health priorities which are measured and reported on. They are also being asked to "advance labour mobility, starting with multijurisdictional credential recognition for key health professionals."[6] Indeed, in health funding discussions between organizations of health providers and the federal Ministers of Health and Mental Health and Addictions, the topic of a pan-Canadian approach to licensure was included.

If a pan-Canadian approach to licensure becomes a reality for health practice in Canada, it must confer authority to harmonize the very significant discrepancies that exist among provinces and territories in requirements for registration as a psychologist. These range from a "graduate degree (masters or doctoral) with a major in psychology or a graduate degree with content substantially equivalent to a graduate degree with a major in psychology"[7] to a "doctoral degree in psychology".[8]

Navigating the differences between a master's degree in psychology or its equivalent and a doctoral degree in psychology has kept Canadian regulatory bodies of psychology preoccupied since 1995 as they endeavour to comply with AIT and CFTA.[3] These differences have been made more complex in a changing mental health practice environment over the past decades – one which has seen the development of a newly licensed class of health providers in some jurisdictions (i.e., psychotherapist), the registration requirement for which includes (among other related degrees) a masters degree in psychology.[9]

Health providers learned a lot over the course of the pandemic about what could effectively and efficiently be accomplished via the digital delivery of care. The articles in this issue of *Psynopsis* detail what these looked like for the practice of psychology. One of the perhaps unforeseen consequences, however, has been a recognition of the mismatch between how care is regulated and how it can be delivered. As all levels of government and the health professions navigate this mismatch, psychology should not miss the opportunity to implement a pan-Canadian entry-to-practice standard for the profession that defines and distinguishes psychology's preparedness, scope, and import to the health of people living in Canada.

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A REGULATORY PERSPECTIVE ON TELEPSYCHOLOGY

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Those first days and weeks of pandemic lockdown, starting in March 2020, were intense times for psychologists across the country. Questions about how to meet client needs competently, ethically, and safely in this new environment were top of mind for individual practitioners, and also for regulators of the profession. Some actions taken by regulators during the early days of COVID were temporary moves suited for the public health emergency of the days; others have longer-lasting implications, especially with respect to telepsychology.

- Many psychology regulatory bodies were engaged with governmental officials in early days as public health decisions were made about whether to designate psychological services as "essential", thereby permitting them to occur in-person. Regulatory bodies communicated public health expectations for in-person service.

- In many cases, in-person service was either not permitted or was not feasible. The relatively few psychologists experienced in telepsychology practice in March of 2020 were able to proceed as usual or adapt, perhaps needing to newly outfit a home space for secure and confidential work. The larger proportion of psychologists and mental health professionals new to telepsychology practice were faced with client needs, sometimes exacerbated by the stresses of the pandemic, and questions about whether and how to respond.

- All psychology regulatory bodies had in place telepsychology standards, practice guidelines, or checklists, of varying detail, and these were drawn to registrants' attention. These typically were anchored in the core Code of Ethics or Code of Conduct adapted by the regulatory body, with added particulars regarding telepsychology. Common factors included a reminder that provision of telepsychology services is acceptable if one has competence in providing services via the modality they wish to use, and where that modality is congruent with the client's needs and capabilities. Key to the provision of services via telepsychology is ensuring that informed consent for services delivered in this manner is obtained, ensuring the security of the modality, ensuring the confidentiality of client information, and having a back-up plan in case of technological failure.

- In general, regulatory bodies have been reluctant to codify the specific technologies which meet appropriate security and confidentiality thresholds, given the evolving nature of such technologies. Even so, with many psychologists newly exploring possibilities for telepsychology practice, most regulatory bodies did share information about alternatives that might be explored, and cautions about utilizing platforms regularly used in personal lives without due diligence.

- In general, regulatory bodies have been reluctant to codify specific psychology practices appropriate or not appropriate for telepsychology, instead expecting psychologists to make evidence-informed judgments based upon available research. The telepsychology evidence base has been developing substantially since onset of the pandemic.

- As the pandemic lockdown began, every Canadian jurisdiction except Quebec required that psychologists registered elsewhere also hold some sort of registration in their jurisdiction to provide telepsychological services into their jurisdiction. Within days of lockdowns beginning, every jurisdiction took steps to enable continuity of care for clients located in a different jurisdiction due to COVID, such as those caught during lockdown, or needing to move to care for an ill family member. Strategies included use of existing temporary/courtesy/special registries or simple notification and without payment of fee or requirement of documentation, and explicit decisions not to pursue actions for unauthorized practice for psychologists doing such work.

- Later decisions in each province enabled provision of services from university or college psychology training clinics or counselling services to students of the institution residing in a different province due to COVID restrictions.

- Regulatory bodies adapted their own practices as a result of pandemic restrictions, including moving to virtual Board meetings, providing virtual oral examinations, conducting investigations virtually, and in some instances, conducting disciplinary hearings virtually. Some jurisdictions plan to continue such virtual practices post-pandemic.

The dramatic increase in telepsychological services since onset of the pandemic has refocused regulators' attention on the challenging issue of interjurisdictional telepsychology. Currently, three jurisdictions (Quebec, Nova Scotia, New Brunswick) have determined that telepsychology services provided to their residents by psychologists outside their jurisdictions can be appropriately regulated by the psychologists' home jurisdictions, which would be responsible for receiving and acting upon complaints. Eight jurisdictions (British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Prince Edward Island, Newfoundland and Labrador, Northwest Territories) have determined that they must regulate provision of telepsychology services received by their residents from psychologists outside their jurisdiction, when the residents are located in their own jurisdiction, and that appropriate regulation requires some form of registration in the jurisdiction of the client. In each case, jurisdictions are making good faith efforts to interpret what is required and what is possible according to current legislation, regulations, and legal advice.

Member organizations of the Association of Canadian Psychology Regulatory Organizations (ACPRO) are endeavouring to identify mechanisms to facilitate access to appropriately regulated interjurisdictional telepsychology practice that is competent, safe, and ethical. For jurisdictions requiring some form of registration in the client's jurisdiction, there are circumstances in which full registration in the jurisdiction of the client is considered appropriate. But there are other circumstances in which an expedited and low-cost registration process would be considered appropriate. Both the public and providers of telepsychological services would benefit from clarity about the requirements for practice into each jurisdiction. To that end, ACPRO is actively engaged in work toward a Memorandum of Understanding (MOU) that would identify those jurisdictions not requiring some form of registration in the client's jurisdiction and, for the remaining jurisdictions, specify steps toward securing a registration certificate for "Limited Telepsychology Practice" (the title would vary from jurisdiction to jurisdiction). Such an MOU would link to a common application form, a common form for verification of good standing in the home jurisdiction, and identified categories of practice eligible for a Limited Telepsychology Practice certificate applicable to each jurisdiction, including details about duration of such certificates and any applicable fees. ACPRO expects to report progress during this year.

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SUPPORTING TELEPSYCHOLOGY IN RURAL, REMOTE, AND NORTHERN CANADA

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Telepsychology grew exponentially during the COVID-19 pandemic when clinicians across Canada scrambled to provide quality mental health services while abiding by public health recommendations (e.g., social distancing). Psychologists working in rural, remote, and northern communities (RRN) were often familiar with the benefits of telepsychology, with many having provided telepsychology prior to the onset of the COVID-19 pandemic.[1] Virtual healthcare services have their roots in RRN areas of Canada. By the mid-1990s, telemedicine, in some form, was available across all provinces and territories, with a few provinces (e.g., Newfoundland & Labrador) adopting telephone connections to enhance consultation opportunities to RRN areas since the early 1980s.[2]

While we continue to advocate for the need for psychologists to live and work in RRN areas of Canada, telepsychology has the opportunity to address some of the many service gaps. However, we also acknowledge that ongoing access difficulties in RRN Canada is a complex issue that may not be solved by telepsychology; much work remains in this area.[3]

As telepsychology expanded during the pandemic, RRN-based psychologists benefited from increased access to virtual platforms to enable provision of psychological services, as well as connection to our urban-based peers in a way that felt equalizing. For example, prior to the pandemic, RRN psychologists were often the only individuals joining meetings virtually – at times not being able to easily identify / see who was in the room (e.g., for individuals sitting outside of the camera view and for less-than-ideal video quality), to hear what was being said, or to seamlessly participate in the discussion. With the onset of the pandemic, these difficulties, if present, were experienced by everyone in virtual meetings; solutions became more readily available. Despite individuals reporting increased experiences of social isolation,[4] RRN psychologists were already familiar with this aspect of RRN work (i.e., being the only psychologist in the clinic, and perhaps within a few hundred kilometers), and therefore virtual meetings and learning opportunities increased our sense of professional connectivity.

Clinically, RRN-based patients may not have experienced such a boon of access. Research suggests that the majority of growth in virtual service provision and access during the pandemic was within urban settings, even when accounting for population differences. For example, Chu, et al.[5] noted that in Ontario, more urban-based patients accessed telepsychology compared to rural patients, per capita. Although more information is needed regarding patterns of use of telepsychology during the pandemic, it appears that telepsychology access barriers may differ based on geography. It is also possible that RRN residents are not referred to telepsychological services because there are limited providers offering these services in RRN areas or, even if services are technically available, local providers may not be aware of how to refer their patients. Further, in 2023, broad-band internet connection or solid cell phone reception is still not always reliable in all RRN communities. If it is available, the additional costs can be taxing to RRN residents' budgets. Canadians continue to pay some of the highest costs for both cellphone and internet services,[6] and many RRN residents struggle to reliably access these services from their homes.

Assuming that RRN residents would like to access telepsychology, how can we, as a psychological community, support RRN residents to be able to access this service? Further, how can we best support psychologists working within RRN settings to be able to offer telepsychology services? Perhaps some of the questions regarding infrastructure require ongoing advocacy and education of decision-makers regarding the practical limitations of telepsychology in RRN areas – something we can encourage across members of the CPA, our sections, and the psychological community at large.

We can also improve telepsychology services by addressing cultural components to RRN psychological care, as practitioners. The CPA Ethics Code encourages all psychologists to practice cultural humility, and to provide a culturally safe environment for the people with whom they work. When psychologists provide telepsychology services in rural, remote, and northern communities, we are encouraged to reflect on their awareness of their client's perspective and geographic location, and how rurality may impact the client's experiences.

The following questions may provide a useful guide to practicing in rural, remote, and northern communities. Do clients have all practical components necessary to engage in the telepsychology session? Is telepsychology providing a hardship for the client, or creating an inequity compared to in-person services? We also recommend that providers visit the community, in order to enhance understanding and knowledge of clients' day-to-day experiences. We also strongly recommend that providers are familiar with the local norms, values, and culture that may be having a significant impact on the client's current experiences and circumstances. Links with local practitioners (e.g., healthcare staff) that may be involved in clients' care can be extremely beneficial, including awareness of local crisis and mental health services available in case of emergency. Additionally, we recommend psychologists consider if stigma impacts whether or not someone may choose to use a local service. For example, is the local ER staffed by a family member or close friend? In some communities, the anonymity offered by telepsychology may be a factor to consider.

Telepsychology services have an important role to play within RRN areas of Canada. We encourage those providing these services to do so mindfully, with careful consideration.

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A JOURNEY TO THE NORTH TO DEVELOP A TELEPSYCHOLOGY PROGRAM

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The field of telepsychology and mental health (TPmH) has undergone fundamental developments in recent years. The COVID-19 pandemic instigated widespread shifts to remote telemedicine models and highlighted a longstanding need for support in rural regions.[1,2] The Ontario Institute for Studies in Education (OISE) Psychology Clinic at the University of Toronto was ahead of this curve. For the past 11 years, we have been developing telepsychology pedagogy for clinicians-in-training and TPmH supports for rural Northern Indigenous communities in Canada through a partnership-based model.

This program responds to current calls in our broader field in that our curriculum and practice are simultaneously remote and culturally responsive,[3] and are also dedicated to training a new generation of psychologists in TPmH through pedagogical alterations in adaptive teaching strategies and technological expertise.[2,4] However, the greatest success of our program is its unyielding commitment to what Jean-Charles, et al.[1] call a "partnership approach: the involvement of all stakeholders and multilevel collaboration to … further develop telepsychology services to better support … mental health". This approach is crucial for working with historically disenfranchised communities.[3,4]

The success of OISE's Telepsychology Program is due to our long-term relationship with Indigenous colleagues who have guided us at each turn. This collaboration attended to the "specific needs"[4] of communities through a direct and wholly equitable partnership approach with our Indigenous colleagues who: consulted upon pre-program development as well as provided advice throughout implementation; offered crucial support on community-appropriate and accessible resources that could be utilized to better learning outcomes for Indigenous youth; created guiding directives for each individual community's priorities; and challenged Western psychological assessment models at financial, temporal, and methodological levels.

OISE Psychology Clinic's Telepsychology Program developed as a response to the intervention model and sought to meet the urgent needs of participating communities. TPmH in our clinical training program is imbricated with the following core competencies.

CONNECTIVITY

The first issue was securing a reliable connection. When mandated stay-at-home orders swept the globe in March of 2020, communication technologies such as Zoom and Microsoft Teams swiftly took hold. However, when we initiated our program in 2014, these technologies did not exist. While many schools in Canada were linked through fibre optic cable, some of the Northern Indigenous schools were only outfitted with satellite internet connectivity. We began by using Vidyo because of its capacity for video conferencing at 500Kbs and have continued with this technology.

We ensured all partner communities were made aware of our disconnection policy. If we became disconnected, we attempted to reconnect for up to five minutes. After such time, we called the designated school number. Finally, we would contact the emergency number on file.

PRIVACY

Privacy was the next key area. In the traditional school psychology model, clinicians and clinicians-in-training are in the same room with the teacher or student that they are working with so privacy can be guaranteed. With the additional factor of vast distances, this traditional understanding of privacy was unsettled. We addressed this challenge through individual consultation with each community, inquiring as to the best locations within each school for private conversations. We indicated that privacy could not be guaranteed within the school setting. We explained to everyone that, if at any point they did not feel safe to speak, they could put up their hand and we would pause the session until we as a group decided to continue. At the outset of a session, we asked the community technician to sweep the room so that everyone on the call was made aware of each other.

TRAINING

Doctoral students connected with a school for two hours per week. Teachers participating in the program were encouraged to sign up for 20-minute sessions for eight weeks. This consultation model addressed around 80% of the presenting problems. For the remaining 20%, we required more in-depth information. Based upon community feedback, we began flying in professional literacy and numeracy consultants to perform in-person classroom observations and on-site assessments, the data from which we used to develop appropriate recommendations, and to build relationships.

TELE-ASSESSMENT

Despite demonstrated achievements, our project remained limited in that we could only visit a given community once per year. We began to brainstorm the possibility of providing remote assessments through a direct-to-school model, wherein a dedicated room in the community school was outfitted with teleconferencing equipment and a community member was trained to host the sessions and provide technical support and systems management. With this set-up in place, our team could connect from the OISE Psychology Clinic and conduct assessments in real time in each community.

In preparation for implementing this model, we performed critical analysis on our testing materials, including review of such elements as: standardization, impact, psychometrics (reliability and validity), test security, and copyright of the testing materials.

As we moved into a direct-to-school model, we determined that we would first need to assess the tools' reliability and validity. Most of the work on reliability and validity of tele-assessment concerned the older population.[5] In terms of child and youth populations, there is a growing body of literature that has shown the reliability of tele-assessment when using cognitive assessment tools,[6] and academic assessment tools[7] (see also the article on tele-assessment in this issue). A key study in this area is Wright's which showed that the Wechsler Intelligence Scale for Children – Fifth Ed. (WISC-V) as delivered through a direct-to-home model was as reliable and valid as an in-person version.[8] Wright documented that the system they used would support as low as 200KB; there were no perceived differences if a student connected through a tablet or via a computer; 21% of sessions had technology issues but these issues resulted in less than 1% of spoiled subtests; and, finally, though 47% of sessions had some disruption (doorbell ringing, family member entering), these did not impact the reliability of the test.[8]

To address copyright, we used a document camera to display the stimulus pages. For the motor tests that we needed to physically ship (e.g., Beery VMI, KTEA response books), we sent the materials in envelopes with security strip features. To track student engagement, we set up one tablet in the rear of the room so that the camera captured students from behind.

OISE Psychology Clinic's Telepsychology Program is a collaboration with Indigenous community educators that seeks to realize our mission of supporting students beyond geographic boundaries. We are honoured that Northern Indigenous communities allowed us to be a part of their educational journey.

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UNGUIDED INTERNET-DELIVERED COGNITIVE BEHAVIOURAL THERAPY: WHY, HOW, AND WHAT NEXT?

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Since the beginning of the 21st century, advances in digital technology have radically changed the way we work, learn, play, socialize, shop, and, indeed, provide and receive psychotherapy. Internet-delivered cognitive behavioural therapy, or ICBT, is the most common type of digital mental health intervention.[1] It typically consists of a series of online lessons or modules that teach clients the same coping skills as they would learn in traditional, face-to-face cognitive behavioural therapy, but it offers several unique advantages; for instance, it can be accessed anytime, virtually anywhere, and with a high degree of privacy and convenience.[2,3]

Another key advantage of ICBT is that it can be offered with minimal therapist guidance or even in an unguided, self-help format. The prospect of a therapy without a therapist may seem counter-intuitive to some, but in a world where individuals and healthcare systems cannot always find or afford therapists (and where some people prefer to address their mental health problems independently), effective standalone interventions are valuable.[2,3] Additionally, therapy without a therapist is nothing new; for example, several meta-analyses from the 1990s found that self-help cognitive behavioural therapy books showed results comparable to face-to-face cognitive behavioural therapy.[4–7]

Importantly, ICBT works. Several hundred randomized trials over more than two decades have demonstrated that therapist-guided ICBT is approximately as effective as face-to-face therapies for treating a range of emotional disorders.[8] Unguided ICBT programs tend to show comparatively smaller treatment effects and lower client engagement,[9–11] but many researchers have argued that unguided ICBT is justified by its cost-effectiveness and scalability; that is, once created, an unguided ICBT program can be offered efficiently on a large scale, while therapist-guided interventions are often hampered by limited funding or availability of therapists.[12,13]

Intriguingly, now that the effectiveness of ICBT has been well-established in the research literature, many researchers are shifting their focus to identifying strategies for improving it. Several groups have provided recommendations for developers of ICBT and other digital mental health interventions, and a common theme is that clients will show greater benefits if the intervention they are using is designed to be more engaging.[14–17] Empirical support for this proposition is emerging. For example, a framework called persuasive systems design has been used to classify design principles that are theorized to make digital mental health interventions and other digital technologies more engaging, such as tailoring them for specific user groups or providing opportunities for social support among users.[16,18] We recently conducted a meta-regression showing that more persuasive systems design features predicted greater efficacy in unguided ICBT for depression.[19] This finding suggests that design matters, and there is likely untapped potential for designing more effective ICBT interventions in the future.

Another promising area for further optimization of unguided ICBT and other digital mental health interventions is the application of experimental research designs to rigorously test the degree to which specific elements of a treatment contribute to its efficacy. Particularly promising are factorial randomized trials, which allow multiple treatment elements to be experimentally manipulated within a single study. For example, in a recent factorial randomized trial, ICBT was simultaneously compared with or without a pre-treatment motivational interviewing component and with or without a post-treatment "booster" lesson.[20]

A third exciting avenue for improving unguided ICBT and other digital mental health interventions is the use of artificial intelligence to provide individually tailored treatment within the context of an unguided intervention. Indeed, digital mental health interventions consisting of text-based conversational agents powered by artificial intelligence have already shown good outcomes in the research literature,[21,22] and there may be significant further advances in this area in the coming years.

Perhaps the greatest barrier to the optimization of unguided ICBT and other digital mental health interventions is the gap between research and practice. Most empirically supported ICBT interventions are not publicly available,[23] and of the many thousands of publicly available ICBT apps and websites, only a few hundred are empirically supported.[24] However, efforts to better regulate the provision of ICBT and other digital mental health interventions appear to be underway; for instance, the U.S. Food and Drug Administration has begun approving certain digital mental health interventions,[25] and there are now several organizations providing recommendations to help consumers find evidence-based digital mental health interventions.[26–28]

In conclusion, over two decades of research have demonstrated that unguided ICBT is helpful for a range of emotional disorders.[8] It may not be as effective as therapist-guided interventions, but in a world of limited resources wherein some clients prefer to manage mental health concerns independently, its scalability and cost-effectiveness have earned it a place in modern mental health care. There is also a considerable gap between research and practice in unguided ICBT that will need to be bridged. Nevertheless, there are several exciting avenues for continued improvement of unguided ICBT and other digital mental health interventions, including efforts to make it more engaging for users, the application of experimental research approaches to optimize specific elements of interventions, and advances in artificial intelligence. The exciting research in this area provides reason for optimism that the true potential of unguided ICBT for helping people overcome mental health challenges will continue to be unlocked in the coming years.

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THE NEED FOR INNOVATION AND DIVERSIFICATION IN YOUTH MENTAL HEALTH: LESSONS LEARNED FROM KIDS HELP PHONE

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INTRODUCTION

As workplaces, social services, schools, and relationships move increasingly online, mental health services must realize the significance of online platforms to stay relevant and meet people where they are. This is especially true for young people, a population that is both more comfortable with digital communication[1-3] and is enduring considerable unmet needs. In Canada, the burden of youth mental health concerns is substantial; 18.5% of adolescents aged 15–24 are affected by mental health and/or substance use disorders,[4] and yet only 43.8% of Canadians with such concerns will receive the care they need and deserve.[5] It is thus imperative that we develop new ideas to advance youth mental health care beyond traditional approaches and identify examples of innovation and technology to fill the dismal treatment gap.

Kids Help Phone (KHP) provides one such example. Since 1989, KHP has supported young people across Canada with nearly 4.1 million service interactions in 2022 alone. Young people contact KHP for a wide array of issues including mental health concerns, abuse in the home, social isolation, substance use, concern for a friend or family member, sexual health, and suicidal intent. The age of service users can range from five to 30 years old, and 46% of service users state in post-service surveys that if they had not contacted KHP, they would have done nothing else.[6] For decades, KHP has directly heard the evolving issues faced by young people, learned which technologies best suit their preferences, and experienced significant growth via broadening and digitizing its clinical offerings. This article will describe learnings from this ongoing innovation, highlighting insights from a national e-mental health service with particular attention to non-verbal options such as Live Chat and text support.

INNOVATION WITH NON-VERBAL SERVICES

KHP was first established as an independent, charitable telephone helpline for children and youth who were experiencing abuse in the home. At that time, the organization was chiefly concerned with prioritizing service user accessibility by requiring no parental involvement, and this emphasis on youth autonomy remains central to KHP today. In the early 2000s, KHP recognized that young people were experiencing barriers accessing its phone service and were searching for additional support options. While there was not yet strong evidence of the potential impact of non-verbal clinical services, these technologies became worthy of investigation and KHP's Live Chat service was launched in 2011. Following its launch, Live Chat's demand grew alongside demand for phone counselling; in other words, rather than split demand, providing Live Chat doubled it. When asked via survey why service users chose Live Chat over the phone service, 66% reported that they were uncomfortable speaking to someone verbally, 57% preferred written communication, and 54% did not have sufficient privacy to speak on the phone.[7]

As volume for Live Chat continued to grow, KHP launched a short messaging service (SMS)-based helpline in 2019 with the intention to better support young people without access to an internet connection. Unlike KHP's phone and Live Chat services, which are run with professional counsellors, the texting service uses a volunteer-based model wherein trained volunteers are live-monitored by clinical staff. This allowed the texting service to scale as its volume quickly grew. Today, the texting service supports the highest volume of KHP's one-on-one service interactions, with 224,948 conversations in 2022.

Originally, the three different services (phone, chat, and texting) were each launched to provide young people with different technological access points, but over time KHP has noted that young people with different issues and age groups gravitate toward distinct platforms. For example, suicide is discussed almost twice as frequently via text and Live Chat (17% of conversations on each platform) as it is via phone (9% of conversations).[8] One possible explanation for this is that service users may prefer the perceived anonymity of text-based interactions when seeking support for suicidal thoughts or intentions, compared to phone conversations. These variations once again demonstrate that different services suit the needs of young people in distinct moments, and that expanding offerings to include varied technologies and communication styles are beneficial for ensuring relevance and empowering client choice.

LOOKING AHEAD

Traditionally, evidence-based mental health services have required inflexible in-person sessions, have been costly to deliver, and are inconsistently accessible to young people due to social, administrative, and economic barriers.[9,10] Thus, while these services may generate positive impacts, the provision of these services alone and in this way may no longer be the most ethical option for meeting demand at scale. In a space with significant unmet need, it is imperative that we all strive to combine evidence with innovation and create new solutions to ensure all young people receive the support they deserve. Over the past 34 years, KHP has continued to build new services and leverage technology to meet diverse needs, and now offers phone, Live Chat, and texting services, as well as an online peer-to-peer platform and psychoeducational tools and resources. Importantly, KHP's use of technology has evolved alongside youth over time. For example, KHP launched a web application in 2012 but later discontinued it due to booming availability of mental health applications and resulting low usage. However, through innovation and applied trial and error, KHP has been able to adapt to better serve young people in the ways they choose to seek help, and continues to support more young people each year.

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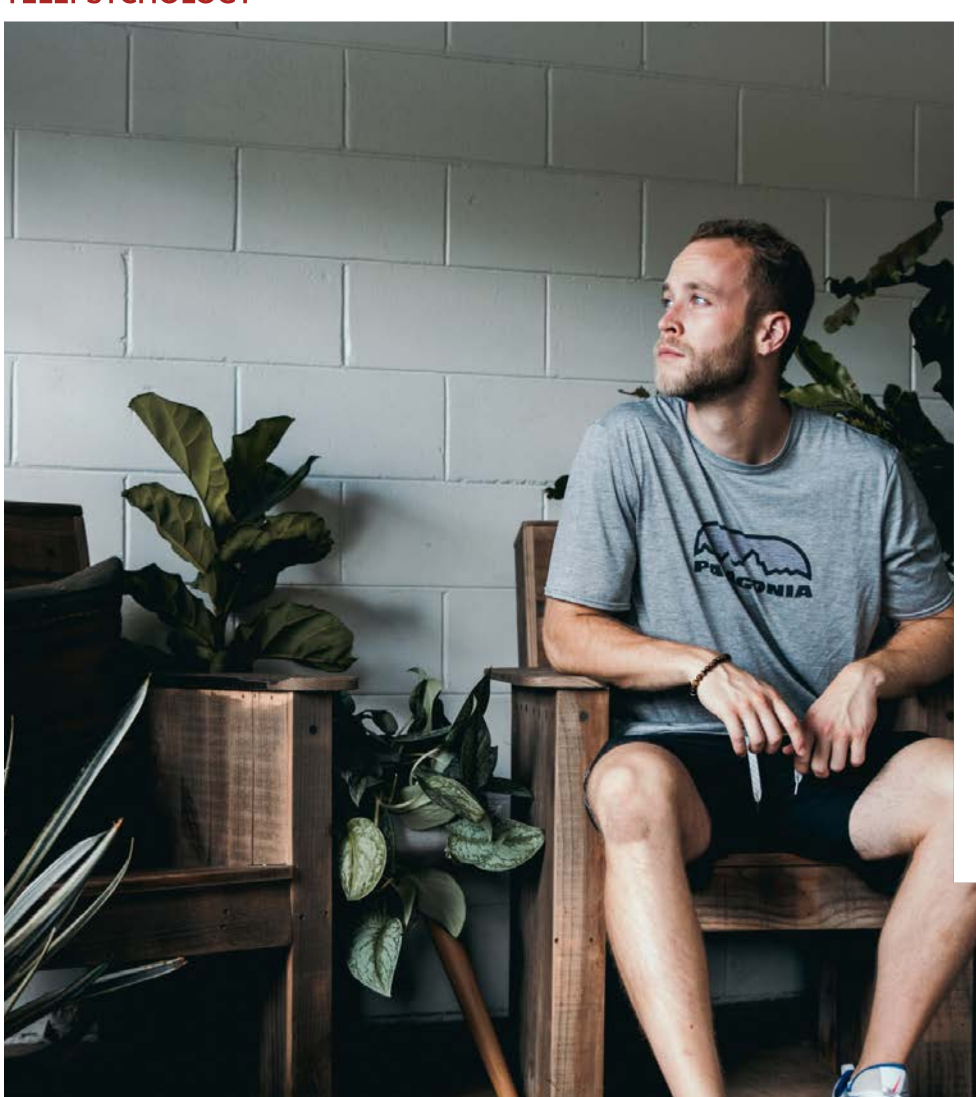

A DIGITAL PSYCHOSOCIAL INTERVENTION TO SUPPORT RECOVERY AND PREVENT RELAPSE IN INDIVIDUALS RECEIVING TREATMENT FOR PSYCHOSIS

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Psychosocial interventions have been proven to be effective to support recovery in individuals receiving treatment for schizophrenia spectrum and other psychotic disorders (SSPD); however, access to these interventions has historically been limited due to factors such as a lack of trained professionals and challenges in engaging patients in such therapies. Moreover, considering the impacts of COVID-19 on the accessibility of services, the incentive to explore the potential of technologies (beyond videoconferencing) to deliver psychosocial interventions has become even more urgent.

Our clinical research team (ymhtech.com) is leading research on the use of technology to improve access to psychosocial interventions. One example of our research projects is "Horyzons-Canada (Horyzons-CA)." Horyzons-CA is an online therapeutic intervention supporting the psychosocial recovery (social, mental, and physical well-being) of individuals receiving treatment for SSPD.[1] Horyzons-CA is an adaptation of the MOST platform, originally designed and tested in Australia through a multidisciplinary team, led by psychologists and other researchers.[2] We are investigating the adaptation, impact, and implementation of Horyzons-CA as a complementary bilingual service to outpatient care, to support the recovery of those diagnosed with SSPD, including first-episode psychosis (FEP).

HORYZONS-CA

Horyzons-CA provides access to various mental health support services, including evidence-based psychosocial therapeutic tools, clinical moderators, peer support moderators, and a community of peers.

Horyzons-CA is informed by self-determination theory, positive psychology, and supportive accountability.[3,4] Self-determination theory proposes that pursuits fostering a sense of autonomy, competence, and relatedness are internally rewarding.[5] The platform provides users with the autonomy of engaging with a range of individuals (e.g., clinical moderators, peer workers, peers), therapeutic activities on diverse topics (e.g., sleep hygiene, coping with anxiety), and mediums to access information (e.g., comic, video, audio, text). In other words, many features are offered without prescribed usage requirements to nurture a sense of autonomy and to match individual preferences. Horyzons-CA also fosters competence by reminding users of their strengths through a short onboarding questionnaire; these are also emphasized by moderators in their interventions. This approach is concordant with knowledge from positive psychology which affirms that interventions should help individuals optimize their well-being through inner strength development.[6] The online community helps to foster a sense of relatedness by allowing users to interact with each other. The supportive accountability model, which proposes that human support can enhance the effectiveness of digital health interventions,[7] is operationalized through the presence of peer support and clinical moderators.

Digital psychosocial interventions, such as Horyzons-CA, do not replace cognitive behavioural therapy or other treatments offered by clinicians; instead, they support the mental health recovery of individuals by providing complementary care through a blended model. These digital interventions can provide patients the opportunity to consolidate what they have learned through non-restricted access to therapeutic materials and continuous support in-between appointments with health professionals, including psychologists and case managers.

PHASE ONE: ADAPTATION STUDY

As a first step, Horyzons was adapted to the Canadian context and its acceptability was evaluated from the perspectives of patients and mental health service providers.[1,8] The research took place in two specialized FEP clinics located in Ontario and Quebec. The study recruited 11 participants between the ages of 19 and 37, along with 15 clinicians. The feedback from participants living with FEP and clinicians provided the necessary insights to adapt Horyzons and move forward with Phase two: a live pilot study.

PHASE TWO: LIVE PILOT STUDY

In the live pilot study,[9,10] 20 young adults receiving specialized care for FEP were recruited to explore the acceptability, utility, safety, and use of the newly adapted Horyzons-CA platform. The research team investigated the potential role of Horyzons-CA in sustaining recovery and preventing relapses in young adults receiving specialized services for FEP. At baseline, prior to intervention access, and then eight weeks following access, participants were interviewed about their mental health and well-being; in addition, their perspectives on Horyzons-CA were shared in focus groups. The success of this study provided the necessary evidence to obtain funding from the Canadian Institutes of Health Research to support the professional translation of Horyzons-CA into French and to conduct a larger implementation study.

PHASE THREE: PRAGMATIC FEASIBILITY STUDY

Currently, the aim is to expand the evaluation of Horyzons-CA in terms of its acceptability, safety, and utility with 100 to 150 participants between the ages of 18 to 50 living with SSPD in Montreal. In this phase, a bilingual moderation team is available to participants. At baseline and 12 weeks after intervention access, participants are interviewed about their mental health and well-being. Group meet-ups through video chat are conducted to discuss recovery-focused themes, including narratives of recovery, nutrition, and return to work, and to coach participants on how Horyzons-CA can best be used to maximize its potential. Focus group discussions are also conducted throughout the project, the insights from which are used to improve the intervention. Moreover, clinical and peer moderators are completing journal entries to provide their overall experiences of receiving training on Horyzons-CA and its implementation.[11]

This important adaptation, implementation, and evaluation research on Horyzons-CA sets the foundation for expanding its application to other mental health populations across Canada. Our vision is that digital psychosocial interventions, such as Horyzons-CA, become therapeutic tools that can be adapted and implemented by psychologists and clinicians working with clients coping with a range of mental health issues, through a multidisciplinary approach, to optimize and supplement the mental health services offered to Canadians. Such platforms can provide the necessary and integrated tools for therapists to deliver hybrid models of care, continuity of care, and flexibility in terms of individual and group-based interventions to meet the needs and preferences of a diverse population.

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CLINICAL CONSIDERATIONS FOR CONDUCTING PSYCHOLOGICAL TELE-ASSESSMENT

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Hexagon Psychology

The landscape of psychological assessment and testing is changing. Many of the approaches and techniques that were once taught in graduate school are being revised based on emerging theories, evolving best practices, and novel methods which are becoming mainstream across North America. One such innovation, accelerated out of necessity due to the COVID-19 pandemic, is psychological tele-assessment.

The federal and provincial restrictions imposed by the COVID-19 pandemic placed the clinical practice of psychology in a precarious and, what many felt to be, relatively uncharted position. For psychologists to maintain their ethical responsibility for treating their existing clients or meeting the clinical caseload expectations imposed by their employers, the pivot to telepsychology services was either strongly encouraged or mandated.

Telepsychology encompasses the provision of psychological services using a range of telecommunication modalities such as videoconferencing, text messaging, telephone, voice over internet protocol, and more.[1] The shift to telepsychology represented an unknown clinical, ethical, and legal environment for which the formal education and supervision of many psychologists was unlikely to have prepared them for. Many were quick to adapt to counselling within the virtual space but were more hesitant to consider psychological tele-assessment. Some psychologists halted their assessments and evaluations during the COVID-19 pandemic or completed them in-person while using personal protective equipment (e.g., gloves, masks, face shields, plastic screens).[2]

The ability of psychologists to avoid the pressure to conduct tele-assessment, along with the perception of validity or reliability concerns inherent with testing clients during a global pandemic, slowed the adoption of tele-assessment. Subsequently, regulatory bodies, psychological associations, test publishers, academic researchers, and psychologists have recognized the potential benefits of tele-assessment and are in the process of establishing, or already have established guiding literature that should help address the uncertainty and hesitancy.[3,4,5]
Very quickly, guidance on performing psychological tele-assessment during the COVID-19 pandemic was released,[6] including additional empirical evidence supporting general equivalence of administration formats for common test measures.[7] The aforementioned guidance includes recommendations on how to administer or substitute for tests that require manipulation of physical materials. Beyond what was already considered best practice for conducting psychological assessments, the authors recommended that extra care and caution needed to be granted to the topics of test security, client appropriateness for testing, client technology proficiency, obtained data quality, subtest substitution, and test score interpretation within widened confidence intervals. Since then, the professional and academic communities have continued to produce recommendations to support psychologists in conducting psychological tele-assessment. The following suggestions represent an abbreviated list of such further guidance that can support clinical mastery of this modality.[5,6]

ETHICAL CONSIDERATIONS FOR TELE-ASSESSMENT

- The risks and benefits of performing psychological tele-assessment should be closely inspected by psychologists before beginning to pursue such an approach. They should, with input and information from the client, carefully consider the best approach to take.
- Tele-assessment may not be suitable for all clients. For example, clients may not have access to (or may struggle with using) technology. They may have behavioural or cognitive limitations that severely impact the validity of tele-assessment results, or they may be too young. If locally available, accessible, affordable, and timely in-person assessment remains the recommended service option.
- Consent processes and forms should be updated to reflect the privacy and security risks associated with internet communication. This includes an endorsement from the client that they would not engage in recording or streaming of their session without psychologist consent.

CROSS-JURISDICTIONAL AND OTHER LEGAL CONSIDERATIONS

- Psychologists are encouraged to reach out to the regulatory bodies in the provinces or territories in which their tele-assessment services may be received. Each jurisdiction offers unique regulations surrounding virtual services and who can practice with or without specific licensure.
- Professional liability insurance coverage should include telepsychology services.

SPACE AND TECHNOLOGICAL CONSIDERATIONS

- All psychological tele-assessment should be conducted in a private space with adequate front-facing light for both the psychologist and client.
- Psychologists will at minimum require a high-quality computer, webcam, microphone, headphones, stable internet connection, and a screen large enough to see multiple documents and the client simultaneously.
- Clients will at minimum require a high-quality computer, webcam, microphone, headphones, stable internet connection, and a screen large enough to see the psychologist and the testing materials they may be displaying. It is recommended that the client's screen not be less than 10 inches.

DIRECT TESTING COMPETENCY

- The psychologist should take time to examine which psychological instruments they are competent to administer in-person and determine whether the test publisher has released guidance on the virtual assessment of these instruments (e.g., how to administer or substitute for tasks that require object manipulation).
- Time should be dedicated to practicing the virtual administration of the test. Psychologists are encouraged to practice setting up their technology and assessing mock clients or colleagues. When learning this new modality, psychologists are advised to go slow, be patient, and continually ask for feedback from their mock clients and colleagues.
- For a psychologist's first tele-assessment case with a real client, they may consider practicing in a hybrid manner where portions of the evaluations are completed in-person and others through online services. This allows the psychologist to test the limits on any scores or observations made during tele-assessment, should they feel the need to ensure their accuracy.

INTERPRETATION OF TESTING DATA

- Psychologists should continue to prioritize an understanding of sources of error, including test administration modality. Composite scores should be preferentially interpreted, including confidence intervals, and always in context of other sources of information.

These considerations remind psychologists that any form of psychological assessment requires sound judgment and ethical reasoning, and that no single score obtained from a psychological testing session should ever make or break a clinical decision, even under the most optimal of conditions. Psychologists are right to approach psychological tele-assessment with a critical and cautious eye. At the same time, these qualities should never overpower the creativity and curiosity needed to explore new methods of meeting the needs of our clients.

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ADAPTING A PSYCHOLOGY TRAINING CLINIC TO PROVIDE VIRTUAL DELIVERY OF CARE

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The Psychology Training Clinic (PTC) is a partnership between Toronto Metropolitan University (TMU) and Unity Health Toronto (UHT). PTC provides students from TMU's Clinical Psychology Graduate Program with the opportunity to develop initial clinical experience and provides exposure to interprofessional practice in a primary care setting. PTC also increases access to psychological services for UHT's patients, many of whom come from marginalized and at-risk populations.

Each year, approximately eight students complete their first clinical placement at PTC. Each student conducts assessment and treatment with four to five patients over the 10-month practicum, with sessions recorded for student and supervisory review.

Prior to the COVID-19 pandemic, all PTC services were provided in-person. While the benefits of virtual delivery of care were well-known (including improving patient access and general equivalency in clinical outcomes and patient satisfaction),[1-3] many of these studies presumably involved clinicians who had already developed foundational clinical skills with in-person interactions. It was not clear whether novice therapists providing care virtually would be as effective. Additionally, the literature pointed to challenges in providing virtual delivery of care, including lower clinician confidence[4] and the need to respond to unexpected disruptions in services and manage additional privacy and boundary issues.[5] For these reasons, we presumed the challenges associated with delivering care virtually might best be approached later in student training.

The start of the COVID-19 pandemic in March 2020 resulted in unprecedented global disruptions in social, employment, educational, and healthcare settings and the need to re-evaluate the pros and cons of providing virtual delivery of care. During the early months of the pandemic, PTC developed a plan for virtual delivery of care with the following policy assumptions: 1) novice students are best able to engage in clinical activities by coming into the clinic, at least initially; 2) students can complete administrative work from home, including report writing and participating in supervision; 3) patients should participate in clinical services via virtual delivery of care to the greatest extent possible. We thought these policies provided the best balance of benefits (e.g., student access to robust IT systems, privacy, an on-site supervisor, and peer support) and risks (e.g., minimized risks of COVID-19 transmissions, disruptions in patient-facing activities, and unplanned or urgent situations where novice students had limited abilities to respond and would find stressful). As students developed skill and experience, their individual circumstances and resources could be assessed and they could be permitted to provide clinical services virtually from their own homes, if appropriate.

With these policy assumptions in place, specific resources and procedures were developed with the full support of both partner institutions, including:

1. Selecting Zoom Healthcare as a virtual care platform due to its ease of use, familiarity to students and patients, and its ability to save recordings to secure hospital servers for later review.
2. Providing students with remote access to write reports and review session recordings for supervision from home while keeping all patient information on secure hospital servers.
3. Developing a comprehensive policies and procedures manual including detailed directions.
4. Developing a virtual delivery of care training plan with videos and readings for students and supervisors.[6-9]
5. Scheduling a clinic 'soft open' to allow students to develop familiarity with systems and processes using mock data and role plays.
6. Adapting the clinic's assessment and progress monitoring battery. An e-form was created for the Depression Anxiety Stress Scales, 21-item version (DASS-21),[10] facilitating secure electronic transmission, completion, and documentation of symptoms. A satisfaction questionnaire was later implemented for patients to provide anonymous feedback.

While outcome data for PTC were not available for preceding years, data collected after implementation of the virtual delivery of care program suggest that PTC provides clinically effective services and high levels of patient and student satisfaction.

For 2020–2021, almost all sessions were provided virtually, with a low drop-out rate (7.5%), and most patients who started treatment completed a reasonable course of treatment with pre–post measures (77%). The patient sample showed statistically significant changes and large effect sizes on all three scales of the DASS-21. At the start of treatment, 71% of patients scored in the severe or extremely severe range on at least one DASS-21 scale. At discharge, only 23% continued to do so. A satisfaction questionnaire was introduced mid-year. Of 15 patients who were sent the survey, 11 (73%) responded, with a strong majority providing positive feedback about their therapist, therapy, and clinic services. Eight out of 10 students (80%) responded to a qualitative program satisfaction questionnaire regarding their placement. All respondents stated that the practicum met their expectations and that they would recommend the practicum to other students. Students described their supervisors as warm, flexible, available, knowledgeable, and providing developmentally appropriate guidance.

During 2021–2022, there were fewer drop-outs and more complete patient data, possibly as a result of fewer disruptions due to pandemic factors and increased supervisor experience managing delivery of care virtually. Almost all sessions were provided virtually, with a low drop-out rate (3.3%), and all patients who started treatment completed pre–post measures. The patient sample showed statistically significant change on the DASS-21 and large effect sizes for the Depression, Anxiety scales, and a medium effect size for the Stress scale. At the start of treatment, 76% of patients scored in the severe or extremely severe range on at least one of the DASS-21 scales. At discharge, only 24% continued to do so. Although a low number of patients (41%) completed the anonymous client satisfaction survey, 100% of those that responded provided positive feedback about their therapist, therapy, and clinic services. All students responded to a quantitative survey regarding their placement at PTC and provided positive feedback about supervision and the practicum.

Despite the challenges associated with implementing a virtually delivered care program, these data suggest that novice therapists can learn to deliver effective psychological services virtually. We hope the lessons learned will be useful in other settings and situations involving training and supervision of student therapists.

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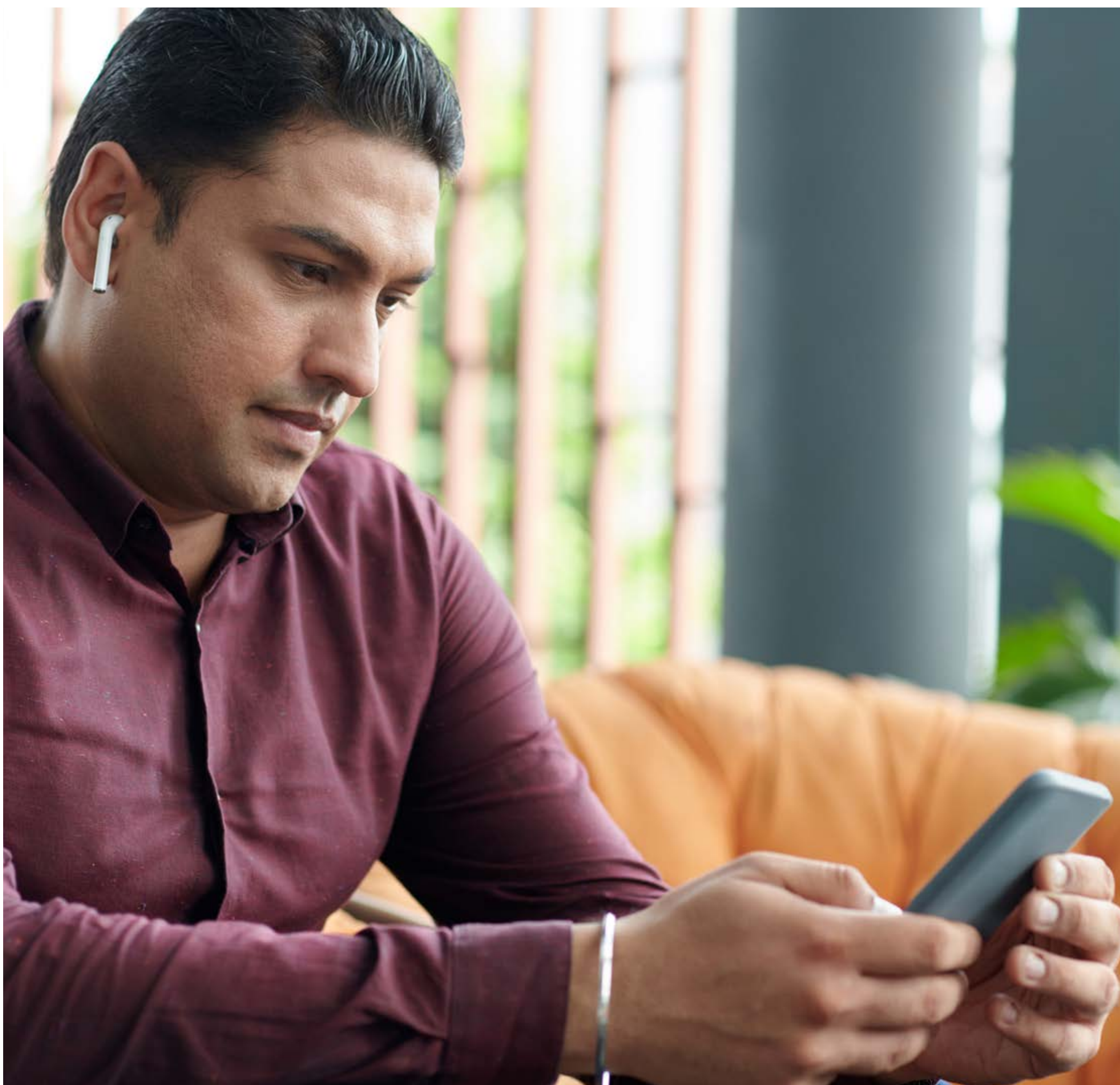

PARAPROFESSIONAL ROLES IN E-MENTAL HEALTH

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In Canada and throughout the world,[1] there is a scarcity of all mental health professionals, perhaps especially psychologists.[2] Although people live in all areas of Canada, mental health professionals are concentrated in the major cities. This shortage is accompanied by severe restrictions in mental health budgets that, although they have improved in recent years,[3] are not yet proportionate to the burden of mental health problems. Moreover, with limited pediatric mental health professionals and growing waitlists, investment into adopting complementary family-centred solutions will be necessary to ensure timely access to effective care.

e-Mental health provides an opportunity to expand services by developing innovative approaches that can reach more people in need. Some e-mental health is self-guided and this serves an important role. However, for significant mental health conditions causing impairment, e-mental health programs that include some human contact are usually more effective. Often the involvement of a human in e-mental health improves outcomes, in part by reducing dropouts and increasing compliance.[4] People are social and some respond better to social influence and problem solving than non-human social influence and problem solving. Human contact may range from very short encounters to more lengthy interactions.

Paraprofessionals, those who are not in regulated professions, can play an important role in scaling up evidence-based interventions.[1] In addition, e-mental health can be an ideal way to use paraprofessionals because electronic support for the paraprofessional can be programmed into the interface between the client and the provider.

The Strongest Families Institute's (SFI) (formerly Family Help) e-mental health system of care is an example of a Canadian not-for-profit charity that makes extensive use of paraprofessional coaches and is grounded in 20 years of social science research. SFI's paraprofessional telephone coached programs have been shown to overcome diagnosable mental health disorders[5] and is easily scaled. SFI has reduced waitlists in several Canadian provinces and currently serves over 11,000 families/clients annually, with capacity to continue to expand. SFI telephone support coaches deliver programs for anxiety, nighttime bedwetting, and disruptive behaviour in children, and anxiety and depression in adults across Canada. SFI's stepped care programming and innovative technology platform (IRIS)[6] provides a universal mental health approach.

SFI's coaches are selected based on personal attributes that will foster strong therapeutic alliance with children and parents over the telephone,[7] ability to follow SFI protocols, and problem-solving abilities. They receive intensive training on program protocols, program skill-based content, and how to customize care to meet clients' needs, including program skill adaptations to address COVID-19-related impacts. SFI's IRIS platform[6] provides detailed protocolized telephone scripts to follow and guides coach behaviour. Automated prompts, reminders, and quality assurance flags occur throughout any session. Coach supervision, guidance, and support provide an extension of the skills of the coach. SFI coaches are telephone ready within weeks of completing intensive training.

Selection, training, supervision, and a defined scope of practice are key elements of success in the role of a paraprofessional.[8] Selection should include a strong ethical sense, an eagerness to learn, a commitment to evidence-based practice, adherence to protocols, schedule flexibility to accommodate convenient appointment times (i.e., evening/night), and acceptance of the guidance that is inherent in following scientific evidence rather than just "gut instinct". Training often focuses on the tasks to be completed by the paraprofessional and "red flags" that can alert to the need for consultation or referral as part of risk management. Supervision of paraprofessionals will depend on the setting and can be by a psychologist, another health professional, or by a more experienced paraprofessional. Defining scope of practice is critical so that the paraprofessional does not exceed their competence.

Major advantages of paraprofessionals are they can be trained in a much shorter time and as a result can overcome shortages in health personnel; they can be recruited to have key characteristics of the clients/patients they are serving and thus increase the acceptability of care to disadvantaged communities; and they are less costly to employ.

The major limitations of paraprofessionals are that their training is not as inclusive as that of a health professional. Health professionals in mental health will have many years of training in most or all aspects of mental health. A paraprofessional will have less education and is frequently trained in a limited number of tasks. Because of their limited training, it is especially important for them to know the limits of their competence and have access to experienced paraprofessional supervisors and mental health professionals.

Leveraging the advantages of research, technology, and capable paraprofessionals (who are highly trained and monitored) can provide promising, validated, and cost-effective solutions for primary mental healthcare reform in Canada. Broad system integration of evidence-based, scalable solutions, such as the SFI system of stepped care, provides a variety of programs and coaching intensities as a population-based mental health approach. Moreover, effective paraprofessional solutions can complement the current system so licensed mental health professionals can focus their expertise on more complex and severe cases in need of expert care. Such e-mental health paraprofessional solutions can help bridge the access gap, alleviating the strain on the system, while improving the lives of Canadian children, adults, and families.

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TELESUPERVISION: OPPORTUNITY, RISK, AND RESPONSIBILITY

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As we all know from the pandemic, videoconferencing technology enables audio-visual communication at a distance. This was vital when travel and in-person gathering were not occurring. Crucially, videoconferencing enabled professional psychology to continue many of its core functions, including clinical supervision, which supports student training and fulfills ethical and legal mandates for public protection in training and regulatory contexts. Although the easing of pandemic restrictions has lessened the profession's dependence on videoconferencing, its convenience and educational value mean that supervisors will likely continue to use it. In addition to its benefits, however, videoconferencing also carries risks and limitations. Although telesupervision encompasses both videoconferencing and telephonic modes of communication as they relate to supervision, I focus on videoconferencing owing to its greater novelty and complexity. Specifically, the present article highlights important considerations for supervisors for the safe and effective use of videoconferencing related to: (a) supervisory oversight of how supervisees use videoconferencing with clients, and (b) videoconferencing as a means of delivering supervision.

As telesupervision builds on the fundamentals of in-person clinical supervision, a brief description of supervision is in order. Clinical supervision is a relationship-based form of education and training between a supervisor and one or more supervisees characterized by mutual respect, safety, and trust that supports, guides, and evaluates their work. Its objectives are to: (a) provide clinical oversight of services within the supervisor's competence, (b) aid supervisees' competency development, and (c) help supervisees manage the emotional impacts of clinical work. This is achieved through collaborative goal-setting, feedback, reflection, and teaching. Supervisees play an active role in supervision by preparing for supervision meetings, informing supervisors of their work and their clients' well-being, making use of supervisory feedback, and carrying out assigned responsibilities.[1,2]

When overseeing the work of a supervisee who is using videoconferencing to deliver services to a client, some of the risks that supervisors need to manage relate to: the technology, the client and their location, and the psychological impact of teleconferencing. Regarding technology, there are many potential weak links in the internet chain that may render client communications insecure and vulnerable to breaches of confidentiality. Supervisors need to obtain guidance from IT professionals regarding safe practices, apps, devices, and connections. The second, related consideration is that risk management with teleconferencing requires educating and gaining the cooperation of clients. This process ensures the security and adequacy of their devices and connections and the privacy of their location. Supervisors ensure that their supervisees engage in safe and effective videoconferencing practice with their clients.

Additionally, videoconferencing has a psychological impact on users that can reduce the effectiveness of supervisees – and supervisors. Because clinical work and clinical supervision are intrinsically relational, supervisors and supervisees must appreciate how videoconferencing may affect these relationships. Remote communication tends to diminish the experience of human co-presence and its resulting interpersonal energy. Also, without some of the non-verbal information that provides much of the shared context necessary for empathy, mutual understanding can become more difficult. These problems are compounded when inevitable degradations of audio or video quality occur. Sometimes the anxieties aroused by such tenuous connections result in a tendency to skip over the relational "warm-up" activities that build connection prior to "getting down to business". Similarly, there may be a risk of scheduling consecutive meetings without including time for breaks in-between. Over time, the cumulative impact of such depleting experiences contributes to Zoom fatigue – a weariness arising from remote encounters that results in interpersonal distancing and passivity. Consequently, effective communication with technology requires greater forethought and effort to ensure clarity, transparency, explicitness, and attention to relationship-building and human comforts. These considerations apply both to supervision and to client services delivered via videoconferencing.

When providing supervision via teleconferencing, supervisors have an opportunity to model good telepractice by addressing the adequacy of the internet connection, attending to the supervisee's well-being, and concluding with a summary of next steps and inquiring about the supervisee's satisfaction with the meeting and supervisory relationship. Telesupervisors also model and encourage appropriate self-care, especially as it relates to videoconferencing. This can be accomplished in part through thoughtful scheduling of videoconferencing meetings to avoid Zoom fatigue and by promoting warm, supportive, and effective relating within meetings, including discussing the risks of interpersonal distancing, fatigue, and passivity that can accompany videoconferencing. Telesupervisors may further enhance supervision by taking advantage of the opportunities provided by digital technology to observe supervisees' work (either live or via recording), or to provide live supervision.[3] Similarly, telesupervisors (and supervisors-in-training) may, with consent, record and review telesupervision sessions for their own learning and professional development. In group supervision via videoconferencing, supervisors ensure that each supervisee receives sufficient guidance and support from the supervisor and group members.

In summary, telesupervision extends in-person supervision into the oversight and use of videoconferencing. When the risks of videoconferencing are understood and well-managed, supervisors can leverage its benefits to enhance clients' access to service, the education of trainees, and the versatility of the supervisory process.

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MORE THAN APPS: PSYCHOLOGY'S CONTRIBUTION TO DIGITAL MENTAL HEALTH

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e-Mental health (eMH) involves much more than the thousands of simple apps available through an internet search. It includes tools that support measurement-based care, electronic records that facilitate the sharing and documentation of client information, technology that supports treatments such as biofeedback and virtual reality-based therapy, and video conferencing platforms that have become the default clinic space. Given the rapid expansion of technology-based tools in mental health care, the role of psychology in guiding this work at a system level is more important than ever.

ACCESS TO AN EXPANDED MENU OF TREATMENT OPTIONS

At a time when demand for mental health care far exceeds supply, technology has the potential for expanding the menu of treatment options, whether it be extended access to providers across multiple regions, or through the development and scaling of low-intensity mental health literacy tools, apps, and peer support. Increasingly, people looking for mental health support search for it online, with most making use of internet searches.[1] Facilitators of online help seeking include convenience, perceived anonymity, and confidentiality, particularly for youth up to age 25 years. Barriers involve concerns about paywalls, credibility of web-based resources, and suboptimal satisfaction with the experience.[2] As with most internet queries, trustworthiness is a challenge. Psychology's proficiency in evaluation, outcome measurement, and psychometrics must be adapted to inform consumer choice from the expanding array of options available online.

Most of the approximately 20,000 available mental health apps lack efficacy. Frameworks have been established by psychologists to guide selection of effective digital tools,[3] but it is unclear whether such guides are accessible to the average consumer. While there is evidence that validated mental health digital apps are better than no intervention, there is less clarity about the added value to psychotherapy or psychiatric care.[4,5]

Research is needed to better understand the importance and impact of personalized treatment options in order to understand what works for whom and under which circumstances. This can include an evaluation of combined treatment offerings that can inform trial-and-error selection of resources.

WEB DESIGN FOR THE INTEGRATION OF POPULATION AND CLINIC-LEVEL INTERVENTIONS

Like other health professionals, psychologists are familiar with less-than-optimal applications of technology to their workflow. Many health websites and portals have design limitations. The user journey must be a major component of the intervention just as the therapeutic alignment is for face-to-face care. In developing Wellness Together Canada (WTC), a Health Canada-funded online mental health portal that provides low intensity supports to more than three million people, we engaged with a Canadian social enterprise firm run by a team of inventors and behavioural scientists. Behavioural science guides the ongoing design of the portal through focus group testing, user experience analysis, and various user feedback platforms. In user feedback surveys for people "satisfied" or "highly satisfied" with the portal, one of the top reasons was ease of use.

Most provinces and territories are implementing population level eMH tools but the level of public engagement with these tools is unclear. While some provincial and territorial governments (e.g., Newfoundland and Labrador, New Brunswick, Northwest Territories, Prince Edward Island) are linking their websites to WTC and encouraging providers to refer clients to the portal, many are not. Further scaling of this platform into provincial and territorial care systems could allow for the transfer of portal wellness tracking data into clinical records, contributing to a more holistic type of measurement-based care. Integration would also provide ongoing access for clinicians and their clients to a broader continuum of supports to build out more holistic treatment plans. While such integrated platforms have the potential for informing a powerful A.I. learning-based system of care, questions of privacy and data ownership will need to be thoughtfully considered.

SUPPORTING PREFERENCE-BASED QUALITY CARE

Wellness tracking using mobile devices is still a largely untapped opportunity for behavioural health care.[6] Smartphones and smart watches collect a vast amount of data relevant to mental health, including sleep and activity patterns. These data can be integrated with self-reported mental health to inform consumer- and clinic-based mental health treatment decisions. There are a lot of e-mental health choices, but not a lot of support for making the choices. Most digital apps offer low intensity support in the form of mood tracking, journaling, and psychoeducation. Even fewer offer peer support, goal/habit setting, or expert coaching. Web-based systems need to be designed and implemented to support informed choice,[7] given that supporting client preference in treatment selection decisions has been shown to improve satisfaction and outcomes when two or more efficacious treatments are available.[8]

VIRTUAL CARE – SYSTEM DESIGN, DEVELOPMENT, AND IMPLEMENTATION

Psychology is a discipline of disciplines. Expertise from industrial organizational psychology, social psychology, community psychology, neuroscience, cognitive science, and other psychology-based fields is needed to adapt practices for the hybrid mental health workspace. Research and industry offer many potentially successful innovations, but these innovations will likely fail to reach their full potential without the participation of psychologists in the design, testing, monitoring, and implementation processes of evidence-informed learning-based systems.

There are many opportunities for psychologists to leverage technology to advance some of our most unique contributions to society – program evaluation, assessment and outcomes monitoring, and understanding psychological experience. Large scale digital health innovations are needed to address the crisis of mental healthcare access. The success of those mental health innovations could depend on the extent of ongoing and future psychology research and program development partnerships with government policymakers and industry.

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

In the early 2000s, a mounting body of research demonstrated great excitement and optimism surrounding the development and utility of technology-mediated psychotherapeutic services within our Canadian context. Indeed, in 2011, a national research study conducted at the National Research Council of Canada indicated that, among the hundreds of participants sampled across the country, clinicians had overall positive attitudes toward the use of e-mental health and saw this as a way of decreasing barriers to accessing services.[1] Additionally, the study found that receiving training in telemental health, being in the mental health field for longer, and perceiving the technology as easy to use were factors associated with more frequent use of telemental health services.

THE EVOLUTION AND CONTINUING NEEDS OF E-MENTAL HEALTH IN CANADA

DEANNE C. SIMMS, Ph.D., C.Psych., Founder & CEO, ThriveSpace Health and Wellness

Unfortunately, despite these encouraging findings and an anecdotal sense of enthusiasm for integrating technology into mental health service offerings, there continued to be considerable barriers to opportunities for training and adoption of these technologies in both the public and private health sectors across the country at the time.

Nevertheless, many practitioners overcame significant challenges to employ technology-mediated services in their practices. At the time, challenges to implementation included but were not limited to systemic, financial, technological, and professional factors. In 2015, I began my practice of providing remote-delivered services through a secure patient portal specially designed for providing psychological services. This means of delivery was well-received by clients, and was in keeping with the values of providing accessible and acceptable services to patients when and where they needed it most. As momentum built in the sector, e-mental health gradually became part of the formal and informal health service offerings in regional and provincial landscapes. This expansion was encouraging, but also necessitated increased evaluation and mindful implementation to ensure client safety and optimal outcomes.

Over the early part of the last decade, while there was a growing interest in engaging in e-mental health services (from both clinicians and clients), advancements felt at times glacial. However, the COVID-19 pandemic accelerated the adoption of e-mental health services across Canada. Early in the pandemic, there was a well-documented exponential increase in remote-delivered mental health programs, services, and applications. This was a welcome change in a mental health system that was already stretched thin, at a time of unprecedented population mental health needs. It was encouraging to see meaningful erosion of barriers that had previously contributed to inequity and inaccessibility of services and, moreover, this expansion of services and utilization provided a much-needed opportunity to evaluate the effectiveness of e-mental health services. Indeed, the monumental growth and development of e-mental health may perhaps be one of the silver linings of the COVID-19 pandemic.

Despite the exciting opportunities and benefits of growth in e-mental health, there are still challenges that need to be addressed. For example, as the field continues to advance, so too grows the need for evaluation and regulation to ensure aspects of safety and security. In order to address some of these needs, the Mental Health Commission of Canada's (MHCC) e-Mental Health Collaborative was developed. The purpose of this group is to engage in knowledge exchange activities and undertakings and to provide input and consultation to the MHCC to help guide their decision-making on priority areas and initiatives in the space of e-mental health. Here stakeholders, such as mental health professionals, are able to use research and practice knowledge to contribute meaningfully to the policy and advocacy work that is of fundamental importance to the continued growth and robust development of the e-mental health sector.

For example, following the proliferation of mental health applications into the market and health sphere, there is now a need to evaluate service offerings to ensure they are evidence-based, in keeping with relevant standards and regulations, and ultimately improving access and care for people living in Canada. To address this need, the MHCC has done tremendous work in determining key elements of national standards for mental health applications. A first draft of standards was developed by the MHCC spanning six domains: (i) data and privacy, (ii) clinical evidence, (iii) clinical safety, (iv) usability and accessibility, (v) security and technical stability, and (vi) cultural safety, social responsibility, and equity. A draft of the standards was open for public review in Spring, 2022 and continues to be developed, currently.

In addition to the above, the reactive and fast-paced development of regional, provincial, and national e-mental health offerings during the pandemic resulted in a difficult-to-navigate patchwork of services that is often fragmented. As such, there exists a continued need to coordinate and consolidate services in order to decrease the burden of access or navigation that exists for clients. Currently, several actors (see other articles in this issue of *Psynopsis*), including the MHCC and expert stakeholders, are engaging in efforts to develop an e-Mental Health Strategy for Canada.

While the expansion and extension of e-mental health services has been encouraging, there are a number of continuing and future areas of need identified in this space: ensuring equitable access to services for all Canadians in the context of systemic, geographical, and other barriers; increasing and maintaining funding to support development and sustainability of e-mental health services; standardization of these services and meaningful integration into existing health structures/systems; as well as improved training for practitioners that is applied and integrated in early phases/stages of training.

At long last, the promise of the field of e-mental health has begun to be expressed and experienced in our Canadian context. The rapid expansion of services in response to the COVID-19 pandemic outpaced early efforts to evaluate and implement services in a standardized, evidence-based, and coordinated manner. Nevertheless, there currently are efforts underway to ensure that regulation and structures are developed that ensure the robust expansion of the field, with the primary focus being the safety and satisfaction of clients. As scientist-practitioners, psychologists are uniquely positioned to participate meaningfully in the continued advancement of the field by bringing an informed and impactful voice to undertakings and decision-making processes in various forums.

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

CPA HIGHLIGHTS

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!

NEW POSITION STATEMENT: PROMOTION OF GENDER DIVERSITY AND EXPRESSION AND PREVENTION OF GENDER-RELATED HATE AND HARM

The Canadian Psychological Association (CPA), through its Code of Ethics and policy statements, has long held a commitment to human rights, social justice, and the dignity of persons. Despite this commitment, echoed in amendments to Canada's Human Rights Act and the Criminal Code, and in the Universal Declaration of Human Rights, gender-based stereotypes, prejudice, and discrimination continue to persist across social systems and services (e.g., education, health, justice).

With the rise of gender minority hate and violence worldwide, this policy statement outlines the discrimination that people of gender minority face, as well as the changes that need to be made to redress it. The CPA commits to helping to bring about these changes and calls on legislators, policy makers, and agencies and individuals who deliver health and social services to assert their commitments to join us.

View the full Position Statement, authored by Drs. Jessé Bosse and Ada Sinacore, on our website under 'Position and Policy Statements'.

2023 FEDERAL BUDGET FALLS SHORT FOR MENTAL HEALTH AND RESEARCH

The CPA and the Canadian Alliance on Mental Illness and Mental Health (CAMIMH) commented on the recently released 2023 federal budget – which fell short when it comes to investments in mental health. See news releases at the CPA and CAMIMH websites.

The Canadian Consortium for Research (CCR), of which the CPA's Deputy CEO is Chair, also commented on the recently released 2023 federal budget, noting its disappointment in the lack of investment in Canada's research culture, global relevance, and Canada's next generation of researchers. See budget response at the CCR website.

CPA APPEARS BEFORE SENATE SUB-COMMITTEE ON VETERANS AFFAIRS

The CPA was asked to appear before the committee to speak to emerging treatments for Canadian Armed Forces and RCMP veterans suffering from occupational stress injuries. The CPA's brief was developed and delivered by Dr. Andrea Lee, Policy Associate of the CPA. See our opening statement under 'advocacy' at the CPA website.

STUDENT RESEARCH GRANTS

The CPA has announced the recipients of this year's student research grants. These grants recognize exceptional student research in all areas of psychology. Grants were provided by the CPA, including some in partnership with the Canadian Society for Brain, Behaviour and Cognitive Science (CSBBCS), and by BMS Canada. A full list of this year's recipients is posted on the CPA site under 'science'.

CPA HIGHLIGHTS

NEW "PSYCHOLOGY WORKS" FACT SHEET: SPINAL CORD INJURY

Prepared for the CPA by Dr. Andrei Krassioukov, Professor, Division of Physical Medicine & Rehabilitation, Faculty of Medicine, the University of British Columbia (UBC), Chair and Associate Director, Rehabilitation Research, International Collaboration on Repair Discoveries (ICORD); and Anh-Duong (Jennifer) Phan, Research Assistant, Rehabilitation Research, ICORD. Find this under 'fact sheets' on the CPA website.

NEW "PSYCHOLOGY WORKS" FACT SHEET VIDEOS

The CPA has created 12 new fact sheet videos available in English and French, touching on subjects like 'Coping with Emergencies, Disasters and Violent Events', 'Physical Activity, Mental Health, and Motivation', and 'Workplace Burnout'. Find the new videos on the CPA website under 'fact sheets' and on our YouTube channel.

CPA RELEASES ROADMAP TO GUIDE FEDERAL-PROVINCIAL-TERRITORIAL COLLABORATION IN MENTAL HEALTH & SUBSTANCE USE HEALTH

Knowing that First Ministers were meeting February 7th to discuss the future of health care, the CPA released a roadmap to assist the federal, and provincial and territorial governments as they discussed how to increase investment in publicly funded mental health and substance use health services. The roadmap, which contains 10 recommendations, is based on a series of key informant interviews with a series of stakeholders. Following the First Ministers Meeting, the CPA issued two news releases in early February. You can find both under 'advocacy' at cpa.ca.

WHO WE ARE

ABOUT US

The Canadian Psychological Association (CPA) was founded in 1939 as the national association for the science, education and practice of psychology in Canada. We were incorporated under the Canada Corporations Act, Part II, in May 1950 and received our Certificate of Continuance under the Canada Not-for-Profit Corporations Act (NFP Act) in August 2013. With over 7,000 members and affiliates, we are Canada's largest national association for psychology.

VISION

A society where understanding of diverse human needs, behaviours and aspirations drive legislation, policies and programs for individuals, organizations and communities.

MISSION

Advancing research, knowledge and the application of psychology in the service of society through advocacy, support and collaboration.

OUR STRATEGIC GOALS

1. As an association, we are guided by the vision that the science, practice and education of psychology has broad and deep relevance to public policy and the public good. We aim to realize this vision by being an association that:
2. Supports and promotes psychological science to advance knowledge and to address the concerns of people and the society in which we live and work.
3. Meets the needs, supports the growth and enhances the impact of the discipline and profession.
4. Advocates for access, resources and funding for psychological services and research, in parity with physical health, for the people in Canada.
5. Addresses the education, training and career development needs of students, educators, scientists and/or practitioners of psychology across their lifespan.
6. Promotes and models equity, diversity and inclusion in all we do.
7. Is accountable to Indigenous people through the recommendations of the CPA's response to the Truth and Reconciliation Commission (TRC) of Canada's report.

CPA GUIDING PRINCIPLES

- Evidence-based practice, policy and decision-making.
- Respect our organizational mission in all things: support and promote the development of the discipline and profession and its contributions to the people and society in which we live and work.
- Deliver value to members and affiliates.
- Respect, integrity, diversity and inclusion guides all our activity.
- Model the principles of the CPA Canadian Code of Ethics in all we do.
- Collaborate meaningfully and constructively with the CPA's and psychology's partners and stakeholders.

CPA OPERATING PRINCIPLES

- A commitment to best practice in the governance and management of the association.
- Organizational effectiveness. Our strategic goals reflect and respond to the needs and views of our membership and stakeholders. We align operations to strategic goals. We balance the need for continuity of policy and programming with the need to respond to changes in the organization's climate and context. We walk the talk of respect and collaboration among Board, management, staff, members, affiliates, partners and stakeholders.
- Provide psychology across Canada a professional home. We can do this by being a convenor and by supporting networks and communication among scientists, practitioners and educators in psychology.
- Have an opinion, lend a voice, make change for the good. We engage members and their expertise in making contributions to public policy.
- See, hear and consider a diversity of perspectives from among members, affiliates, partners and stakeholders when addressing issues, problems, policies and initiatives facing psychology or the organization.

Canadian Psychological Association 2022

7,460
MEMBERS AND AFFILIATES

50,464
SOCIAL MEDIA FOLLOWERS

245
ONLINE CPD COURSES

12
AWARDS

3
JOURNALS

1
ACTIVE WORKING GROUPS

11
ALLIANCES/ COALITIONS

57
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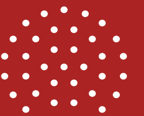
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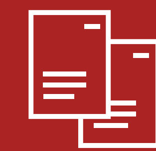
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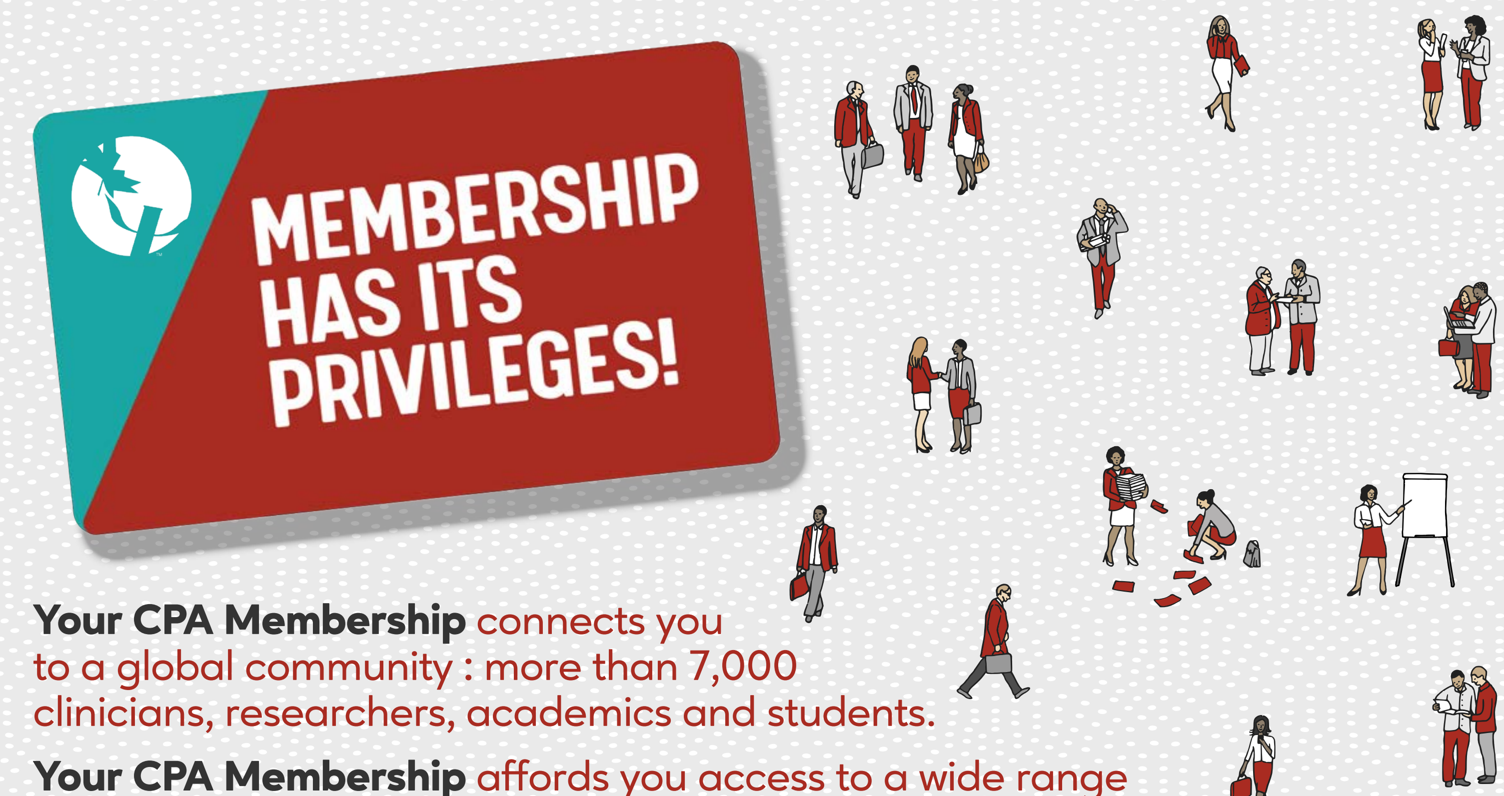

Your CPA Membership connects you to a global community : more than 7,000 clinicians, researchers, academics and students.

Your CPA Membership affords you access to a wide range of personal and professional benefits, including access to :

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- Our 190+ **Continuing Professional Development courses**
- **Podcasts** on timely topics like Remote Practice, Racial Injustice, Vaccine Disinformation, Supporting Female Mental Health Professionals with Self-Care and The Naomi Osaka Effect
- Our 20+ **grants and awards** including student conference, research and knowledge mobilization grants, and service member and humanitarian awards
- **Discounts, learning and networking opportunities** that are available to you through our Career Fairs and Annual Convention – the premier psychology conference in Canada
- **Resources and publications** including a monthly newsletter, quarterly magazine, fact sheets, journals and a discount on PsychNet Gold
- The ability to develop your **leadership skills**, **get published** or **build your resume**
- Our ongoing **advocacy** work on relevant issues like conversion therapy, tele health therapy and mental health parity

Your CPA Membership provides us with the ability to support, promote and advocate for you, our members, affiliates and associates.

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