



Winter 2014

### Inside this issue:

Message from the Chair	1
See you at the Convention	2
Neuropsychology Guidelines for Epilepsy Surgery	3
Psychology in Bariatric Surgery: A Review of the Evidence for Best Practices	4
Student Column	7
It Doesn't Have To Hurt: Strategies for Helping Children with Shots and Needles	8
Member Profile: Dr. Joyce D'Eon	9
Call for nominees for our Section's award	10



### Message from the Chair:

#### Some Challenges and Benefits of Hospital Based Practice

Kerry Mothersill, Ph.D., R. Psych.

Practicing Psychology in the publicly funded health care system in Canada isn't for everyone. Opportunities exist for employment within many settings, including the correctional system, private practice, EFAP programs, post-secondary educational clinics, etc. Each setting has its own rewards and challenges. Hospitals and outpatient programs have their unique assortment of challenges and opportunities.

As reported by Owens et al. (2013), hospital psychological services in Canada are predominantly organized in either some form of a matrix system (39% - where psychologists report to both a program as well as a discipline manager) or a program management model (16% - where psychologists report solely to a program manager with perhaps support from a professional practice leader).

Program managers typically come from professions other than psychology and can have variable degrees of awareness of the academic /professional training of psychologists as well as the range of competencies and skill sets (assessment, intervention, program development and evaluation, consultation, training and supervision) that they bring to patient care teams. This variability can sometimes limit the range of opportunities for professional service delivery by psychologists.

Government pressures on

health care funding have resulted in organizations reducing the costs of program operations and not expanding services to keep up with population growth. Sometimes it seems that treatment has become the process by which a referral is transformed into a discharge by the least expensive service unit in the shortest possible timeframe. Managers and staff alike often feel squeezed and frustrated.

Educating program managers about the discipline and profession of Psychology can help them make informed decisions in hiring the best mix of practitioners to provide the services needed by the population served. The Guidelines Committee of the Section is developing a template for a "Resource Guide for Managers" that can be adapted for local use. The Guide will provide program managers with information that highlights the depth and breadth of skills that psychologists can apply, not only to patients, but also to the program and the wider hospital/health care community.

When it is suggested that psychologists are too expensive, I try to help managers realize that they are likely not utilizing psychologists to the full scope of their practice. As Murdoch (2013) has cogently demonstrated, the extent of training in mental health services (not including the other skill sets noted above) that psychologists

undergo is significantly greater than many other professions. Services created and provided by highly skilled psychologists can yield cost-effective benefits and reduce waitlists and referrals. (See, for example, the Section-sponsored workshop by Furer et al at the CPA Convention in June in Vancouver). Psychological services also produce cost-offset benefits to organizations.

In contrast with the challenges, the rewards and benefits of hospital and clinic practice are plentiful, including the opportunity to exercise multiple skill sets, practice in concert with other professionals, provide service to a wide range of client problems, mentor new professionals and contribute to effectiveness of a health care organization. These benefits can be enhanced by psychologists adopting the following perspectives:

- 1) Create a culture of excellence in psychological practice. Doing the best possible job maximally benefits clients, enhances professional self-efficacy and is a subtle but powerful form of advocacy.
- 2) Promote evidence based practice and the process of ongoing inquiry and discovery.
- 3) Create and participate in communities of practice (e.g. CBT, psychological assessment, neuropsychology, health



Winter 2014

## Newsletter of the CPA Section of Psychologists in Hospitals and Health Centres

Volume 2, Issue 1

### Message from the Chair:

#### Some Challenges and Benefits of Hospital Based Practice (Cont'd)

psychology) among psychologists. Consultation with peers stimulates ideas, increases knowledge, and yields excitement.

4) Foster program development and evaluation opportunities wherever possible. Program managers will delight in the creation of service delivery options that meet organizational objectives. Two of the section sponsored symposia at the CPA Convention will present ways in which clinical research can be conducted successfully alongside busy practices.

5) Develop forums where psychologists can share knowledge, skill and insight. Organizations hunger for creating capacity; this can be satisfied by in-house presentations and workshops.

6) Keep everything focused on service to patients. That is why health care organizations exist.

Owens, S. J., Wallace, I. L., Kristin, K. R., Thomas, C., & Dobson, K. S. (2013) Hospital psychology in Canada: An update. *Canadian Psychology*, 54, 147-152.

Murdock, D.D. Cross disciplinary training in mental health: A preliminary comparison (June 2013). Poster presentation at the CPA Convention, Quebec City.



Victoria Hospital, London

### See You at the Convention!

Kerry Mothersill. Ph.D., R. Psych.

The Section of Psychologists in Hospitals and Health Care Centres is sponsoring the following sessions:

- Thursday, June 5 – 4:00 to 5:55 PM, [Workshop: Psychology Leadership in Hospitals and Health Care Settings](#) (Vicky Wolfe, Peggy O'Byrne and Simone Kortsee).
- Friday, June 6 – 8:00 to 8:55 AM, [Section Annual Meeting](#)
- Friday, June 6 – 11:00 AM to 12:25 PM, [Symposium. Conducting Research in Hospitals and Clinics: The Challenges and Successes](#) (Ingrid Schoting, Ingrid Fedoroff, Barb Backs-Dermot, Quincy Robin Young and Kerry Mothersill ).
- Friday, June 6 – 12:30 to 2:25 PM, [Section-Sponsored Posters](#).
- Saturday, June 7 - 11:00 to 11:55 AM, Symposium, [Leadership in Hospital Psychology: Establishing Research Programs and Positions](#) (Joyce D'Eon, Josee Geller, Giorgio Tasca and Kim Corace).
- Saturday, June 7 – 12:00 to 1:55 PM, [Workshop: Large Group CBT Educational Intervention for Anxiety Disorders: A Wait List Management Strategy](#) (Patricia Furer, Rehman Abdulrehman and John Walker).

## Neuropsychology Guidelines for Epilepsy Surgery

Mary Pat McAndrews, with contributions from Mary Lou Smith, Susan Hayman-Abello and O. Carter Snead III



Toronto Western Hospital

A team of Ontario Neuropsychologists was invited to participate in drafting provincial guidelines for Epilepsy Surgery Centres of Excellence. This was part of a larger task force, under the auspices of the Critical Care Services of Ontario, that aimed to increase access to specialized services for individuals with epilepsy through the establishment of a broader network of epilepsy care centres that could provide standardized evaluations (e.g., EEG, MRI, Neuropsychological assessment) that could then feed into regional surgical centres. The Epilepsy Implementation Task Force (EITF) was established in June 2013 to develop and implement a provincial framework to maximize value from the system of epilepsy care in Ontario.

Epilepsy is second only to headache as the most common chronic neurological condition, with a prevalence of 4-5/1000 individuals; that means approximately 55,000 adults and 10,000 children in Ontario. Of those, approximately one-third are refractory to medication and approximately 60% of those individuals are candidates for epilepsy surgery. Surgery can alleviate seizures as well as lessen the associated burdens of epilepsy that include psychiatric and cognitive co-morbidities, lessened educational, occupational and social opportunities,

and higher mortality. However, only approximately 2% of eligible epilepsy patients in Ontario get potentially curative surgery, in part due to inadequate knowledge about, access to, and organization of key resources in epilepsy surgery in the province. An important component of the solution was increased funding to epilepsy monitoring units, in which continuous EEG and video recordings play a critical part in determining whether a location where seizures start can be identified. Happily, some of the funding also increased the complement of neuropsychological staff at the three current Ontario surgical centres: SickKids, London Health Sciences Centre (LHSC), and University Health Network (UHN) and introduced new neuropsychological capacity in Hamilton, Ottawa, and (eventually) Sudbury.

O. Carter Snead III, a pediatric epileptologist at SickKids and lead of the EITF, identified a number of working groups to produce the guidelines for Regional Epilepsy Surgery Centres of Excellence. The neuropsychology team included Drs. Mary Lou Smith (chair) from SickKids, Susan Hayman-Abello from LHSC and Mary Pat McAndrews from UHN; all are experts in assessing individuals with epilepsy in surgical practices. As noted in the guidelines (soon to be published), the goals of a pre-operative assessment are threefold: (i) to obtain a baseline against which post-surgical change can be measured and from which the ability to participate in specialized procedures can be ascertained, (ii) to determine whether the pattern of cognitive strengths and weaknesses/deficits identifies a lateralization and localization of cerebral dysfunction that is consistent with other information regarding the seizure focus, and (iii) to predict the potential cognitive impact of any planned surgery. Our mission was to articulate guidelines for carrying out pre-operative assessments in terms of the nature of cognitive domains surveyed and types of tests required, specifying the indications and general protocols for specialized testing (e.g., intracarotid anes-

thetic procedure or IAP, mapping of language areas with fMRI or electrical stimulation), expressing the need for post-operative assessment so that prognostication regarding cognitive change can be evidence-based and individual patient's functional outcome can be identified, and outlining the roles, qualification, and responsibilities of neuropsychologists and psychometrists in epilepsy evaluation.

The process for generating these guidelines was interesting. In addition to drawing upon our own experience in epilepsy (collectively approximately 70 years), we also did a survey of colleagues in Epilepsy Surgery centres around the world, getting responses from 10 Canadian programs (from Halifax to BC), 13 in the US, and 3 in Germany, England, and Australia. Our first question was whether they used guidelines (had developed their own guidelines or were using ones developed elsewhere). To our surprise, the answer was 'no', although there were certainly 'best practices' in place at many institutions for assessment protocols that were typically based on published protocols in the literature or standardized batteries suggested by clinical practice, literature, or research common data elements. There was considerable variability in terms of whether or when centres used specialized procedures such as IAP (some saying 'never' and others in certain indications), whether neuropsychologists participate in language mapping using fMRI and/or electrical stimulation (either alone or in conjunction with neurologists or neurosurgeons), and whether post-operative assessment was a standard of care (the modal response was to do so at one year but in many centres it was only done if patients presented with cognitive complaints after surgery). Of interest, many of our colleagues welcomed the publication of such guidelines, as they could not only inform best practices but also be used to argue for augmentation of services (e.g., seeing all patients following surgery) where budgetary factors otherwise might constrain service delivery. That would certainly be an outcome that we could all get behind!

Cond't on page 4...

## Neuropsychology Guidelines for Epilepsy Surgery (cond't)

From my now first-hand experience, I can say that this mission of developing best-practice guidelines is both rewarding and frustrating, sometimes in the same breath, as one must balance the ideal and the pragmatic,

recognizing that any 'gold standard' is likely to have a bit of lead in the mix! However, if I were starting a clinical epilepsy service from scratch, having such standards to rely upon would be hugely beneficial. I hope

our section on Psychologists in Hospital and Health Centres may eventually be a go-to place for guidelines and standards across the domains of practice in which we serve.

## Psychology in Bariatric Surgery: A Review of the Evidence for Best Practices

Daniella Sandre, Psy.D., C.Psych. and Julie Beaulac, Ph.D., C.Psych.

Obesity is increasingly becoming a major public health issue (Simon et al., 2006), with prevalence rates reaching as high as 34.4% in the United States and 24.1% in Canada (Statistics Canada, 2013). As a consequence of rising prevalence rates both within and outside of North America, obesity has now been deemed a global epidemic (Statistics Canada, 2013). And although there exists a wide range of available obesity-related treatments, many are unable to produce long-term weight loss in those seeking help (Canetti, Berry, & Elizur, 2009; Sarwer, Allison, Bailer, Faulconbridge, & Wadden, 2013). Consequently, over the past 15 years, bariatric surgery has become increasingly prominent as a treatment option for managing or eliminating co-morbid conditions (e.g., diabetes, hypertension) and facilitating long-term weight loss (Sjostrom et al., 2007). In Canada, the rates of bariatric surgeries more than doubled from 2003 to 2007 (Chistou & Efthimiou, 2009). Specifically, from 1993-2003 there was a nationwide average of approximately 500 surgeries per year with a documented and significant increase to 1313 surgeries performed in 2007 (Christou & Efthimiou). And though all provincial health care programs will cover the cost of bariatric procedures, these surgeries themselves are not available in every province

across Canada (Denette, 2010). Publicly funded surgical sites are presently available in Nova Scotia, New Brunswick, Quebec, Ontario, Saskatchewan, Alberta, and British Columbia (Martin, Klemensberg & Chaim, 2011). [and Manitoba since 2012 – Ed.]

The Ministry of Health and Long Term Care in Ontario has been funding certain types of bariatric surgery (e.g., Roux-En-Y Gastric Bypass, Sleeve Gastrectomy) since 2009. There are now four Bariatric Centres of Excellence in Ontario where these procedures are performed. These include The Hamilton Bariatric Centre of Excellence, The University of Toronto Collaborative Bariatric Surgery Program, The Ottawa Bariatric Centre of Excellence, and The Guelph Bariatric Centre of Excellence. In addition, four Regional Assessment and Treatment Centres have opened in Windsor, Thunder Bay, Sudbury, and Kingston, where pre-surgical assessments and post-operative follow-up care are conducted. Since funding was introduced for weight loss surgery within the province of Ontario in 2009, approximately 1600 surgeries have been performed at the Ottawa Bariatric Centre of Excellence.

### Bariatric Surgery and Mental Health

Bariatric surgery programs are also increasingly recognizing the importance of addressing the mental health needs of their patients in order to optimize readiness for surgery (Bauchowitz, et al., 2005). The National Institutes of Health recom-

mends that psychological health and ability to implement behavioural change should be monitored both in the pre- and post-surgical phases (Bauchowitz et al., 2005). Consistent with this recommendation, the supporting literature suggests that most bariatric surgery programs require a pre-operative psychological or psychiatric evaluation (Bauchowitz et al., 2005; Lau et al., 2007; Sarwer & Fabricatore, 2008). In the United States, many insurance companies require these assessments before they will provide funding for the surgery (Bauchowitz, et al., 2005). Some authors suggest that all patients being considered for bariatric surgery be referred for psychosocial evaluation (Mechanick et al., 2013) and that those patients with known or suspected history of psychiatric illness or substance abuse undergo a more formal mental health assessment (Mechanick et al., 2013).

In Ontario, Psychology is represented among the multidisciplinary teams at The Ottawa Hospital, Thunder Bay Regional Hospital, UHN-Toronto Western Hospital, and Windsor Regional Hospital. Within The Ottawa Hospital's Bariatric Surgery Program more specifically, pre-surgical psychological assessments are conducted for those patients identified by the multidisciplinary team as having unmanaged symptoms of psychological disorder, disordered eating, and/or difficulties adhering to treatment recommendations. Pre-surgical candidates with intellectual disability are also referred periodically for assessment related to capacity to consent to surgery.

## Psychology in Bariatric Surgery: A Review of the Evidence for Best Practices (Cond't)



St Boniface Hospital, Winnipeg

### Pre-Surgical Psychological Evaluations

It is recommended that pre-surgical assessments include exploration of medical history, social support, eating habits, history of psychiatric disorders and treatment, abuse history, and substance use (Sarwer & Fabricatore, 2008; Sogg & Mori, 2009; VA Bariatric Surgery Workgroup, 2006). Gender identity issues, ADHD, and borderline personality features are more recently recommended as areas warranting clinical investigation (Mental Health Task Force for Bariatric Surgery Programs in Ontario, 2013). Motivational factors should also be explored, including surgery-specific knowledge, goals for surgery, and ability to implement and maintain recommended dietary and behavioural changes (Grothe, Dubbert, & O'Jile, 2006; Mechanick et al., 2013; Sogg & Mori, 2009). Finally, exploration of barriers to behavioural change should also be addressed with the aim of facilitating problem solving around these issues in order to optimize the likelihood of successful weight management outcomes (Lau et al., 2007).

It is recommended that the evaluating clinicians hold a professional license authorizing them to formulate and communicate clinical diagnoses as well as to conduct psychological assessments and interpret psychological test materials (LeMont, Moorehead, Parish, Reto, & Ritz, 2004). Specialized knowledge about weight loss surgery, obesity, and eating behaviors are also recommended (Sogg & Mori, 2009). Specifically, these clinicians should be authorized in the provision of psychotherapeutic intervention with specialized training in addressing those issues that are likely to be most salient for patients presenting for weight management intervention

(LeMont et al., 2004). For example, clinicians in this field should be able to demonstrate understanding of the ways in which certain psychosocial factors (e.g., psychological distress, disordered eating, financial resources) might impact post-surgical outcomes (LeMont et al., 2004; Sogg and Mori, 2009). Finally, evaluators should be able to identify vulnerabilities and/or risk factors that may compromise a patient's post-surgical outcomes – particularly given the fact that bariatric surgery requires significant pre- and post-operative lifestyle change for which some individuals may be very difficult (LeMont et al., 2004). To this end, other authors have suggested that the concept of pre-surgical “assessment” be expanded in order to comprise a more “comprehensive weight management intervention approach” (Lau, et al., 2007, p.8). Such an intervention would include behaviour modification, cognitive behavioural therapy, and strategies for promoting physical activity in addition to the more traditional pre-surgical assessment protocol (Lau et al., 2007).

With regard to the structure of these evaluations, much of the literature suggests the combination of a clinical interview in conjunction with standardized self-report measures (Grothe, Dubbert, & O'Jile, 2006; Mechanick et al., 2013; Sarwer & Fabricatore, 2008). The American Society for Bariatric Surgery (LeMont, Moorehead, Parish, Reto, & Ritz, 2004) lists a number of recommended psychological assessment tools, which include both self-report symptom measures (e.g., Beck Depression Inventory-II), disordered eating measures (e.g., Binge Eating Scale), personality inventories (e.g., Personality Assessment Inventory), quality of life measures (e.g., Quality of Life Questionnaire), and structured diagnostic interviews (e.g., SCID). The use of these individual tools tends to vary greatly; however, across assessment sites, with no currently agreed upon standard with regard to pre-surgical assessment protocol (Bauchewitz et al., 2005; Grothe et al., 2006; Pull, 2010).

### Surgical Exclusion Criteria

Not only do the assessment protocols tend to vary widely from site to site, researchers have yet to identify any reliable predictors of post-surgical outcomes

(Bauchewitz et al., 2005; Grothe, Dubbert, O'Jile, 2006; Pull, 2010). Nevertheless, in general, clinicians seem to agree that such factors as symptom severity, level of psychosocial functioning, and degree of symptom management are important considerations in the determination of surgical candidacy (Sogg & Mori, 2009). In addition, there is some consensus regarding those actors that represent contraindications to surgery. These contraindications include: active substance abuse, bulimia, psychosis, poorly controlled psychiatric illness, and recent incident of suicide attempt and/or self-harm (Mechanick et al., 2013; VA Bariatric Surgery Working Group, 2006). Specifically, the Mental Health Task Force for bariatric surgery programs in Ontario recommends that those patients demonstrating severe and unstable mental illness (e.g., multiple emergency room visits, recent psychiatric hospitalization, recent incident of self-harm/suicide attempt), demonstrate at least one year of mental health stability prior to being considered a surgical candidate. A patient's ability to adhere to medical treatment recommendations as well as required lifestyle changes is an important factor to assess as an indicator of motivation and readiness for surgery, as is their knowledge of the surgical procedure and post-operative risks and regimens (LeMont, Moorehead, Parish, Reto, & Ritz, 2004; Sogg & Mori, 2009). Guidelines have clearly expressed that, “patients with severe psychopathology should be excluded, as should patients lacking motivation to change their lifestyle. Surgery should also be removed from consideration as a treatment option if a candidate is unwilling to agree to lifelong follow-up care.” (Peterhansel, Petroff, Klinitzke, Kersting, & Wagner, 2013, p. 379). A patient's expectations regarding post-surgical outcomes is another worthwhile topic of evaluation (Bauchewitz et al., 2006). Finally, cognitive capacity and ability to consent to the procedure are important areas of assessment (LeMont, et al., 2004; Mental Health Task Force for Bariatric Surgery Programs in Ontario; Sogg & Mori, 2009).

Cond't on page 6...

## Psychology in Bariatric Surgery: A Review of the Evidence for Best Practices (Cond't)

It is worth noting that a diagnosis of binge eating disorder is not typically an absolute contraindication for surgery given that the literature on this topic is mixed with regard to its impact on post-surgical outcomes (Bauchewitz et al., 2006; Sogg & Mori, 2009; VA Bariatric Surgery Working Group, 2006).

Binge eating is a fairly common phenomenon among patients seeking bariatric surgery, with prevalence rates ranging from 6% (Allison et al., 2006; Sansone, Schumacher, Widenerman, & Routston-Weichers, 2008) to as high as 69% (Adami, Gandolfo, Bauer, & Scopinaro, 1995, as cited in Mitchell & deZwaan, 2012). Once again, the findings on this issue are inconsistent, and in most cases, when a relationship between binge eating and post-surgical outcomes is found, it is relatively weak (Engel, Mitchell, De Zwaan, & Steffen, 2012). Instead, Coughlin and associates (2013) suggest that post-operative eating behaviors and pathology (e.g., loss of control eating and grazing) are better predictors of poorer post-surgical outcomes.

### Pre and Post-Surgical Intervention

In the event that psychological and/or behavioural difficulties are identified during the pre-surgical assessment, some authors also suggest the need for pre- and post-surgical intervention (LeMont, Moorehead, Parish, Reto, & Ritz, 2004). Specifically, it is recommended that candidates who present with these difficulties be given particular attention before undergoing surgery and that special care should be taken to ensure adequate follow-up post-operatively in order to optimize outcomes (Pull, 2010). These services can be offered in a variety of forms, including individual or group therapy, or pharmacological treatment. Finally,

there is evidence to suggest that bariatric surgery patients demonstrate higher risk of suicide as compared to the general population. Therefore, pre- and post-operative follow-up care requires identification and treatment for those patients most vulnerable to self-harming behavior (Peterhansel, Petroff, Klinitzke, Kersting, & Wagner, 2013).

### Moving Forward

The literature on the benefits of weight loss surgery in improving comorbid conditions is abundant (Adams, Schauer et al., 2014; Hsu et al., 1998; Sjostrom et al., 2007). Post-surgical patients will often experience improved diabetes management (if not complete resolution of their diabetes), improved quality of life, reductions in joint pain, and reduced mortality (Adams, Schauer et al., 2014; Sjostrom et al., 2007). Nevertheless, the data on what makes for an ideal surgical candidate is limited. The research has shown that psychological factors are related to post-surgical outcomes (Greenberg, Perna, Kaplan, & Sullivan, 2005; Hsu et al., 1998; Sarwer et al., 2005), however, as mentioned above, the strongest predictors for health outcomes are currently unknown. Knowing this would facilitate development of targeted pre-surgical interventions in order to optimize post-surgical success. Further research on the impact of psychological interventions aimed at preparing patients for surgical treatment is warranted.



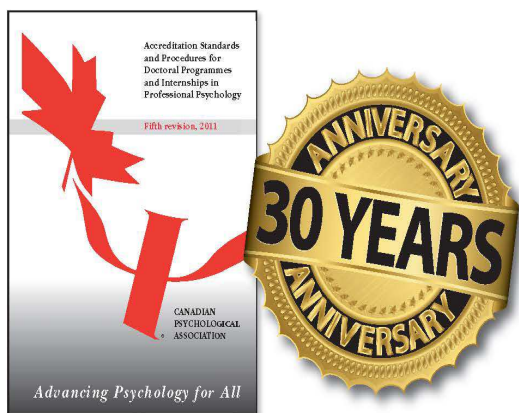
Health Sciences Centre - Winnipeg

## In Matters of Health -Psychology Matters.



Princess Margaret Hospital (Toronto)

# Please join us for a celebration of training!



2014 marks both the 75<sup>th</sup> anniversary of CPA and the 30<sup>th</sup> anniversary of the CPA Accreditation standards. In recognition of this milestone, a celebration of Canadian psychology training will be held on Friday, June 6, 2014 at the CPA Convention in Vancouver, BC. Anyone who has been involved in professional psychology training over the years is welcome to attend. Please see the CPA Convention schedule for more details, and RSVP to [accreditation@cpa.ca](mailto:accreditation@cpa.ca).



## Student Column

Jessica Flores, PHHC Executive Student Representative

Hello fellow student members!

I hope this note finds you well and with your plans for the 5-7 June 2014 CPA Convention in Vancouver coming along smoothly. Three items of interest follow. Please consider each one as we are keen on giving voice to the student members' interests, ideas, and concerns.

1. PHHC Students Meet-and-Greet at the Vancouver CPA Convention this June.

The PHHC student members will proceed to a local coffee shop after the PHHC Section's Annual Meeting wraps-up to network and hear about other's experiences in their program or internship and to learn about each other's research. Please R.S.V.P. by email to [jessica.p.flores@alumni.ubc.ca](mailto:jessica.p.flores@alumni.ubc.ca). Should you not get a chance to R.S.V.P. before the Convention, come anyway! All are welcome.

PHHC Section's Annual Meeting Details: Friday, 6 June 2014, 8:00 a.m. - 8:55 a.m., Room: Georgia A, 2nd Floor at the Convention hotel. Come and see what the section is all about and to meet the Section Executive members. We look forward to meeting you!

2. PHHC Executive Student Representative Volunteer Position

Principal Roles: (a) To represent the Section's student membership's interests at the PHHC Executive meetings that take place once a month, approximately, by teleconference arranged for by CPA; (b) Coordinate the Student Committee and student related events like the meet-and-greet, (c) Solicit student submissions for the newsletter, and (d) Liaise with the CPA Student Section.

Duration: 12 months starting after the CPA Annual Convention, and may be renewed.

Interested? Please e-mail: (a) A statement indicating your willingness to stand for office, and (b) A brief biographical statement to [Kerry.mothersill@albertahealthservices.ca](mailto:Kerry.mothersill@albertahealthservices.ca)

3. PHHC Student Committee. Openings: 3 volunteer positions.

This is a new Committee that will be lead by the PHHC Executive Student Representative and will meet 2-3 times a year, as needed, by teleconference or Skype, and once at the Annual CPA Convention.

Principal Roles: (a) Assist the PHHC Executive Student Representative in connecting with PHHC student members across Canada to establish an ongoing information-feed and network based on student activities such as internships, research, and publications, (b) Propose ideas for inclusion in the Annual CPA Convention's program based on the student members' interests, (c) Propose content for the newsletter's student section, and (d) Help host PHHC student events like the meet-and-greet and represent the PHHC Student Committee at other CPA student related events.

Duration: 12 months starting after the Annual Convention, and may be renewed.

Interested? Please e-mail: (a) A statement indicating your willingness to volunteer, and (b) A brief biographical statement to :

[jessica.p.flores@alumni.ubc.ca](mailto:jessica.p.flores@alumni.ubc.ca).

**Please note:** The 2014 CPA Convention website has been updated with the at-a-glance program and other details, please see: <http://www.cpa.ca/convention>. For the PHHC Section's website, please see: <http://www.cpa.ca/aboutcpa/cpasections/Hospitals>. I look forward to meeting you in June.

Jessica, PHHC Executive Student Representative [jessica.p.flores@alumni.ubc.ca](mailto:jessica.p.flores@alumni.ubc.ca)

**It Doesn't Have To Hurt:  
Strategies for Helping Children with Shots and Needles  
(A YouTube Video)** Dr. Christine Chambers, IWK.

**Image 1: In the video, a young girl tells her mom what she should – and shouldn't – do to help make the needle less painful.**



Surprisingly, despite the availability of numerous evidence-based strategies for reducing needle pain, fewer than 5% of children receive any kind of pain relief for common needle procedures. In fact, 1 in 10 children and adults develop a significant needle phobia, which interferes with them seeking proper medical care.

Our goal is to reduce the pain and distress associated with needles to make children happier and healthier. With funding from the NSHRF's Knowledge Sharing Support program, a team led by Dr. Christine Chambers at the Centre for Pediatric Pain Research at the IWK Health Centre and Dalhousie University, developed a fun and engaging new video for parents about how to manage children's needle pain.

The video, released early November, already has 28,000 views and has been shared widely by a number of organizations, including the American Academy of Pediatrics, the Centre for Disease Control and National Center for Immunization and Respiratory Diseases, the Canadian Institutes of Health Research, and The American Pain Society. It was also picked up by several popular parenting blogs and featured in invited guest posts on the Canadian Association of Paediatric Health Centres and Body In Mind websites.

Please help to spread the word by:

- Watching the video on our website (<http://pediatric-pain.ca/it-doesnt-have-to-hurt>) or YouTube (<http://www.youtube.com/watch?v=KgBwVSYqfps>)
- Completing the anonymous survey on our website
- Sharing the video with family, friends and health care professionals.

We're also on Facebook ([www.facebook.com/CentreforPediatricPainResearch](http://www.facebook.com/CentreforPediatricPainResearch)) and Twitter (@DrCCChambers; #itdoesnthavetohurt)

**Image 2: One effective pain reduction strategy is blowing bubbles. It combines distraction and deep breathing.**





## Member Profile — Dr. Joyce D'Eon

Kerry Mothersill Ph.D., R. Psych. & Bob McIlwraith Ph.D., R. Psych.



by Honours, MA and PhD students. She also steadily ascended the administrative ranks within the Rehabilitation Centre and Ottawa Hospital, becoming Chief of Psychology at TOH in 2006.

In 2002, Joyce received the prestigious CPA Award for Distinguished Contributions to Psychology as a Profession.

As Chief of one of Canada's flagship hospital Psychology services, Joyce was asked in 2010 to join the CPA Task Force on the Future of Publicly-Funded Psychology Services, where she co-chaired the hospital psychology arm of the Task Force (the other two arms were related to psychological services in schools and in corrections). The Task Force identified issues among hospital psychologists in Canada that led to the establishment, at the 2012 CPA Convention in Halifax, of the Section of Psychologists in Hospitals and Healthcare Centres, which now has over 400 members.

Joyce exemplifies the best of leadership qualities needed in hospital psychology. All those who have had the good fortune of working with her have been struck by the brilliance and soundness of her ideas and have benefitted from her kindness, guidance and support. Thank you Joyce, we wish you the best.

Kerry Mothersill & Bob McIlwraith

Dr. Joyce D'Eon, Chief of Psychology at the Ottawa Hospital, is retiring in June following an exemplary career of leadership in science, practice, education and administration. Joyce was one of the founding members of the CPA Section of Psychologists in Hospitals and Healthcare Centres, and served on the Executive as Secretary-Treasurer from the start.

Joyce earned her Bachelor's and Master's degrees from Carleton University and her PhD from Concordia. Along the way she completed a Research Fellowship in the pain clinic of the Montreal General Hospital and a Clinical and Research Fellowship focusing on disability and chronic pain at the Rehabilitation Centre in Ottawa. Joyce's subsequent practice career was spent in the treatment of patients with neurolocomotor disorders and patients with chronic pain. Despite, or perhaps because of, her busy clinical involvement, she published over 20 peer-reviewed publications and two book chapters in the area, as well as dozens of conference presentations, invited workshops and invited presentations, and was investigator or co-investigator on a number of research grants. Joyce has had a long affiliation as a Clinical Investigator with the Ottawa Health Research Institute. She has been a Clinical Professor at the University of Ottawa for over 25 years, taught graduate courses in the School of Psychology and supervised thesis research



**Chair:****Dr. Kerry Mothersill**

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[http://www.cpa.ca/aboutcpa/  
cpasections/Hospitals/](http://www.cpa.ca/aboutcpa/cpasections/Hospitals/)

**Call for nominees for our Section's award**

Section of Psychologists in Hospitals and Healthcare Centres  
Award of Excellence

The Psychologists in Hospitals and Healthcare Centres (PHHC) Section is seeking nominations for the Section Award, to be bestowed annually upon a psychologist who has made significant contributions to psychology in hospitals and healthcare centres. Through his or her efforts on a clinical or administrative level, the recipient of this award will have participated in the advancement of the role and the place of psychology in health-care settings in Canada. Please forward nominations to Dr. Paul Greenman at [paul.greenman@uqo.ca](mailto:paul.greenman@uqo.ca) by May 9th.

Please note that, as per the policies and procedures of the awards committee, candidates who are nominated but who do not receive the award in a given year will automatically be considered for the award the following year.

**Newsletter contributions welcome– instructions to authors**

We welcome submissions from section members to our newsletter. We are interested in hearing from our members to share knowledge, successes and challenges of the hospital based psychologist.

We have developed some recurring columns, but are open to other ideas. The following columns are available for contributions:

1) Open submissions: 500-1000 word column outlining a specific issue; historical review of

a department; or any other topic of interest to the section.

2) Leading Practices: 500-1500 words Reports of psychological services that are considered leading practices, either as a result of recognition by accrediting bodies such as the Canadian Council on Health Services Accreditation (CCHSA: "Accreditation Canada") or similar organizations, or through outcome data that demonstrate the effectiveness of an innovation or an exemplary service model.

3) Recommended reading: 100-150 word summary of any article, book, website, journal, etc that would be of interest to the section.

4) Cross country check up: 500-750 word article outlining an issue or experience that may apply across the country .

5) Student focus: 250-1000 word submission from a student member.

6) Short snappers: 150-175 words describing a new initiative, a promising practice, a summary of a research study, etc.

7) Member profile: 250 word biography including picture of a member.

8) Other areas: announcements, job postings, clinical practice guidelines, management structure.

Please send submissions to: Dr. Bob McIlwraith  
[bmcilwraith@hsc.mb.ca](mailto:bmcilwraith@hsc.mb.ca)