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# PSYNOPSIS

CANADA'S PSYCHOLOGY MAGAZINE

# EVIDENCE-BASED PSYCHOLOGICAL INTERVENTION AND ASSESSMENT: MENTAL HEALTH AND HEALTH PSYCHOLOGY APPLICATIONS

# PSYNOPSIS

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*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 the 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. The CPA's organizational vision is a society that values and applies psychological science in the benefit of persons, communities, organizations, and peoples. *Psynopsis* is one important way that the CPA endeavours to realize this vision.



PSYNOPSIS

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**THE OFFICIAL MAGAZINE OF THE CANADIAN PSYCHOLOGICAL ASSOCIATION**



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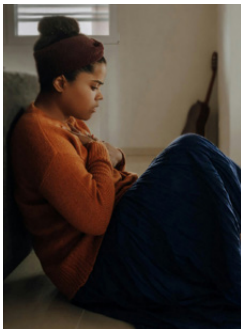

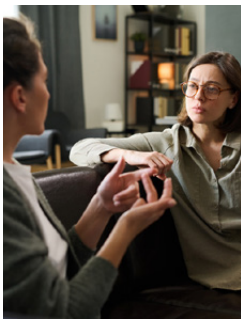

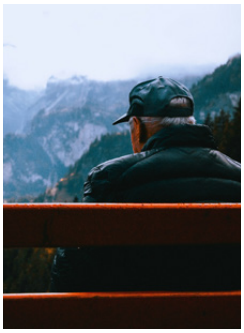

# MESSAGE FROM THE GUEST EDITOR

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

Member at Large, Executive Committee, Psychologists in Hospitals and Health Centres CPA Section; Coordinator, Regional Psychological Assessment Service (Calgary), Recovery Alberta; Adjunct Professor, Department of Psychology, University of Calgary; Calgary, AB

## Evidence-based psychological intervention and assessment: Mental health and health psychology applications

The Psychologists in Hospitals and Health Centres (PHHC) CPA Section was formed in 2012 in order to provide a forum for psychologists who are employed in, practice, teach, or conduct research in hospitals and healthcare settings. The current executive of PHHC invited articles for this issue of *Psynopsis* that illustrated the effectiveness of intervention and assessment advancements in clinical care. All facets of diversity across the life span were deemed to be of particular interest.

The invitation noted that evidence-based psychological services continue to be developed and refined in order to increase effectiveness and improve long-term outcomes.[1,2] Applications to new populations and symptom presentations continue to evolve with research advancements in clinical measurement and psychopathology. Developments in methods of service delivery demonstrate how services can be applied and disseminated in novel ways to increase access to services.[3,4]

The articles in this issue speak to the identified goals from a variety of perspectives. They emphasize the importance of: 1) delivering psychological services through methods beyond the traditional individual therapy model in order to serve the increasing mental health needs of Canadians, and 2) the development of focused services for clinical presentations that have been underserved.

Savard, Provencher, and Godin describe the implementation of the *Le Programme québécois pour les troubles mentaux des autosoins à la psychothérapie* (PQPTM), a stepped-care application of interventions for the treatment of anxiety and depressive disorders with diverse populations and clinical contexts in Quebec. Initial and future evaluation goals are identified. Poulin illustrates a program that enhances access to care and improves clinical outcomes for individuals who live with chronic pain. Developed at the Ottawa Hospital and accessible across Canada, the Power Over Pain Portal focuses on evidence-based care that can be accessed while patients are waiting for medical appointments. Also at the Ottawa Hospital, Pallikaras provides information on a novel transdiagnostic cognitive behavioural therapy (CBT) group intervention for patients with complex regional pain syndrome (CRPS) and supplies some initial outcome data.

Jerrott, Cohen, Hahn, and Durdle report on the innovative Provincial Centre for Training, Education, and Learning program that provides context-specific therapy training to clinicians within Nova Scotia Health. Support and instruction are available for adapting interventions so that they address the needs of clients from a range of diverse and rural populations. Garland emphasizes the importance of identifying the psychosocial needs of cancer patients and points to the clinical effectiveness of evidence-based psychological care. Addressing the needs of pediatric cancer patients, Guarascio and Sultan describe evidence-based programs that support families and caregivers. The programs provide a range of video and interactive activities, supported by telehealth sessions, as well as bilingual six-session interventions. The paper by Hutchings, Curl, and Pritchard discusses the steps needed to develop an empirical foundation for the prevention of suicide among older residents in rural Canada. Recommendations are provided for evidence-based assessment and treatment.

Fishman, McPhee, Ladowski, Lin, and Murphy report on programs that have been developed to assist

older individuals with mild cognitive impairment. Expanding on existing interventions, they describe a novel, low-intensity, high-volume, widely available webinar designed to foster participants' abilities to adopt brain healthy lifestyles, learn practical memory strategies, and develop adaptive coping strategies.

Many thanks to the authors who dedicated their time and shared their knowledge in assembling important information that illustrates how psychological interventions can be disseminated and supported in novel ways to address the needs of diverse clients in accessing services. It is anticipated that the articles will stimulate the development of additional evidence-based approaches to care and generate novel applications so that effective services can be more widely accessible to meet the needs of Canadians.

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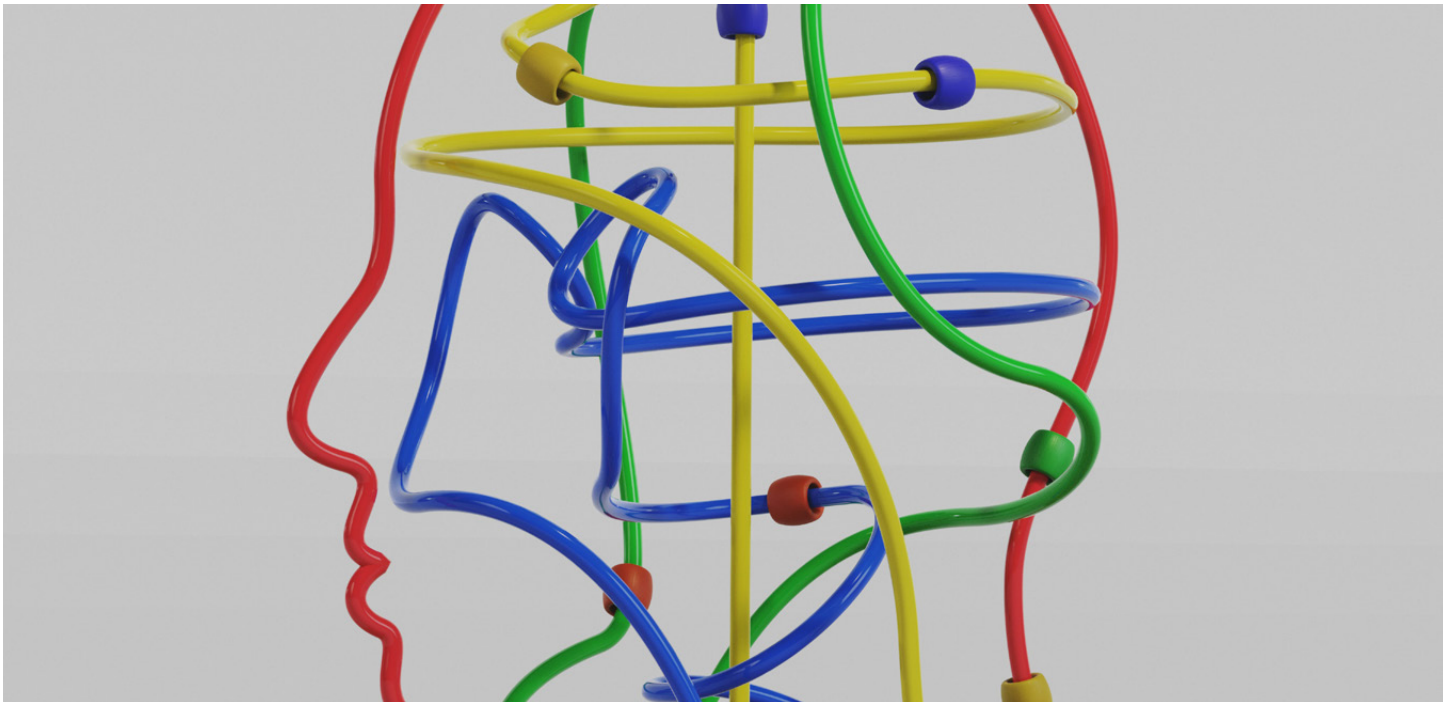


# MESSAGE FROM THE CEO

**Lisa Votta-Bleeker, Ph.D.**
**CEO, CPA, and Editor-in-Chief, *Psynopsis* , Ottawa, ON**

## Welcome to Volume 47, Issue #3 of *Psynopsis* – Evidence-based psychological intervention and assessment: Mental health and health psychology applications

A special thank you to Dr. Kerry Mothersill for serving as Guest Editor of this issue and to the current Executive of the CPA's *Psychologists in Hospitals and Health Centres* Section for their contributions to the production of this issue.

The articles in this issue exemplify psychologists' significant skill set, scope of practice and training, and contributions to the health of the populations they serve. They illustrate the way in which evidence-based psychological services are constantly developed and refined in ways to increase both their effectiveness and long-term health outcomes. They demonstrate how research advancements in clinical measurement and psychopathology contribute to the application of psychological services to new populations and to new presentations of symptoms. They show how delivering psychological services via different and innovative methods and modalities can increase access to those services to meet population needs, whether based on health, age, geography, or diversity. Finally, they also show the expertise that psychologists bring as researchers and program evaluators and the critical role psychologists play as leaders in service delivery in a variety of health domains.

Access to psychological services is necessary for people's quality of life and for optimal day-to-day functioning. To this end, it is critical that hospital administrators, government officials, and decision-makers 1) recognize the significant contribution of psychologists in addressing health and mental health issues, 2) support the funding of publicly-accessible psychological services by increasing the number of psychologists in the public sector, and 3) support the education of the next generation of psychologists through increased investments in training programs.

# FROM THE PRESIDENT'S DESK

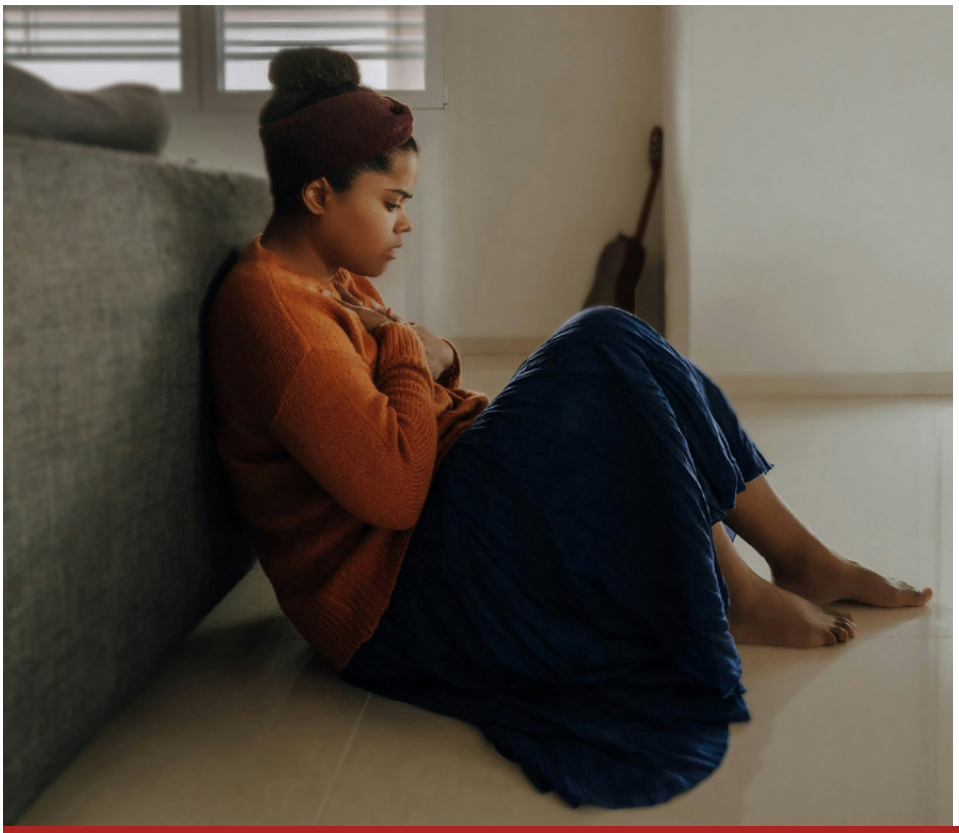
**Steven M. Smith, Ph.D.**
**President, CPA, Professor of Psychology**
**Saint Mary's University, Halifax, NS**

The CPA has always considered that the three pillars of psychology are science, practice, and education, and this has been a focus of how we structure our work within the CPA, and how we present our work to others. Although these three areas of focus are distinct, this does not mean that these three pillars can be fully separated. Each informs the other: effective practice and teaching relies on scientific discovery and analysis; science requires questions to be raised that can be answered through careful research; education requires knowledge of the realities of practice, and the results of scientific discovery. They are all intertwined.

In this issue of *Psynopsis*, edited by Dr. Kerry Mothersill, we focus on the role of application of evidence-based interventions and assessments in mental health and health psychology contexts. Self-rated mental health has declined over the last decade, and there is a continuing need to increase access to mental health supports across Canada.[1,2] This issue of *Psynopsis* not only highlights why approaches to mental health supports have to be evidence-based, but also how these approaches must keep evolving in order to support the needs of our ever-changing population in terms of health, age, and diversity.

This issue also highlights some remarkable and innovative programs being implemented across the country (e.g., Quebec, Ontario, Nova Scotia, Newfoundland and Labrador) and with many different populations (e.g., children, adults, older clients, rural populations, cancer patients). The core theme running through them all is the importance of applying evidence-based approaches to practice, as well as assessing outcomes of programming. We aim for continued improvement and refinement of our approaches to treatment. And that will continue to involve the close interplay between science, education, and practice.

We are grateful to Dr. Mothersill for agreeing to serve as guest editor of this issue, and to all the authors who contributed to the excellent content within it. As always, it is an honour to serve as President of the CPA.



In Quebec, about one person out of four suffers from a mental disorder each year,[1] a situation that has worsened since the COVID-19 pandemic.[2-4] Anxiety and depressive disorders are the most common, accounting for about 65% of diagnosed mental disorders.[5] Access to mental health services was already limited before the pandemic and has since become even more restricted. Indeed, despite the reiterated objective over the past years to reduce the wait times for access to public mental health services, these have continued to rise due to increasing needs and a scarcity in the workforce.[6-9] As a result, more and more people do not receive the services they need to have a good quality of life and to function optimally on a daily basis.

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# IMPROVING ACCESS TO EVIDENCE-BASED INTERVENTIONS FOR ANXIETY AND DEPRESSIVE DISORDERS USING GUIDED SELF-HELP: PROGRAMME QUÉBÉCOIS POUR LES TROUBLES MENTAUX (PQPTM)

**Josée Savard,** Ph.D., Professor, École de Psychologie – Université Laval, Quebec City; Centre de recherche du CHU de Québec – Université Laval, Quebec City; Centre d'études et d'interventions en santé mentale (CÉISM), Quebec City; Centre de recherche du CISSS de Chaudière-Appalaches, Lévis, QC

**Martin D. Provencher,** Ph.D., Professor, École de Psychologie – Université Laval, Quebec City; Centre d'études et d'interventions en santé mentale (CÉISM), Quebec City; VITAM – Centre de recherche en santé durable, Quebec City; Centre de recherche CERVO, Quebec City; Centre de recherche du CISSS de Chaudière-Appalaches, Lévis, QC

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## PQPTM: An innovative care model with major potential for improvement

Le Programme québécois pour les troubles mentaux (PQPTM): des autosoins à la psychothérapie was launched in 2018 to mitigate the shortage of resources and improve access to mental health services for the Quebec population as a whole. The PQPTM is inspired by the Improving Access to Psychological Therapies (IAPT) program, now called National Health Service (NHS): Talking Therapies, which is successfully implemented in England to treat common mental disorders (CMD; anxiety and depressive disorders) using evidence-based psychological interventions.[10,11] Similar to the English program, the PQPTM proposes a stepped-care model that includes low-intensity interventions such as psychological education (educational content offered in written form or during a consultation), self-management (strategies that users incorporate into their lifestyle on their own), and guided self-help (e.g., self-administered cognitive behavioural therapy with the support of a professional). The level and sequence of care received by users is determined according to their needs and preferences, as well as clinical judgment. Furthermore, the interventions are offered by diverse mental health professionals (see Figure 1).

**Figure 1: Care trajectory in Quebec**

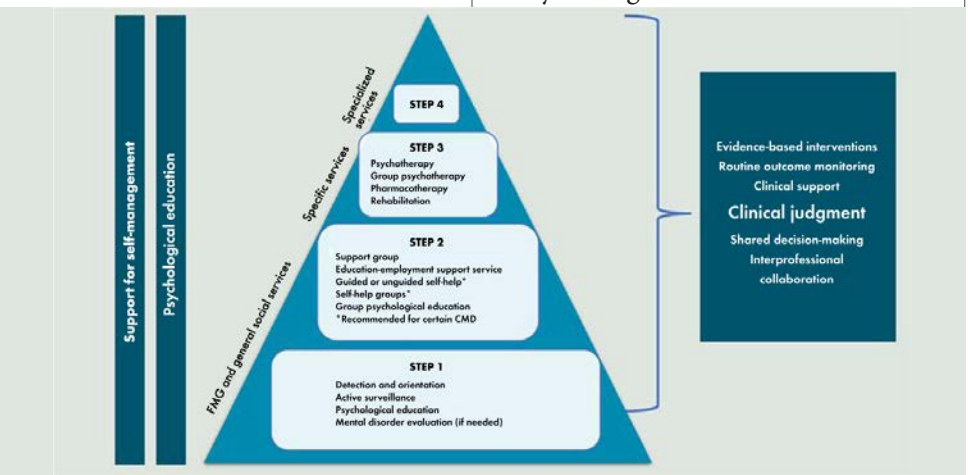


Figure obtained from Guide d'introduction aux autosoins du CISSS-CA[16] and inspired by the Guide de pratique clinique Troubles mentaux fréquents : Repérage et trajectoire de services du Ministère de la santé et des services sociaux (MSSS).[17]

## The vital role of guided self-help in improving access to evidence-based psychological interventions

The integration of guided self-help in routine care offered by the Centres intégrés (universitaires) de santé et de services sociaux [CI(U)SSS] is at the heart of the changes proposed by the PQPTM. This addition to the services being offered is based on the abundant literature supporting the efficacy of self-administered psychological treatments for anxiety and depressive disorders, which has been shown to be comparable in efficacy to face-to-face psychotherapy.[12-14] This is the most innovative of all components of the PQPTM, since psychological education and psychotherapy are already offered in one form or another.

## The importance of close collaboration between researchers and clinical settings

With the goal of contributing to the improvement of service access and its effectiveness, the university researchers on our team have been collaborating for the past five years with three CI(U)SSS. We participated in various committees mandated to implement different PQPTM components (e.g., guided self-help, routine outcome monitoring, psychological education) in these settings, and offered training to the practitioners on evidence-based psychological interventions. In addition, we conducted a preliminary qualitative study during the winter of 2023 at the CISSS-Chaudière-Appalaches that included 13 social workers who had started offering guided self-help (GSH) interventions in their practice.[15] Focus groups were conducted to discuss the barriers and facilitators with regards to program implementation. As for the barriers, the practitioners identified that few users had been offered GHS, and that they felt GSH didn't apply to all users. The limited number of consultations and the adaptation period required to master the GSH were also mentioned. Among the facilitators, the practitioners highlighted the simplicity and credibility of the GSH. They were also perceived as compatible with social work interventions.

## Research project on the implementation of guided self-help in the context of the PQPTM

In the wake of our collaborations with these clinical settings, our research team obtained a grant from the Fonds de recherche du Québec – Santé (FRQ-S; 2023-2026). The objective of this research project is to evaluate whether GSH improves access to evidence-based psychological interventions to treat depressive and anxiety disorders in various clinical settings (Centre local de services communautaires [CLSC], family medicine groups [FMG]) of three CI(U)SSS in Quebec. Ultimately, this project aims to: 1) reduce the gap between research data and mental health practice; 2) improve patient experience and the mental health of users by providing faster access to interventions proven to be effective and that meet their needs; 3) increase the efficiency of services offered to the population; and 4) increase equity by adapting these services to suit different clienteles and contexts. Overall, the project will provide a better understanding of the determinants of successful GSH implementation for diverse populations and various contexts.

# IMPROVING ACCESS TO CHRONIC PAIN CARE

**Patricia Poulin,** Ph.D., C.Psych., Clinical, Health, and Rehabilitation Psychologist, The Ottawa Hospital Pain Clinic; Associate Scientist, The Ottawa Hospital Research Institute; Assistant Professor, Department of Anesthesiology and Pain Medicine, University of Ottawa, Ottawa, ON

In Canada, there are eight million people living with chronic pain.[1] Traditional models of care often struggle to meet the complex and varied needs of people living with chronic pain. Long wait times, inconsistent access to services, and fragmented care are also common issues across our health systems.[2] Our priority-setting partnership project revealed that improving access to chronic pain care was one of the top research priorities identified by people living with pain and their caregivers.[3] Wait times to access specialized programs are often in excess of six months, the maximal medically acceptable wait time.[4,5] Many people wait much longer, and some people living with mental health or substance use disorders are sometimes excluded from entry.[6]

Psychologists are increasingly taking leadership roles in driving health system improvements to increase access to care and improve clinical outcomes.[7] Chronic pain management is no exception. Psychologists at The Ottawa Hospital led the adaptation, implementation, and evaluation of the Stepped Care 2.0 model[8] to improve access to chronic pain care[9] and played a pivotal role in the development of the Power Over Pain Portal[10] to extend its reach across Canada. Trainees in hospital-based psychology have been involved in all activities and authored papers that have garnered attention from clinicians, program managers, and decision-makers at different levels of government.

Our stepped-care model is not a progressive or matching model, but rather a flexible model that provides a range of education and treatment options for people living with pain, offered based on their goals, needs, preferences, and readiness for change, with adjustments made based on responses to treatment. A broad spectrum of services is offered, from self-guided and clinician-guided education to peer-support, group-based therapy, specialist consultations, and case management. A key feature of the model is its focus on rapid access to care. Rather than sitting idle on a waitlist, patients are rapidly offered opportunities to improve their chronic pain literacy and start addressing different factors that may be contributing to their pain experience and disability. Self-directed learning and therapy groups targeting active self-management (pacing, engagement in meaningful activities), fear of movement, social isolation, anxiety, depression, sleep problems, and trauma are all available while patients are waiting for their medical consultations. Our overall framework, guiding principles, and preliminary impact assessment are described in our 2020 paper "Implementation of the Ottawa Hospital Pain Clinic Stepped-Care Program: A Preliminary Report."[9]

Over the past six years, we have been working on evaluating different components of our model. We started with our pain clinic orientation session. This session is designed to improve patients' knowledge of chronic pain and its management, set realistic expectations, and present the various pain clinic programs at The Ottawa Hospital. We found that participants were highly satisfied with the session, appreciated the feeling of community, felt heard by providers, and appreciated the holistic approach presented and programs available. Participants also provided us with valuable feedback to improve the session content. Evaluations of our workshop series and therapy groups are ongoing.

To extend the reach of our stepped-care model and ensure some degree of continuity in services during the COVID-19 pandemic, we also co-led the development of the Power Over Pain Portal. The portal extends the reach of our services, leverages chronic pain management investment and expertise from coast-to-coast, and serves as a vehicle for the spread and scale of digital innovations. It houses evidence-based educational resources that were previously inaccessible or difficult to find under one roof (e.g., the Pain Course,[11-15] Empowered Management,[16,17] Internet-Based Multidisciplinary Pain Acceptance, and Commitment Therapy Program), links to peer support, mental health, and substance use health resources, and it provides users with self-assessment tools to track their health progress. Locally, we tested the acceptability and usability of the portal among patients waiting for care.[18] Sixty patients who were referred to our local pain clinic were contacted to participate in an orientation session to the portal and invited to use the portal over the following four weeks. Of the 45 patients who agreed to participate and completed the portal orientation, 40 completed the four-week follow-up and all 40 reported having used the portal and recommended it as a resource for patients waiting for care. While we continue to evaluate different components and uses of the portal within our clinic, it remains available to the public. The portal has received more than 270,000 visitors, and our associated social media campaign to increase awareness and reduce stigma associated with chronic pain has garnered over 7.5 million impressions.

As we work on improving access to care, we are also cognizant of and are diligently working towards addressing the limitations we have identified in our approaches. For example, we are grappling with how to ensure that our stepped-care model and the Power Over Pain Portal reflect different ways of knowing and healing chronic pain, recognizing the impact of colonial practices, and honouring Indigenous Traditional Knowledge Systems developed over countless generations.[19,20] We are thankful for the researchers, clinicians, lived experience partners and caregivers, trainees, policy makers, Elders, and Knowledge Keepers contributing to making our chronic pain health systems more accessible and equitable.

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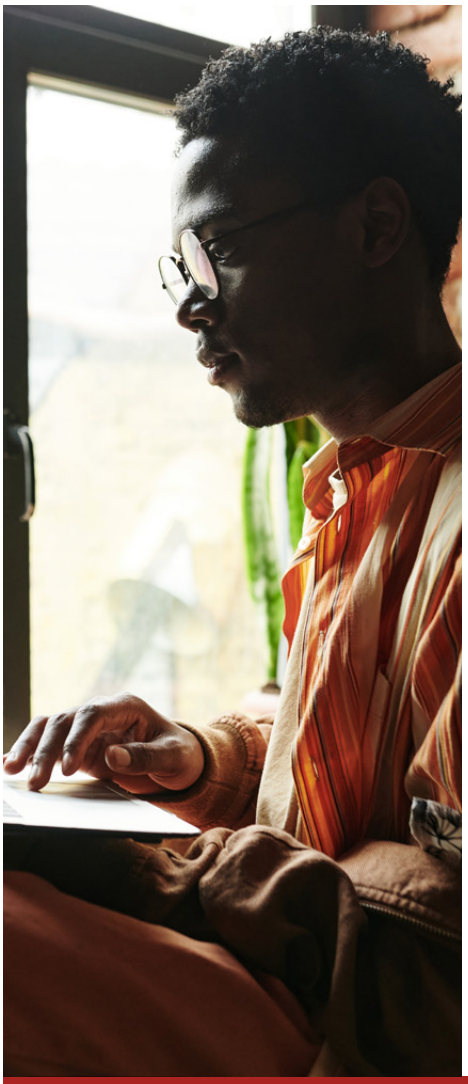


# A VIRTUAL TRANSDIAGNOSTIC COGNITIVE BEHAVIOURAL THERAPY GROUP FOR REFRACTORY COMPLEX REGIONAL PAIN SYNDROME: MEETING THE MENTAL HEALTH NEEDS OF AN UNDERSERVED POPULATION

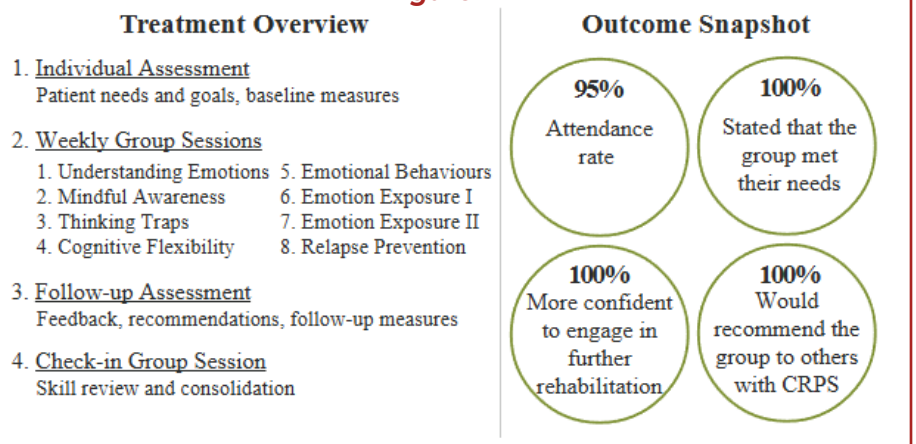
**Vasilis Pallikaras,** Ph.D., C.Psych., Psychologist, The Ottawa Hospital Rehabilitation Centre, Ottawa, ON

After sustaining an injury to a limb, one expects the healing process will resolve pain and difficulties with using that arm or leg. This is not guaranteed. For some, a limb injury leads to developing complex regional pain syndrome (CRPS), a neurological condition that comes with disproportionate pain, reduced quality of life, and disability.[1] Symptoms of CRPS can spread beyond the affected limb to other parts of the body.[1]

A lot is still being learned about the causes and treatment of CRPS. For people with CRPS, symptoms may improve within a year.[2] Persistent cases, however, can lead to long-term disability and drastic changes in one's life, identity, and well-being.[1] Those living with CRPS may face mental health challenges, including anxiety, depression, insomnia, somatic symptoms, substance use, and trauma-related symptoms.[3,4] As such, prompt psychological assessment and intervention are important.

Early interprofessional care is indicated for treating CRPS, combining physical therapy, occupational therapy, pharmacotherapy, psychotherapy, psychosocial support, and procedural options.[1,5] The Ottawa Hospital Rehabilitation Centre serves people living with CRPS in Eastern Ontario. With set hospital psychology resources and high need for services, providing prompt and adequate mental health support to CRPS patients is challenging. To address this, we adapted, provided, and evaluated a transdiagnostic cognitive behaviour therapy (CBT) group based on the Unified Protocol,[6] a modality with promising applications to health conditions.[7] To our knowledge, this is the first application of the Unified Protocol to CRPS patients. By not separating people based on mental health diagnoses, the Unified Protocol allowed us to bring together CRPS patients experiencing diverse emotional difficulties. The main goals of this treatment are to deepen one's understanding of their emotions and to teach them effective ways to respond

**Figure 1**




CRPS, complex regional pain syndrome.

to them. These goals align well with rehabilitation ideology.

The group was personalized to the needs of rehabilitation patients. A participant manual was developed with approachable-language worksheets, relevant examples, and single-page session summaries. Other purposeful choices included encouraging practice of skills, inviting participation, and fostering group cohesion. We evaluated the group by attendance rate, outcome measures, and a participant survey.

Five patients with CRPS, who were not seeing progress in rehabilitation, took part in the group. The group had four phases. First, each patient's needs and goals were assessed to evaluate if this treatment was a good fit. Second, eight weekly sessions covered core parts of the Unified Protocol, adapted to health conditions. Third, an individual assessment a week after the last session sought patient feedback and provided further treatment recommendations. Fourth, a check-in group session was held six weeks after the end of the group to revisit group material. See Figure 1 for treatment and outcome overview.

Participant feedback and pilot outcomes were encouraging. The group was well-attended, with four out of five participants attending every session and one participant missing two sessions due to psychosocial stressors (95% attendance rate). All participants reported that the group met their needs and helped them progress in their treatment goals. Importantly, everyone described being more confident to engage in further rehabilitation after the group, and that they would recommend this group to others with CRPS. Outcome measures supported reductions in experiential avoidance (four out of five patients), disability (four out of five patients), catastrophic beliefs about pain (four out of five patients), depression and anxiety (three out of five patients), and traumatic symptoms (three out of five patients). During and after the group, physiotherapists in our centre noted improved engagement in physical therapy for group participants. Providing measurement-based care helped both clinical practice (e.g., participants reflecting on their measures) and organizational efforts (e.g., presentations to hospital staff and leadership).

As the participant statements below convey, beyond coping tools, this group provided a sense of connection and understanding.

"The group helped me accept my diagnosis. I can't say enough about how appreciative I am to be able to participate in this group."

"This group has been a huge support and learning experience for me. I have learned so much about emotions. Being able to connect and relate to people in my situation has made me feel less alone and more understood."

"The group helped me relate with other people with CRPS and I have skills to try and manage challenges."

"I felt a sense of belonging and connecting to everyone in the group. I felt more in control."

"I felt more connected, understood, and resilient."

This project broadens the reach of evidence-based psychological treatment to underserved patients with complex physical conditions. The overlap between physical and psychological symptoms in CRPS underscores the role of psychological care in interprofessional rehabilitation. We intend to continue offering this group to patients living with CRPS, making adjustments based on patient and provider feedback. We also plan to provide this group to patients experiencing emotional challenges while rehabilitating from other conditions. Overall, virtual Unified Protocol groups seem to hold promise for rehabilitation populations.

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# BRIDGING THE GAP: EXPANDING ACCESS TO EVIDENCE-BASED MENTAL HEALTH CARE THROUGH IN-HOUSE TRAINING AND SUPPORT

**Susan Jerrott, Ph.D.; Jacquie Cohen, Ph.D.; Christian Hahn, Ph.D.; and Heather Durdle, Ph.D. Psychologists, Provincial Centre for Training, Education, and Learning, Nova Scotia Health, NS**

The demand for mental health care has steadily risen across Canada in recent decades.[1,2] The impacts of increased demand are exacerbated in Nova Scotia, where demand exceeds the national average, and much of the population lives rurally with limited access to services. Additionally, there are not enough trained mental health professionals to meet the need.[3,4] To address these challenges, public healthcare organizations hire clinicians from a range of professional backgrounds into roles that focus significantly on the provision of psychotherapy; however, many of the corresponding university training programs include no formal preparation in psychotherapy.[5] In addition, many of those hired are early-career professionals who require ongoing training and consultation.

To ensure that Nova Scotians can access evidence-based mental health care, Nova Scotia Health (NSH)'s Mental Health and Addictions Program (MHAP) launched the Provincial Centre for Training, Education, and Learning (PCTEL) in 2019. PCTEL offers training to approximately 2300 MHAP staff. The team includes 16 advanced practice leaders (APLs; primarily psychologists, Master's-pre-

pared social workers, and an occupational therapist) who have specialized training in evidence-based assessment and psychotherapy for mental health problems.

## Improving clinical care

PCTEL provides training tailored to clinicians' developmental stages, the level of care they provide, and the specific needs of the populations they serve. Instead of relying on more generic, external workshops that may not reflect the realities or nuances of our healthcare system or communities, we develop and deliver targeted, context-specific training that is directly applicable to clinicians' day-to-day practice.

PCTEL offers 50 courses each year, ranging from introductory (e.g., Clinical Documentation, Introduction to Motivational Interviewing) to advanced (e.g., Cognitive Processing Therapy for Post-Traumatic Stress Disorder, Full-Model Dialectical Behaviour Therapy [DBT], Clinical Consultation). Training emphasizes practical application, and experiential components include role plays, practice with case examples, case presentations, readings, and homework assignments. Many trainings include follow-up consultation, review of recorded sessions, written case conceptualizations, and deliberate practice to further support learning.

PCTEL also plays a key role in developing NSH's clinical care pathways. These pathways are informed by review of the best available evidence and existing clinical practice guidelines in other jurisdictions to develop care pathways aligned to the local context within Nova Scotia Health. The care pathways take into account Nova Scotia's unique demographic context, which includes a large rural population, widespread socioeconomic challenges, and the unique histories and strengths of newcomers, Mi'kmaq, and African Nova Scotian communities. Cultural responsivity is central to PCTEL's work. Specific courses on topics such as Navigating Minority Stress, Transdiagnostic 2SLGBTQIA-Affirmative Cognitive Behavioural Therapy (CBT), Gender-Affirming Care, and Indigenous-Adapted CBT are offered by PCTEL. This helps ensure that clinical care is not only grounded in evidence, but is also inclusive and responsive to culture, minority stress, resilience factors, and intersectionality.

## Evaluating effectiveness

Overall, clinicians report that PCTEL trainings have improved their confidence and skills. On a confidential questionnaire, the most common response to questions about satisfaction with the training and willingness to recommend it to others was "strongly agree". Managers say they are more confident in their teams' clinical skills, and mental health leadership recognizes that this kind of professional development contributes to stronger teams and services.

Anecdotal reports from APLs and clinicians suggest that clinicians' therapy sessions improve over time with targeted feedback. For example, sessions become more structured and collaborative, and clinicians increasingly demonstrate effective use of active therapy skills. APLs also report higher scores on structured, competency-based tools such as the Cognitive Therapy Rating Scale-Revised (CTRS-R) after clinicians receive feedback on their initial videotaped sessions.

## Ongoing challenges

Recruiting APLs who bring both lived experience and clinical expertise in areas such as gender-affirming care, neurodiversity, and adapting psychotherapy for Indigenous and racialized populations takes significant time.

Another barrier to furthering the work of PCTEL is misunderstanding of what evidence-based treatment entails and the concern that this approach will neglect important individual differences among clients. To help address this, PCTEL offers webinars, communities of practice, and a monthly bulletin that breaks down key concepts into practical terms. We also engage in ongoing self-reflection as a team, regularly examining our practices to ensure we model the principles that we teach.

Retention of trained clinicians presents another challenge. One avenue through which PCTEL encourages highly trained clinicians to remain within NSH is supporting these advanced-level staff in developing their skills in clinical consultation and pursuing certifications through organizations like the Canadian Association of Cognitive and Behavioural Therapies, the DBT-Linehan Board of Certification, and the World Professional Association for Transgender Health (WPATH). These certifications strengthen leadership capacity and help clinicians feel supported in remaining within the public system.

## Next steps

Looking ahead, PCTEL is expanding its evaluation efforts. While clinician satisfaction and consultation outcomes are routinely measured, the next step is to assess how training influences clinician skill and client outcomes over time. Our goal is straightforward: to ensure that every Nova Scotian who seeks care receives effective, evidence-based treatment that is based on sound case conceptualization and cultural responsivity.

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

# THE VALUE OF PSYCHOLOGISTS IN CANCER CARE: ENHANCING PATIENT EXPERIENCE AND CLINICAL OUTCOMES

**Sheila Garland,** Ph.D., R.Psych., Professor of Psychology and Oncology, Memorial University, St. John's, NL

The integration of psychological services within cancer treatment has evolved from being non-existent, to an ancillary (nice-to-have) treatment, to being an essential aspect of comprehensive whole-person cancer care. Only formally recognized in the 1990s, psycho-oncology is a unique subspeciality that addresses the psychological, social, and behavioural dimensions of cancer across the disease trajectory.[1] This interdisciplinary field is concerned with the impact of cancer on patients, families, and caregivers, as well as psychological and behavioural factors that influence disease risk, progression, and outcomes. Psycho-oncology integrates clinical and health psychology, psychiatry, social work, nursing, and other allied health disciplines within oncology settings, all of which focus on developing, providing, and evaluating evidence-based interventions to address the short- and long-term physical, psychological, and social impacts of cancer.

## The unique role of psychologists in psycho-oncology

Psychologists bring specialized expertise to cancer care through an advanced understanding of the normative range of reactions to a cancer diagnosis; knowledge of human behaviour, cognition, and emotion; and training in assessment, diagnosis, and treatment of psychological disorders. They can provide comprehensive psychological and neuropsychological assessment, deliver evidence-based psychotherapeutic interventions, and operate within a family systems approach to address cancer's impact on relationships and families.

Psychologists also have research methodology skills essential for developing and testing interventions, plus psychological testing expertise enabling objective assessment of cancer-related cognitive and functional

impairments, essential for informing return-to-work plans. Some psychologists also have training in behavioural medicine, which uniquely positions them within comprehensive cancer care teams to assess for health behaviours and psychological factors which may be obstacles to treatment adherence and negatively affect treatment outcomes.

## Psychological distress in cancer: Scope and consequences

Psychological distress is a normal experience when faced with a life-altering and potentially life-limiting diagnosis; however, when this distress exceeds the coping resources available to an individual, it can contribute to impaired functioning and long-term disturbance. In a multicentre, epidemiological study of 3724 people diagnosed with various types of cancer, roughly one in two report clinically significant distress.[2] People diagnosed with any stage or type of cancer can experience clinically significant psychosocial difficulties. These impacts can include anxiety, depression, sleep difficulties, cognitive disturbances, and physical problems, which can create cascading effects on the individual and their family throughout treatment.[3]

Early distress is a reliable predictor of long-term adjustment difficulties[4] supporting the need to move beyond reactive approaches and toward early intervention and preventive strategies.

When psychological needs remain unaddressed, patients often experience preventable suffering and negative impacts on quality-of-life and treatment outcomes.[5]

## Distress screening: From identification to intervention

Systematic screening for psychological distress has become standard practice in oncology settings internationally.[6] Validated screening instruments enable healthcare teams to identify patients requiring psychological support, shifting from reactive to proactive care models.[7] Unfortunately, screening alone is not sufficient. The critical factor lies in systematic response to identified concerns and robust response mechanisms linking screening to timely, appropriate psychological interventions that meaningfully improve both clinical outcomes and patient experience.[8]

## Clinical effectiveness of psychological interventions

Systematic reviews and meta-analyses consistently demonstrate positive outcomes from psychological interventions in cancer populations.[9,10] Quality-of-life improvements are particularly notable among patients receiving cognitive behavioural therapy, mindfulness and acceptance-based interventions, psychoeducation, and supportive counselling.[11] In addition to addressing emotional well-being, psychological therapies contribute to better management of cancer-related pain, fatigue, sleep disturbances, and other treatment side effects. These therapies also play a critical role in encouraging behavioural and lifestyle changes, including smoking cessation, improved nutrition, and increased physical activity, which positively impact treatment outcomes and overall health. The benefits of psychological therapies extend to caregivers and families, equipping them with tools to manage stress and improve communication.[12] In palliative and end-of-life care, these therapies address existential distress, facilitate meaning-making, and enhance spiritual well-being.[13]

## Healthcare system integration and efficiency

Unaddressed psychological needs create system inefficiencies while reducing patient satisfaction. People diagnosed with cancer who experience high levels of psychological distress demonstrate distinct healthcare utilization patterns, including lower healthcare service ratings and higher overall utilization rates.[14] Conversely, integrated psychological care contributes to efficient healthcare delivery through improved treatment adherence, reduced emergency visits, and enhanced patient-provider communication.[15]

## Conclusion

Psychology is vital to cancer care because it directly enhances patient experience and clinical outcomes. From reducing psychological distress and improving quality of life for patients and families to optimizing healthcare utilization, psychologists are an essential element of comprehensive cancer treatment. Healthcare systems that integrate systematic psychological care, including distress screening and evidence-based interventions, provide superior patient experiences while achieving better clinical outcomes.

The investment in psychological care during the experience of cancer is a humanitarian imperative and clinical necessity. As healthcare systems evolve toward patient-centred care models, the integration of psychologists in cancer centres remains fundamental to achieving optimal outcomes for patients, families, and healthcare systems.

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

# EVIDENCE-BASED PSYCHOSOCIAL SUPPORT FOR PARENTS CONFRONTED WITH PEDIATRIC CANCER: CURRENT PRACTICES AND FUTURE PERSPECTIVES

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A pediatric cancer diagnosis affects a family's psychosocial well-being. Parents of children with cancer often experience stress, uncertainty, loss of control, anxiety, depression, and traumatic symptoms, including hyperarousal and avoidance.[1,2] Family routines often shift to accommodate treatment demands.[2,3] Siblings may undertake additional responsibilities, which can limit their engagement in social activities.[4] Parental mental health is closely linked to children's emotional well-being, development, and academic functioning.[2] Given these cascading effects, psychosocial support is essential. In recent decades, researchers have developed targeted interventions to alleviate parental distress and foster resilience among families facing pediatric cancer.[5]

Psychosocial teams seeking to support families with evidence-based care can choose between two leading interventions: Bright IDEAS (BI) and the Surviving Cancer Competently Intervention Program (SCCIP).[5] Both programs were recommended by the American National Cancer Institute (NCI) following evaluation across three criteria: research integrity, impact, and dissemination, each rated on a five-point scale.[5,6]

BI is a manualized, individually delivered intervention designed to alleviate caregiver distress by increasing awareness of stressors, strengthening problem-solving skills, and restoring optimism.[5] The intervention follows a five-step process based on problem-solving skills training.[5,7] Materials include instructor/parent manuals and worksheets.[8] BI was initially an eight-session intervention targeted towards mothers,[9] but was later expanded to include fathers.[8] Recognizing that eight meetings may exceed training demands, the initiators redefined "completion" as skill-based rather

than time-based. Providers now guide users through the resolution of three problems within two to four sessions. While originally delivered by research assistants with graduate training in clinical psychology or behavioural health,[9] BI is now offered by experienced pediatric psychosocial oncology professionals, including psychologists, social workers, and advanced practice nurses.[8,10] The program has been adapted for caregivers of children with sickle cell disease, mothers of children with autism spectrum disorder, adult cancer survivors, and young adults, with content tailored to each population.[7,9,11-15]

Another widely used intervention is SCCIP, a manualized program designed to reduce post-traumatic stress symptoms in adolescent cancer survivors and their families.[16] Grounded in cognitive-behavioural and family therapy approaches, this intervention aims to prevent cancer-related traumatic stress symptoms.[17,18] It focuses on identifying and reframing beliefs about cancer-related challenges. SCCIP targets symptoms of intrusion, avoidance, and arousal, as well as social support and family communication. The intervention relies on multifamily discussion groups, where parents share experiences and coping strategies. SCCIP is a one-day intervention that consists of four 60–90-minute sessions, delivered individually and in groups by providers with a psychology background.[16] Several adaptations have been developed based on the same theoretical model, namely SCCIP-Newly Diagnosed (SCCIP-ND)[17,18] and Electronic SCCIP (eSCCIP)[19,20]. SCCIP-ND offers three 45-minute sessions, followed by three booster sessions delivered over four to six weeks postdiagnosis.[17,18] eSCCIP features four self-directed, web-based modules completed over a month.[19,20] It integrates video content and interactive activities, supported by telehealth sessions with trained clinicians.

While BI received high NCI scores for dissemination and research integrity, its impact was lower due to its original focus on individual sessions with mothers.[6] The program also experienced a high dropout rate due to its time-intensive format. SCCIP lacked specificity in its manual and received fair scores on dissemination and research integrity, but a lower impact score. Given recent adaptations, an updated NCI evaluation may be warranted. Although both programs are available in English and Spanish,[8,20] they were developed for an American population, raising questions about cultural and linguistic applicability in the Canadian context.

Building on the strengths of these interventions and informed by potential interventionists and parent-partners, Canadian clinicians developed, refined, and tested the "Taking Back Control Together/Reprendre le Contrôle Ensemble" (TBCT/RCE) program.[1,2,6,21] The process followed the Obesity-Related Behavioural Intervention Trials (ORBIT) recommendations, which include structured phases for behavioural treatment development, refinement, and pretesting.[22,23] This program targets problem-solving skills and dyadic coping (i.e., a couple's ability to manage stress together)[24] as parents navigate their child's diagnosis. TBCT is a manualized, six-session intervention available in English and French. It comprises four individual and two couple sessions, each lasting 60–90 minutes, and provides personalized and collaborative support. During initial feasibility testing, sessions were administered by psychology interns and postdoctoral fellows.[1] TBCT is now delivered by social workers and psychologists specializing in pediatric oncology.[21] The program is flexible in its intensity, allowing clinicians to condense sessions if caregivers quickly master problem-solving skills. TBCT adapts to various family structures; it offers individual sessions for single-parent families, prioritizes co-parenting responsibilities (e.g., decision-making and communication) over intimacy for separated parents, and includes step-parents in the process for blended families. Although TBCT is a relatively recent intervention, findings suggest it holds promise as a scalable and adaptable support mechanism.[1,21] Further research is needed to evaluate the program's efficacy, long-term impact, and uptake across treatment centres. A current initiative is leveraging dissemination science strategies to build an intervention capacity across three treatment sites in Canada.[21]

Given the emotional impact of pediatric cancer on families, accessible, evidence-based psychosocial programs are essential. Interventions like BI and SCCIP have become integral to the clinical toolkit for psychosocial clinicians supporting affected families. More recently, the Canadian initiative Taking Back Control Together has emerged as a promising contribution. By targeting individual and relational coping, TBCT aims to reduce parental distress, strengthen family functioning, and improve the quality of life of families facing pediatric cancer. This initiative reflects an ongoing effort to develop a context-specific, evidence-informed approach in Canada. However, as programs continue to emerge and evolve, important questions arise: what defines an intervention as evidence-based, and which core components should be preserved to maintain its integrity, receptivity, and scalability?

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

Suicide has become an increasingly concerning issue within various age groups, ethnic groups, and social statuses.[1] Older adults (i.e., aged 60 years and over) are particularly at risk for suicidal ideation and suicide-related behaviours,[2] with Global Health Estimates 2019 showing 27.2% deaths from suicide are among people aged 60 or over.[3] Unfortunately, research on preventing suicide in older adults is minimal. Although the literature is small, several factors have been identified which are associated with suicidal ideation and related behaviours in older adults, including marital status, employment status, and presence of chronic disease.[4-6]

# BUILDING AN EMPIRICAL FOUNDATION FOR RURAL SUICIDE PREVENTION AND INTERVENTION IN OLDER CANADIANS

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Similarly, there is a growing recognition of the prevalence of suicide in rural communities[7-8] and the lack of research in that area.[9-10] Indeed, higher suicide rates have been found in rural compared to urban areas in multiple Canadian provinces.[7-8] Furthermore, the probability of being exposed to and negatively impacted by a suicide may be particularly high in rural compared to non-rural areas. Indeed, the current estimate that 135 people are exposed to every suicide death[11] may represent a substantial proportion of rural and remote communities (e.g., Red Bay, NL has a population of 142,[12] meaning a suicide death would likely impact all members to some degree, greatly disrupting community functioning). Furthermore, lower population densities correlate with fewer resources available or accessed to assess and treat suicidality.[13] As such, rural older adults may be particularly at risk due to the intersectionality of age and location. Thus, suicide among older adults in rural places warrants a closer examination.

## Overview of project

We repeated a broader literature search we conducted for a project on suicide in older adults to specifically look at those papers from rural, northern, and/or remote (RNR) areas. The purpose was to ensure we had a good representation of the existing empirical research on suicide in older adults from RNR spaces. We consulted with librarians at our home institution to create a search strategy that would cast a wide net and allow us to collect the best set of relevant knowledge on the topic. Thus, we included "rural", "remote", and "northern" as population keywords as these descriptors are often used in Canadian research and included studies that either included only adults aged 60 and above or had a group that only included participants aged 60 and above. Ultimately, our search uncovered 33 articles related to suicide in rural older populations, with a median sample size of 998. We pulled information from each article relevant to suicide in rural older adults.

There were a few key results we would like to share. First, only two studies, or 6%, investigated Canadians. Most studies on suicide in rural older adults are conducted in China (over 50%) or the United States (15%), highlighting the potential lack of information applicable to older rural Canadians. In fact, one-third of all the research articles we found seemed to reference the same 242 individuals who died by suicide in China. Second, while most researchers indicate that they studied rural populations (94%), over half of these did not explicitly explain or describe the meaning of rural. Third, researchers more often studied death by suicide when compared to suicidal ideations or attempts. This finding aligns with past research on rural suicide.[14] This is an important distinction as current theories often explain that ideations will eventually transition to suicide attempts and deaths, meaning early intervention is important. Studying earlier points, prior to transition, are needed.[15]

## Evidence-based assessment and intervention recommendations

Although only one article explored treatment for suicidality (and that study[2] looked specifically at follow-up post-attempt), there were 11 studies that identified factors related to increased suicidal thoughts among older adults who live in rural areas. Factors associated with increased suicidal ideations in rural older adults included experiencing mistreatment,[16] having both parents alive,[17] increased functional limitations,[1-2,4-6,9-10,14-19] increased perceived burdensomeness,[20] and increased health problems,[6, 21-22] including cognitive challenges.[6,22] Although past mental health history is considered a risk factor for suicidality more generally, when looking at older adults, it was not always present among the older adults in rural areas experiencing suicidal thoughts and/or behaviours.[23] For that reason, it is important that clinicians, especially in rural spaces, assess and screen for factors unique to this population.

Given the heterogeneity of rural spaces in Canada, and the variety of risk factors identified among rural seniors to-date, it is important for clinicians to be aware of empirically identified risk factors that heighten suicide risk in this vulnerable population, to prevent older individuals moving from ideation to action. Clinicians should be mindful of cultural considerations that may be at play, especially when practicing in RNR spaces,[24] so they are able to ensure they are screening for suicide in older adults using factors that are related to suicide in their own communities and culture. As a starting point, clinicians may wish to consider whether their older rural clients have multiple health problems, experience end-of-life issues, and/or are having difficulty adjusting to life cycle transitions, as these clients may be at heightened risk for suicide,[23] while continuing to be mindful of factors unique to their cultural context. It is important, given the variability within RNR spaces in Canada, that researchers conduct empirical studies to identify the screening/assessment protocols that are effective for Canadians so we can help to identify at-risk older Canadians sooner along the trajectory and employ evidence-based interventions.

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# FROM CLINIC TO COMMUNITY: EXPANDING ACCESS TO PSYCHOLOGICAL CARE FOR MILD COGNITIVE IMPAIRMENT THROUGH AN INNOVATIVE WEBINAR INTERVENTION

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Multicomponent interventions rooted in the neuropsychological science of aging are evidence-based approaches to support older adults navigating memory concerns.[1] Individuals living with mild cognitive impairment (MCI), a clinical diagnosis that reflects cognitive decline greater than expected for one's age without significant loss of functional independence, are a specific subgroup of older adults who may benefit from these interventions. While individuals with MCI are at an increased risk for developing dementia, this progression is not inevitable. Lifestyle practices can significantly influence the risk of future dementia, with research suggesting that up to 45% of all-cause dementia cases may be attributable to modifiable lifestyle factors.[2]

The Learning the Ropes for Living with MCI program, developed at Baycrest in Toronto, Ontario, is an evidence-based, manualized, multicomponent group intervention designed to

support older adults living with MCI and their family members.[3]

The program promotes the adoption of healthy lifestyle habits and practical memory strategies to optimize brain health and everyday functioning. The program also includes a psychosocial component for family members aimed at building adaptive coping strategies and improving communication skills.

Launched in 2002, the Learning the Ropes for Living with MCI program has been implemented across numerous hospitals, research centres, and memory clinics across Canada. Program participants are more likely to demonstrate gains in both their knowledge and use of memory strategies compared to those on the waitlist to participate in the program.[4] However, as in many areas of health and neuropsychology, challenges remain in ensuring equitable access to treatment. These limitations include the availability of trained professionals to facilitate these programs, the program's capacity, the time commitment needed, the requirement of a formal MCI diagnosis to participate, and the geographic location of the program.

To address these gaps in service delivery and knowledge translation, the Learning the Ropes Foundations webinar was developed. This a publicly available, self-paced resource that communicates three key teachings from the original program's evidence-based principles. This 40 minute interactive webinar is a low-intensity, high-volume (LI-HV) intervention; LI-HV approaches are increasingly valued given their potential to provide psychological strategies to broader audiences, particularly those with unmet mental health care needs.[5] The Learning the Ropes Foundations webinar incorporates interactive polls, visuals, closed captions, demonstrations, and downloadable tip sheets. Ultimately, the goals of the webinar are to foster participants' abilities to adopt brain-healthy lifestyles, learn practical strategies to support memory, and implement adaptive coping strategies. The webinar was created using an agile development framework to gather real-time feedback on its clarity, relevance, ease of use, and effectiveness. The Learning the Ropes Foundations webinar is available in English, French, and Spanish. Since its launch in January 2024, over 3000 individuals have accessed these resources, inclusive of both national and international viewership.

Following the free interactive webinar, individuals with cognitive decline and their family members were invited to complete a feedback survey about their participation.[6] The majority of respondents shared that the interface was easy to use, the webinar communicated helpful information, and they learned something they could apply to their everyday lives. Moreover, most respondents reported feeling motivated to implement at least one behaviour change (i.e., using a memory organizer, engaging in recreation activities, building adaptive coping strategies) after participating in the webinar. Qualitative feedback such as "…knowing that someone cares about MCI and has solutions" and "…it gave me tips to help me hold on to my brain power" reinforced the webinar's positive impact and value.

Importantly, the findings from our survey suggest that LI-HV interventions can be well-received by at-risk older adults, and may promote motivation for positive behaviour changes outside of traditional one-on-one or direct group care settings. The free, private, and self-directed format enables individuals who may be reluctant to seek public resources to engage with valuable cognitive health information in a comfortable setting. The webinar can also be easily disseminated by healthcare providers as an educational tool. By empowering individuals to manage their cognitive health and reaching a wider audience, the webinar has the potential to reduce or delay reliance on direct healthcare services, which may ultimately contribute to more efficient resource use.

Both the Learning the Ropes for Living with MCI program (in-person and virtual offerings) and the Learning the Ropes Foundations webinar highlight the essential role of psychology in promoting cognitive health. Psychologists are uniquely equipped to address the emotional impact of memory decline, integrate cognitive rehabilitation strategies, and empower individuals to adopt evidence-based tools that support their independence and well-being.

For many older adults, a diagnosis of MCI can feel daunting. Psychological support grounded in research can help transform uncertainty into action and foster hope for continued independence, purpose, and quality of life. When we as psychologists extend our work beyond in-person therapy, we reduce the impact of geographic, linguistic, financial, and resource barriers, honouring the core goals of psychology: accessibility, empowerment, and prevention.

To learn more about the Learning the Ropes for Living with MCI program or the Learning the Ropes Foundations webinar, please visit www.baycrest.org/ltr. The Learning the Ropes Foundations webinar can be accessed in English (www.baycrest.org/ltrfoundations), French (www.baycrest.org/ltrfoundationsfr), and Spanish (www.baycrest.org/ltrfoundationsesp).

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There has been an increasing demand for mental health services, including psychological services, as the public becomes more aware of and open to accessing these services. The media has played a huge role by covering issues such as traumatic stress in first responders and in the military, as well as the emotional effects of the COVID epidemic.

# COLUMN FROM THE SECTION OF PSYCHOLOGISTS AND RETIREMENT, CANADIAN PSYCHOLOGICAL ASSOCIATION

## PSYCHOLOGISTS IN CANADA: HOW MANY ARE THERE?

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**Juanita Mureika,** M.A., L. Psych. (retired), Fredericton, NB

**Dawn Hanson,** M.A. (retired), Winnipeg, MB

Recent acts of violence by people with mental health problems in Nova Scotia[1] and in British Columbia[2] have also highlighted the need for services. Parents are facing increasing challenges raising children as the world changes from generation to generation, bringing with it new issues such as the impact of technology and social media on developing children. The increasing identification of attention deficit hyperactivity disorder (ADHD)[3] and the lengthy wait times or expense of accessing a psychological assessment are examples of issues some parents are facing.[4]

It is not just the public, however, who have noted the dearth of psychological services in Canada. During the regular meetings of The Canadian Psychological Association's (CPA) Section of Psychologists and Retirement, psychologists retiring from private practice frequently raised the issue of how difficult it was to find another psychologist to whom to transfer their clients. The question arose, then, of how many psychologists are providing mental health services in Canada?

In order to answer that question, a request was sent to each psychologist regulatory body in Canada asking for the number of psychologists who were registered to provide a psychological service autonomously. An additional question was asked as to what types of client groups (adults, children, adolescents, etc.) each psychologist served. Finally, as a rough proxy for turnover, a request was made for the length of time each psychologist had been registered.

Every province, except for the Northwest Territories, responded to the request, so unfortunately, references to Canada in this article do not include them. From this survey, we found that there were 19,618 registered psychologists in Canada. With a population of 40,201,168 at the time, that means that there are 49 psychologists per 100,000 Canadians. This number, however, varies widely across the country. At the low end, are the provinces of Manitoba, Ontario, and British Columbia with only 16, 24, and 25 psychologists per 100,000 people, respectively. At the high end are Alberta and Quebec with 79 and 96, respectively.

In terms of clients being served, of the seven provinces that track this information, adults were the most common client group being served. Fewer psychologists accept referrals for adolescents, and even fewer see children.

Another issue that arose from the survey was the average age or length of time psychologists had been registered. The majority of psychologists were mid or late in their careers, with from 10 to over 25 years of practice. Of the two provinces that provided age information, the median age of psychologists in Ontario is 51, and in Alberta is 45. Relative to other provinces, Alberta also had a large number of young members (median age 35) under supervision at the time of the survey (1086 or 22% of their total membership). They will soon swell the number of registered psychologists in that province.

Are there enough psychologists in Canada to meet the current and future needs of the population? Although we have looked at the supply side of this equation, it is difficult to assess the demand side. There are, however, some indications of the demand situation. A recent analysis of all areas of psychological practice, including education, law, and government, found that there is an expected shortage of psychologists over the period of 2024–2033.[5] In terms of psychologists employed in the public sector, there has been a notable decline of those in hospital settings.[6] In Quebec, the province with the highest ratio of psychologists per population, it can take from six months to two years to see a psychologist in the public system.[7] In Newfoundland, wait times to see a psychologist in the public system range from 18 months to five years for adults and from 12 to 27 months for children.[4] When the Nova Scotia government announced its plan to include psychologists in its public health care plan,[8] some psychologists voiced their opposition to the impending bill, arguing that they did not have the capacity to meet the increasing demands that would result from this bill.[9]

The psychology profession has made some efforts to increase the availability of psychological services. For example, Prince Edward Island, Ontario, and Manitoba have begun registering Master's level practitioners for autonomous practice under the title "Psychological Associate" – a situation similar to what is being proposed by the American Psychological Association.[10] At this time, however, only 1.6% of psychology practitioners in the country are Psychological Associates.

Further work needs to be done. At the root of tackling the shortage of psychologists in Canada is a need to increase the capacity of education and practical training opportunities for psychologists. Continued advocacy work with governments needs to be done, particularly with provincial governments because of their responsibility for the delivery of health care. It is our hope that having current accurate information on the number of psychologists in the country will be of assistance with this important work.

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# CPA HIGHLIGHTS

**A list of some of our top activities since the last issue of *Psynopsis*.**

Be sure to contact membership@cpa.ca to sign up for our monthly Psygnature e-newsletter to stay abreast of all the things we are doing for you!

## 86TH ANNUAL CPA CONVENTION

The CPA's 86th annual convention was held in St. John's, Newfoundland, in June. More than 1500 attendees filled meeting rooms for presentations across 37 different scientific program streams. Next stop, Montréal! The 87th annual convention will be held from June 4th-6th in Montréal in 2026.

## LUNCHBOX LECTURES SERIES LAUNCHED

The CPA has launched a new series of monthly noon-time talks called the Lunchbox Lectures. This is an opportunity to hear from leading researchers and practitioners across the full spectrum of psychological science. Each session highlights current issues, emerging research, and innovative approaches shaping the discipline of psychology. https://cpa.ca/lunchbox/

## NEW EPISODES OF THE MIND FULL PODCAST

The *Mind Full* podcast brings psychological science and concepts to a general audience, highlighting issues and discussing new research with a behavioural lens. Find *Mind Full* wherever you get your podcasts to listen to recent episodes about criminal profiling, academic achievement, and the experiences of contingent workers in Canada.

## NEW "PSYCHOLOGY WORKS" FACT SHEETS

Psychology Works fact sheets are designed to give you information that you can trust. With that in mind, we have created two new fact sheets about young kids and screens, and also teens and screens. Use them as a resource, a reference, or just to learn more about this topical subject.

## CPA PROVIDES INPUT INTO 2025 FEDERAL BUDGET

Now that the federal government has committed to a fall budget, the CPA provided its views via a Brief to the House of Commons Standing Committee on Finance. As part of its strategic alliances, the CPA has also contributed and shaped the Briefs of the Canadian Alliance on Mental Illness and Mental Health (CAMIMH), the Canadian Consortium for Research (CCR), and the Extended Healthcare Professionals Coalition (EHPC) that were also submitted. The CPA has also requested to appear as a witness to the Committee hearings.

## CPA'S 2025-2030 STRATEGIC PLAN

The CPA's Board of Directors has released the CPA's 2025-2030 Strategic Plan. They thank all members, affiliates, and associates who took the time, whether as individuals or as part of a collective, to provide input as part of our open consultation and call for feedback. With the new Strategic Plan, we have refreshed the CPA's Vision, Mission, and Strategic Priorities.

The CPA podcast **Mind Full** brings a psychological lens to subjects that are important to Canadians

MIND FULL
— A CPA PODCAST —

soundcloud.com/user-389503679

# LAUREATES OF THE CPA 2025 CERTIFICATE OF ACADEMIC EXCELLENCE

# LAURÉATS DES CERTIFICATS D'EXCELLENCE UNIVERSITAIRE DE LA SCP 2025

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Emma Sampson
Hayley Green

**Masters Thesis**
Meaghan Hymers*
Tessa Cosman*

## BROCK UNIVERSITY
### Department of Psychology

**Honours Thesis**
Sara Palewicz
Lisa Boivin-Rutherford
Mimi Juffe

## CAPE BRETON UNIVERSITY
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**Honours Thesis**
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Kiyara Letlow
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## CARLETON UNIVERSITY
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Brianne Morris
Kelsey May
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Yulia Gmiro
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**Doctoral Thesis**
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