Canadian Clinical Psychologist

Editor:
David S. Hart

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Message from the Chair

Rhona Steinberg

The Clinical Section Executive has been busy, both with convention planning and the dissemination to various organizations of the *Definition of Clinical Psychology*, and the Information Brochure. The definition and brochure were circulated to the Canadian Council of Clinical Psychologists (CCCPP), Council of Provincial Associations of Psychology (CPAP) and the Canadian Register of Health Service Providers (CRHSPP). There were discussions at their meetings and differing points of view emerged from the different organizations. On one hand, CCCPP liked the definition and endorsed it wholeheartedly; on the other hand, both CPAP and CHRSPP voiced concerns about the definition. There were no comments about the brochure. Since the executive assumed there would be many opinions about the documents, a conversation hour during the CPA convention was scheduled so that further discussions about the definition could take place. This hour should provide a venue for a very lively debate on the issues. I feel that all members of the Clinical Section should be present to make their views known.

The general business will follow directly after the conversation session. At this meeting these documents will be voted upon. This will be an opportunity for all members of the section to make an impact on the direction of clinical psychology in Canada.

The executive has also been very active contributing to the CPA convention program. We nominated Dr. William Marshall as an invited speaker and as you can see in the latest edition of *Psynopsis*, Dr. Marshall has been selected as one of the two invited speakers. His topic "The Value of Assessing and Treating Sex Offenders" will examine four main issues: empathy, intirnacy, deviant sexual preference and treatment outcome. It should be a very illuminating talk and I hope many of you will attend. The executive also suggested two pre-convention workshops: one by Sandra Butler entitled "Sexual Abuse and the Healer" and the second one by David G. Hart (not our illustrious editor) entitled "Critical Incident Stress and Trauma Debriefing-An Applied Workshop." These two workshops should be most illuminating and participants will take away many ideas which will be very useful in their clinical practice. It will be very difficult to chose between these two important topics.

It is time for the call for nominations for the executive of the Clinical Section. The two vacant positions are chair-elect and member-at-large. If you know anyone (including yourselves) who you would like to see provide leadership for clinical psychology in Canada, please forward the nomination to Dr. Michael Vallis. It is very important to become involved. **Don't wait for the next person to do it for you!!** There are many pressing issues that concern clinical psychologists, i.e., should it be mandatory for psychologists to be registered with CHRSSP or is provincial registration sufficient to practice psychology in a hospital milieu? Don't let someone else make these decisions for you.

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Issues in Canadian Hospital Psychology

John Arnett organized a symposium on issues in hospital psychology for the CPA 1992 convention. I found the papers stimulating and determined to enable them to reach a wider audience through our newsletter, the Canadian Clinical Psychologist. Here are three of the papers. Absence of the others is not a reflection of lesser merit, but of my ability to buttonhole busy hospital psychologists at a propitious moment.

Hospital psychology clearly faces some important challenges. Your comments will contribute to an ongoing discussion which can help shape the future of our profession. Join the discussion. The re-shaping is proceeding whether we direct it or not. Send comments to: David S. Hart, editor, Canadian Clinical Psychologist, 3962 West 12th Avenue, Vancouver, V6R 2P2.

Four Imperatives

John T. Goodman, Ph.D.
Children's Hospital of Eastern Ontario

There are a large number of issues affecting psychology in hospitals but I believe that the four most important areas could be listed as follows:

1) Hospital psychology should continue to anchor its practice in research
2) Hospital psychology should maintain ties to research and academic institutions – the universities.
3) Hospital psychology should continue its focus on health psychology rather than an exclusive focus on mental health. The differences between psychiatry and psychology as disciplines should be highlighted.
4) Hospital psychology needs to pay more of its own way. Funds in addition to those through the global budget must be found if hospital psychology is to continue to develop.

Psychology is the only health care discipline that originated within the university and then moved into practice in the community. The models espoused for psychology, namely the scientist practitioner or practitioner scholar, carry the implied promise that psychology will evaluate its interventions. I think it is important that psychology continue to evaluate the efficacy of treatments and that we use our skills and empirical research to continue to refine and improve out assessment and intervention techniques.

Hospital psychology should maintain ties to research and academic institutions. This serves to reinforce the academic basis for our profession and also increases the likelihood that evaluative research will be done. Ideally hospital psychology programs would relate to university clinical programs, but not all universities have clinical programs. However, support can be drawn from non-clinical university programs as well. Psychology continues to be the best trained group to integrate research and clinical activity and they are often in the best position to do so. Hospitals are moving toward tertiary level care. This means increased acuity level of patients and it also means an increased cost for patient care. Efficacy and cost effectiveness have become crucial areas that will require applied research information.

Psychology should continue to focus on health psychology rather than just mental health. This would mean that the differences between psychology and psychiatry should be more clearly delineated. No doubt there is some overlap, as with the use of such common therapeutic modalities as psychotherapy, family therapy, group therapy, etc. There are psychologists who want the right to admit patients to hospital and who want the training and the right to prescribe psychotropic medication. I think psychology should continue to do what it does best and for the moment avoid these more contentious issues. We should not avoid them simply because to encourage governments to support a discipline that would add to the overall health care cost.

It is important the psychology begin to pay its own way. In 1987, under the aegis of the Canadian Psychological Association and the Council of Provincial Associations of Psychology, a task force completed a review on the funding of psychological services. Psychology's reliance on global health care dollar budgeting often leaves them in a precarious position. The task force identified three models. The first is a fee-for-service model which would mean that full billing would be made to patients in hospital who receive psychological services. The second involved the utilization of a sliding scale to match billing to a patient's ability to pay. A third model involves the recovery of insurance benefits that would be available through third party insurers. Recovery of benefits is an option that does not impede service accessibility nor does it intrude on patient privacy. However, the rate of return is relatively low. The sliding scale also has the possibility of a low rate of return depending on the socio-demographic characteristics of the population being served. Full billing aimed at cost recovery and ability to meet service needs may have to be looked at very seriously.

Issues in Canadian Hospital Psychology continued

Five Issues

Murray Schwartz, Ph.D.
Victoria General Hospital, Halifax, Nova Scotia

I would like to address five major topics (including a number of sub-headings) that I feel are critical in addressing the issues facing hospital psychology as we head into the 21st century.

Autonomy

(a) To whom does the Psychology Department report? Essentially, is the department independent or is it a sub-department (eg. a subdivision of the Department of Psychiatry)? It is preferable that Psychology report to an administrative head (eg. a vice president or assistant executive director) and not to a clinical department hear (i.e. a director of a clinical service such as Psychiatry or Neurology).

(b) Organizational structure of the institution. Where are Psychological services mentioned specifically on the organizational chart? Are you part of some organizational chart that doesn't mention Psychology as a specific department or column heading (eg. program/matrix organizational chart).

(c) Who controls the purse strings? I suggest that it is better to beg, plead and cajole an administrative vice president than it is to argue for your budget to a department head who has his/her own clinical service to consider first.

(d) Who makes the decisions concerning hiring/firing, job descriptions and standards (eg, quality assurance)? In terms of autonomy, perhaps this is the key. One cannot be master in one's own home if psychologists (presumably the Chief or Director of Psychology) does not determine who gets hired, what their job description states and most importantly, to whom is the staff psychologist ultimately responsible. If the staff psychologist is accountable to a non-psychologist, I would argue that you have the functional equivalent of a non-psychologist countersigning your reports.

Power Structure

(a) Do psychologists have equal access as do other clinical staff to membership on committees, boards and executive committees that determine policy and make decisions in the hospital. Remember that accreditation standards state this as a criterion for accreditation. Consequently if you do not have such access, accreditation can be a potential political lever.

(b) Who does the credentialling for psychologists? Is the Psychology Department the *exclusive* deliverer of psychological services in the hospital? That is, can another clinical department (no-psychologist lead) bring in a psychologist, a researcher or a university appointment and have him/her deliver services to patients for a particular program or clinic? If this is the case, then psychologists are not responsible for credentialling, i.e. setting standards and Q.A.

(c) Can any physician conduct a research protocol that calls for the use of clearly psychological tests and/or hire a psychologist or a psychometrist to do testing without the Psychology Department knowing and/or giving approval for such testing or appointments? Sometimes this can be done by *research* or *affiliated scientist* appointments. Such appointments are a good thing but are dangerous if they in fact threaten the authority, autonomy and responsibility of the Department of Psychology.

Funding

(a) Where are you in the pecking order? This is a constant struggle, especially in these difficult financial times. It's no different from any other clinical service fighting for their fair share of the pie. Fair is the operative word. If you have to be subsumed under someone else's budget, then there is the greater potential for problems.

(b) Who receives the payoff when there is recovery of costs? Do the recoveries come to the Psychology Department, (a Psychology trust fund) or do these recoveries get lost somewhere in general revenues? If the funds (or a percentage of them) find their way to Psychology Department coffers, then you become much more motivated to making sure that such monies are indeed paid and not lost somewhere in a bureaucracy. Also, I suggest you review the fee structure for such items as WCB, out-of-province patients, etc. In my experience, Psychology is inadequately paid on existing fee schedules, especially if you consider a medical visit is 10-15 minutes long, whereas a clinical Psychology visit may be over an hour and a neuropsychology visit may cover the better part of a day.

Visibility

(a) We are doing a very poor job in the public relations department. Not only do the public not know who we are and what we do (or can do), but health care workers including physicians do not know the range of services we can offer. Ashamedly, many psychologist aren't even aware of the changes that have occurred in health psychology in the past decade. Many in related health care fields are surprised to find that we are no longer handmaidens to Psychiatry.

Issues in Canadian Hospital Psychology continued

(b) In hospitals our consults are typically, if not exclusively, driven by physicians. This is probably why Dr. King, speaking earlier, has suggested that we get out of hospitals and go to where we can be more fully appreciated. Not all psychology consults have to be physician driven. It is important, especially in this era of program driven agendas that psychology own/lead some programs and that psychologists have a more consumer driven consultations. Physiotherapy and occupational therapy by statute cannot legally see patients unless they are referred by a physician. We don't have that restriction in our various legislative acts and we should therefore not restrict ourselves unnecessarily.

New Era

(a) Make sure the multidisciplinary teams of which Psychology is a member are partnerships, that is, Psychology is a partner in decision-making, planning, responsibilities, etc. There is a danger in using words like teamwork, co-operation, and other politically correct euphemisms of the 90s which don't mean the same to different groups. Unfortunately, multidisciplinary (often to physicians), simply means a medical head and subordinate others who happen to come from other disciplines. Teams need to have a captain, but they are only truly teams if anyone can get to be captain. That's not the case if its someone else's bat and if you don't play their way you don't play at all or worse yet, you get beaten with it.

(b) Patients in hospitals for the most part, no longer die of infection or acute episodes as was the case decades ago. Thanks to modern medicine we now keep people alive with a variety of chronic conditions. Our challenge for the future in psychology is to deal with these chronic conditions almost all of which have strong psychosocial components (eg. heart disease, cancer, arthritis, organ transplants and dialysis). Hospital psychology in the next century will invest much effort in helping people learn to cope with chronic illness, and devise programs for chronic ambulatory care patients who have to adjust to altered life styles. There is a lot of promise and tremendous opportunities for growth. We have to educate physicians and hospital administrators concerning the critical role that we can play in quality patient care.

Stay Hungry!

Michael C. King
Calgary General Hospital

There was, perhaps, a time when practising psychology in a hospital was the pinnacle of professional practice for a psychologist. Some of us believed that anyway. You got to hang around with the real doctors. Some of the luckier ones even got to wear white lab coats, potent talismans of the clinic and laboratory. What could be better for a scientist-practitioner? Genuinely, though, hospital practice represented a challenge and an opportunity for psychologists, particularly if they ranged beyond the traditional mental health domains for their work.

Now, however, hospitals are less happy places to work than they used to be. Institutionally based health care is under strong attack. Hospital budgets are shrinking. Beds, positions, programs, and whole departments are being cut from the hospital roster. All are feeling the hot breath of euphemism on their necks: down-sizing, right-sizing, rationalization, regionalization. To the south, managed care, the once-and-never saviour of U.S. health care, is coming in for increasing scrutiny as critics draw attention to its failings in the area of its ostensibly greatest promise: cost control. Meanwhile, to ransom them from their fiscal captors, many Canadian health care institutions and organizations are seizing upon managed care in its northern manifestation: Program Management.

Psychology, with few exceptions, is not thriving in Canadian hospitals now. Some departments have been cut outright. Many departments have lost positions or have had to create novel work arrangements to salvage existing positions. Some have disappeared into programs staffed by generic health care or mental health care workers, losing oversight of discipline-specific services in the process. Many others face an uncertain future as hospitals try to trim budgets and live within their dwindling means. The paradox of these developments is that they come at the very time that research evidence is finally starting to show compellingly that the trade we ply is critically important to promoting and maintaining health, and that we can wield powerful methods to reduce unnecessary health care usage while improving the health status of the customers we serve. As Alice (of Wonderland fame) observed: "Curiouser and curiouser!"

I touched on what I felt were the reasons for our current malaise in a recent issue of Rapport, the Newsletter of the Canadian Register. Briefly, we have never been masters in our own professional houses in hospitals. We are the most expensive of the non-physician health care providers now working in hospitals. We may have inadvertently contributed to the disturbing trend toward homogenization of health care workers in institutions by letting our activities drift away from those things we do uniquely well.

It is time for those of us in health care to think hard about where we really should be right now. It may be that we do not belong in hospitals any more, for rea-

Issues in Canadian Hospital Psychology continued

sons that properly have to do with who we are and what we do, rather than with the vicissitudes of hospital policies and politics. (It may be that we should never have been there in the first place. But I'm saving that plot for my next novel.)

Whether we choose to stay in institutional health care or not, we are collectively going to have to get back to the basics of what we do uniquely well. Most of all, however, we are collectively going to have to start thinking like entrepreneurs in the institutional marketplace. This means knowing how the market is structured, who our actual and potential customers are, and what they want. Then, we have to find a way to give them what they want. Practically, this may mean altering or abandoning some of our traditional and cherished activities, exploring new relationships with institutions, and paying constant attention to showing that what we do makes a difference in health care outcomes.

In line with the growing emphasis on teamwork and collaboration in hospitals, we should also look to forge alliances with other provider groups who have shown particular astuteness in navigating the changed political landscape of health care. Nursing is a good example.

If there were a particularly apt slogan for psychologists in health care in the 90's, it might be, in all its multi-layered meanings, the body-builder's exhortation that I used to title this article: Stay hungry!

Networking

Robert Gauthier

On CPA support for required CRHSPP listing for CCHFA accreditation, a letter to the editor

ANP has formally stated our opposition to CPA's proposal that health care psychologist be listed with CRHSPP in order for the health care setting to receive accreditation with CCHFA. A letter was written to the director of CCHFA on February 3, 1993. When this proposal was first made in 1990, we wrote to the director of CCHFA, Ambrose Hearn, to state that we were opposed. Although we do not know if out opposition had direct impact, the regulation was removed from CCHFA standards. Therefore, we were surprised that in September 1992, CPA was again making this proposal.

Dr. Hurley, president of CRHSPP, argues that CRHSPP registration would increase and protect the standards of psychological practice in Canada. In theory, we agree that a national lobbying body would potentially do this. However, our membership questions why CPA could not lobby for psychology. We wrote to our members to ask their opinion on mandatory CRHSPP registration. The respondents asked why this issue has arisen again and why we weren't informed that CPA was again proposing it. They asked why we are the only province, according to Dr. Ritchie, who is opposing mandatory listing.

This last question is concerning to the executive of ANP, which is why we went to the membership to ask for opinions. We did not want to block the proposal if we were missing some important benefit to mandatory listing that the other associations were not. Therefore, we would like to know why other associations are not opposed to the proposal made by CPA Maybe through our position as newsletter editor, you could help us determine this.

The reasons why ANP are opposed to mandatory listing are as follows:

- Health care is a provincial jurisdiction. Apart from provincial registration, hospital psychologists are subject to their institution's accreditation standards. It is our argument that CRHSPP registration would only be a dual registration process that would not add to accreditation standards.
- A published listing of CRHSPP will all health care psychologists would potentially overtax hospital based psychologists who do not charge fees, while diverting clients from private practice.
- The additional cost of another registration is seen as excessive.
- The argument that mandatory listing with CRHSPP raises standards questions the standards of provincial registration bodies. At present, to be listed in the CRHSPP register requires only that one meet provincial standards for registration, so the standards are not raised.

We are open to opposing arguments; however, our official position is that we presently oppose mandatory listing with CRHSPP, a fraternal national body, for health car psychologists.

Sincerely, Robert Gauthier, MEd, Acting President

Networking continued

A Question of Compassion

We are properly shocked and appalled at the misbehaviour of fellow professionals who have been found guilty of abusing a client. Our associations now have established procedures for providing sanctions for misbehaviour. That is proper.

To be accused, however, is not necessarily to be guilty. Yet the effect of being cleared of an accusation, particularly of sexual impropriety with children, may be as severe as for being found guilty. Job and reputation may be lost, family split, personal relationships irretrievably damaged, and one's emotional life scarred. Psychologists should be able to establish supports so that an accused and presumed-innocent-until-proven-guilty colleague is not left to the wolves. What help can a psychologist in Canada expect to get from the professional association?

Does Psychotherapy Merit Public Support?

Chatting to Ken Craig last week, he referred to a conversation he had with a drug company official. He was told that the Canadian Psychiatric Association believes there to be threats to the national health insurance program support for psychotherapy, and that CPA announced plans to investigate the role of psychotherapy and psychiatric care. We have neither heard nor seen any other word of this.

Ken wrote to Pierre Ritchie. "It occurs to me that all the research that CPA and psychologists have done in recent years to demonstrate the value of psychotherapy and reducing health care costs would be useful to the other CPA. This might represent a valuable rapprochement between our organizations."

Ken received this reply from Pierre (now to retire from his position as CPA's Executive Director) which we quote at length (thank you, Pierre) because it puts the question nicely in its complex Canadian context.

"The Canadian Psychiatric Association did mount a fairly large (and expensive) publication education/public relations campaign last Fall. It was directed more broadly to the role of psychiatrists and to psychiatric care rather than just to psychotherapy itself.

I have had a couple of chats with the Canadian Psychiatric Association's Executive Secretary, Dr. Pierre Beauséjour, about this matter. The best way to characterize the current relationship between the two "CPAs" is one of respect and cordiality, but without much interaction. We have actually developed stronger links with the Canadian Medical Association as the comparable national body to CPA for the profession as a whole.

As you know, each provincial government determines what specific services it will support within the criteria, established in the Canada Health Act, which determine eligibility for continued receipt of federal transfer payments. Several provinces have recently mounted formal reviews of their continued support of psychoanalysis. Although several more might well like to de-insure psychotherapy, given the large volume of billings generated (especially by general practitioners) under this category, the consensus is that this would be politically infeasible even in the current era of fiscal restraint.

The larger issue for psychology has always been that the great bulk of the funds spent by provincial governments for fee-for-service psychotherapy is allocated to practitioners who for the most part are not trained to provide this service. CPA is working closely with fellow members of the Health Action Lobby (CHA, CLTC, CMA, CNA, CPHA and the Consumers' Association of Canada) to conduct a major review of the comprehensiveness criterion of the Canada Health Act in the coming year. CPA's presence and contribution to HEAL as one of the seven core members has been a primary vehicle for enhancing psychology's national visibility on the professional front."

Member News

Allan Wilson has now (February 1) moved from a position at the Camp Hill Medical Centre in Halifax to a position across the harbour at the Nova Scotia Hospital in Dartmouth. His position relative to the Clinical Section remains unchanged: he remains our diligent Secretary-Treasurer.

Gloria Eldridge, whose Letter from Kenya you enjoyed in Vol. 2, No.3, has left her position at the Anxiety Disorders Clinic, St. Boniface Hospital, Winnipeg, to assume the directorship of an HIV prevention project in the Community Health Program, Jackson State University, in Mississippi. She continues her periodic work on a similar project in Nairobi.

Ken Craig was awarded a two year Canada Council Killam Research Fellowship. His fellowship commenced in January 1992 and permits him to devote full time to his research on pain. This is indeed a distinction for Ken as only 10 such awards are made annually and those can be to scholars in any discipline. We congratulate Ken in this recognition of his achievements and also take pleasure that a clinical psychologist's scientific merit has been so recognized.

Announcements

Banff XXV March 21-24, 1993

The Banff International Conference on Behavioural Science will celebrate its twenty-fifth anniversary this year. The theme is "Anxiety and depression in adults and children." The program combines plenary presentations and practitioner oriented workshops, attempting to bring together "cutting-edge" knowledge with the challenges practitioners confront on a daily basis. Skiing or leisure in a more relaxed manner continues to be an alternative to afternoon workshops. Those who have been fortunate enough to attend a Banff Conference will attest to the exquisite combination of excellent psychology, three days of nicely balanced presentations and discussions, and a delightful informal atmosphere in magnificent mountain sanctuary. Planning the conference are: Ken Craig (University of British Columbia), Keith Dobson (University of Calgary), Bob McMahon (University of Washington), and Ray Peters (Queen's University). Enquiries should be sent to: Keith Dobson, Psychology Department, University of Calgary, Calgary, Alberta, T2N 1N4. (Phone 403-220-5096 or Fax 403-282-8249.)

Clinical Section Business

Comments on Definition

The definition of clinical psychology and the information brochure were circulated in the Fall newsletter.

Please direct your comments to:

T. Michael Vallis, Ph.D.,
Past-Chair, Section on Clinical Psychology,
c/o Dept. of Psychology, Camp Hill Medical Centre,
1763 Robie Street,
Halifax, Nova Scotia B3H 3G2
Phone 902-496-2509 Fax 902-496-2684

Call for Nominations for Officers of Clinical Section (1993-94)

One of the most obvious and meaningful ways you can show your support for the Clinical Section is to participate in the election process. For 1993-94 the Section requires nominations for Chair-elect (a three year term, rotating through Chair and Past-Chair) and Member-at-large (a two-year position). Continuing members of the executive will be Janice Howes (Chair), Rhona Steinberg (Past-Chair), and Allan Wilson (Secretary-Treasurer). Although there is no requirement, the Section does support equitable geographical representation and gender balance on the executive. Nominees from central Canada are particularly encouraged.

Nominations shall include (a) a statement from the candidate indicating his/her willingness to stand for office, and (b) a letter of nomination signed by at least two Members or Fellows of the Section. Deadline for receipt of nominations is March 31, 1993.

Send nominations for the Executive to:

T. Michael Vallis, Ph.D.,
Elections Chair, Section on Clinical Psychology,
Dept. of Psychology, Camp Hill Medical Centre,
1763 Robie Street,
Halifax, Nova Scotia B3H 3G2
Phone 902-496-2509 Fax 902-496-2684

Call for Nominations for Section Fellows

In accordance with the by-laws for CPA sections, Section 26 is called for nominations from its members for Fellows in Clinical Psychology. Criteria for fellowship are outstanding contribution to the development, maintenance and growth of excellence in the science or profession of clinical psychology. Some examples are: (1) Creation and documentation of innovative programs; (2) service to professional organisations at national, provincial, or local level; (3) Leadership on clinical issues that relate to broad social issues; (4) service outside one's own place of work; (5) Clinical supervision should be equated with research supervision.

In order for nominees to be considered for Fellow status by the executive council, nominations must be endorsed by at least three members or Fellows of the Section, and supportive evidence of the nominee's contribution to clinical psychology must accompany the nomination. Deadline for receipt of nomination is March 31, 1993.

Nominations should be forwarded to:

Dr. Janice Howes,
Chair, Fellows and Awards,
Dept. of Psychology, Camp Hill Medical Centre,
1763 Robie Street,
Halifax, Nova Scotia B3H 3G2
Phone 902-496-2509 Fax 902-496-2684

Clinical Section Business continued

Section 26 Student Award

An award for outstanding student presentation in clinical psychology will be made at the forthcoming annual CPA meeting. This will be an annual award and the recipient will be chosen based on his/her paper submission to CPA. In the case of multiple author papers, the student must be the senior author. Interested students or their faculty advisors are encouraged to submit abstracts for consideration of the Award to the Chair of the Awards Committee. Up to five outstanding presentations will be selected and these students will be asked to submit their complete papers. The Award will then be selected from this group. This Award will consist of a $250 cash award plus a certificate of recognition.

Please forward submissions by March 31, 1993 to:

Dr. Janice Howes,
Chair, Fellows and Awards ,
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The *Canadian Clinical Psychologist* is open for your contributions. Your colleagues would like to read of your recent professional activities as news items of new appointments, awards, etc. in the Member News section, or of research/clinical interests, questions, concerns, observations, etc. in the Networking section. Announcements of conferences, workshops, or meetings, of possible value to non-locals, are appreciated. Let us know what has been going on in your corner of the country. My address is: David S. Hart, 3962 West 12th Ave., Vancouver, BC, V6R 2P2. The Section 26 newsletter will circulate three times per year: Fall, Winter and Spring.