



Fall 2013



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Congratulations Dr. Ian Nicholson: Our First Award Recipient



At the Annual Business meeting of the Section in June, Dr. Paul Greenman presented the first “Excellence in Hospital and Healthcare Psychology Award” to Dr Ian Nicholson.

Dr Nicholson has made, over the course of his 20-year career, substantial contributions to psychology in healthcare centres in Canada and, as noted in one of the nomination letters “to psychology as a profession.” He is a person of many talents, who has worn

many hats: psychologist, teacher, administrator, supervisor, researcher, mentor, colleague, and friend. He has held a number of public service and leadership roles with international, national and regional psychological associations, including APPIC, CPA, CCPPP, and the Ontario Psychological Association. He is renowned for the rigour and integrity of his work and for his ability to instill an understanding of, and appreciation for, the highest ethical standards of

psychological practice in the people he teaches trains and works with. He has been instrumental in securing a permanent place for psychology in Family Health Teams in Ontario, and he continues to play a key role in the development of the profession.

To cite another letter, “He is consistently described by colleagues and former students as the consummate mentor. Whether it was in his role as Training Director, manager lecturer, or colleague, [he] has clearly made a tremendous impact on countless psychologists, many of whom are now leaders practicing within hospital-based settings.”

For all of these reasons, the 2013 Excellence in Hospital and Healthcare Psychology Award is presented to Dr. Ian Nicholson of the London Health Sciences Centre.

Leading Practices : Implementation of a Total Clinical Outcomes Management (TCOM) Approach to Inpatient Mental Health Services at CHEO

Dr. Stephanie Greenham, Children’s Hospital of Eastern Ontario

The Inpatient Psychiatry Program at the Children’s Hospital of Eastern Ontario (CHEO) in Ottawa, Ontario is a 19-bed acute stabilization program for children and adolescents who require a hospital admission to address a mental health crisis. It is staffed by an interdisciplinary team and currently

provides brief crisis stabilization. As part of a restructuring of inpatient mental health services in 1999-2000, psychologists on the team took a lead in introducing an outcomes management approach to inpatient care.

In collaboration with their colleagues, Lise Bisnaire,

Ph.D., C.Psych. (Clinical Director of the inpatient program until 2007) and Stephanie Greenham, Ph.D., C.Psych. (current Inpatient Lead for Outcomes Management and Research) led the process of integrating a comprehensive program evaluation plan into the model of inpatient psychiatry care in 2000.

(cont p. 5)



**The Health Sciences
Centre**
Winnipeg, MB
20 Psychologists



**St. Boniface
Hospital**
Winnipeg, MB
8 Psychologists

Report from the Chair: Dr. Kerry Mothersill



The Section celebrated its first birthday during the Annual Business Meeting (ABM) on June 14, 2013 during the CPA Convention in Quebec City.

The Section has grown quickly over the past year with 442 members at the present time. Thank you for your interest in the activities of the Section; the Executive Committee has a busy year planned.

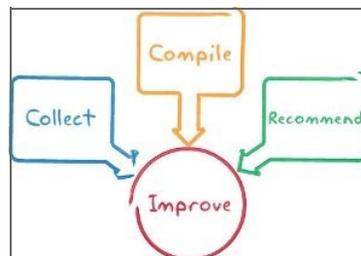
On behalf of the Committee, I want to thank Dr. Vicky Veitch Wolfe (Member-at-Large) and Ms. Marcie Balch (Student Representative) for their hard work during the past year on the Executive Committee. As noted in the Minutes of the ABM as posted in this Issue (see

pgs. 11-14) of the Newsletter, Vicky and her Leadership Committee have established goals and made considerable headway in developing mechanisms for supporting psychologists who have leadership positions in health centres and for mentoring individuals who wish to take on these responsibilities. Marcie has consistently provided valuable student input at the executive committee meetings and supported the Section in sponsoring student related events at the CPA Convention next year. Vicky and Marcie, thank you so much in contributing so ably during this inaugural year.

The Executive Committee welcomes Dr. Margaret O'Byrne (Chief of Psychology, Institut universitaire en santé mentale Douglas, Montréal) into the Member-at-Large position and Ms. Jessica Flores (Graduate Student, UBC) into the Student Representative Position. We look forward to the wisdom and energy that they will bring to the Section. They will join continuing

members: Drs. Joyce D'Eon (Secretary Treasurer), Paul Greenman (Awards), Bob McIlwraith, (Communications), the hard working editor of this second newsletter, and myself as Chair.

The Section was active in sponsoring a number of well attended activities at the CPA Convention, including a symposium on Psychologists in Primary Care, a conversation session on Psychology in Health Care Organizations: What Works well and What Doesn't, a symposium on Psychological Measurement in Hospitals and Health Centres and a number of poster presentations. The November 15th deadline for submissions to CPA 2014 in Vancouver isn't far away. Please consider submissions to the convention that would be of interest to members of the Section. In particular, we encourage submissions in the following areas: innovative practice in hospitals, effective leadership strategies and evidence based assessment procedures.



CALL FOR GUIDELINES

The Guidelines Committee has met regularly over the past several months and is in the process of collecting and developing Leading Psychology Practice Guidelines. The committee has collected a number of these guidelines however, if you are aware of documents that specify the role of psychologists in health care programs, please forward them or relevant references to

Kerry.mothersill@albertahealthservices.ca.

In addition, the Committee will be preparing Psychological Service Facts Sheets, developing guidelines for how the discipline is best managed with service delivery systems, preparing a Psychologists Handbook for health care Managers and partnering with other CPA sections in developing practice guidelines.

The Committees of the Section: Guidelines, Leadership, Communications and Awards welcome your input. Please forward your ideas and suggestions or volunteer to be a committee member!

Our American Cousins: The Association of Psychologists in Academic Health Centres (APAHC)

Joyce D'Eon, Chief of Psychology, The Ottawa Hospital



In February of this year the Association of Psychologists in Academic Health Centres (APAHC)

hosted their 6th National

Conference in Nashville. This conference celebrated the 30th anniversary of the Association and the 20th anniversary of the *Journal of Clinical Psychology in Medical Settings*.

APAHC's is a section of APA's Division 12, the Society for Clinical Psychology, and its mission is to promote the discipline and profession of psychology in academic health centres (see: <http://www.div12.org/section8/index.html>). As the name of the association indicates, the organization has a more specific focus than our new CPA Section on Psychologists in Hospitals in Health Care Centres (PHHC). Nonetheless, the conference covered many topics very relevant to psychologists working in any health care organization

Preconference activities included three, full-day events and covered specific topics: APAHC Early Career Boot Camp; APA Internship and Postdoc Site visitor Training, and; APA Accreditation Self-Study Workshop.

The conference started following the preconference activities with opening addresses. APA's CEO, Norman Anderson, provided a perspective on the changes in the American health care system with the implementation of the Affordable Care Act in an address

entitled *Advancing Psychology's Role in Health: The Next Phase for APA*.

Danny Wedding, who is responsible for the California School of Professional Psychology programs in Hong Kong, Tokyo and Mexico City and works with each of the six California Campuses, presented on *International Frontlines of Psychological Science and Practice*.

Over the following two days 15 consecutive talks covered various aspects of professional practice.

(see: <http://www.div12.org/section8/events2013Conf.html>). Clinical issues were addressed in talks on: Psychology in the Interprofessional Workforce; Psychology Roles in Primary Care; Obesity Management in Adults and Youth; Motivational Interviewing; Working with Difficult Patients; Risk-taking in Youth; Ethical and Legal standards of Electronic Psychology Records. Science was integrated in each of the presentations and there was a specific session focused on publishing in Academic Health Psychology by Janice Stern, Senior Editor for Springer Publishing.

Two of the keynote addresses synthesized particularly broad areas:

Suzanne Bennett Johnson (Distinguished Research Professor at Florida State University and 2012 APA President) provided an insightful and data rich perspective on the importance of human behaviour to health and illness preven-

tion: *Psychology as a Science and a Profession: Successfully Transitioning from Mental Health to Health*.

Cynthia Belar, Executive Director of APA's Education Directorate, discussed the Health Service Psychology Education Collaborative blueprint: *Transforming Healthcare: Implications for Education and Training*.

Differences between the American and Canadian healthcare systems are well appreciated, and those differences extend into the structure, roles, and responsibilities of psychologists in academic health centres. During the conference it was apparent that some of the concerns of our American academic health centre counterparts differ from those that we may experience. Nonetheless, as can be seen from the summary of the talks, many issues are shared and are equally applicable across borders.

For psychologists doing research in academic health science centres in Canada, the APAHC preconference early career boot camp might be worth considering as a way to facilitate networking, problem solving and support for young scientist-practitioners in Canadian health centres. The APAHC program ended with an informal breakout sessions for early, mid and established career psychologists. This might also be a very effective format for us to network and support one another.

As a new CPA Section, we can learn from this Association.





**IWK Health Centre
Halifax, NS
48 Psychologists**



**Royal University Hospital
Department of Clinical
Health Psychology
Saskatoon, SK**

6 Psychologists

Student Column Psychology in Its Adolescence: Identity vs. Role Confusion

Marcie Balch, University of New Brunswick



Most of the details of my internship interviews are a blur, but I distinctly remember this question, posed to me in a semi-formal interview format: *What do you think the role of the psychologist is on a multidisciplinary team?* I think I muttered something about our unique training in a scientist-practitioner model; perhaps I said something about our emphasis on empirically supported treatments; and maybe I even stated the importance of leadership and inter-disciplinary respect. But it was probably apparent then – and just as obvious now, a few years later – that I still have very little idea what our unique role is.

Throughout my training at the University of New Brunswick, I recall having several conversations about what makes psychology distinct from psychiatry; indeed, my responses are well practiced with the general public (see “Psychologists: Who are They and What do They Do?” in the previous issue of this newsletter). But there

was never a conversation about what a social worker is trained to do, or what an occupational therapist is, or even how psychology works in conjunction with psychiatry and nursing in many settings. Looking back on my practica and internship experiences, I feel that negotiating the role of psychology on a team was the most challenging, and the one I was least prepared for from my academic training. In fact, towards the end of my internship, supervision time was not spent on reviewing assessment results or discussing client cases in detail, but on seeking advice on understanding the hospital structure, “chain of command”, and how to approach differing views on client treatment.

Because I have been (functionally, if not yet officially) out of the student role for a few years, I asked a recent practicum student if she felt there was anything missing in her training to prepare her for internship. Without missing a beat, she said, “I had no idea about the hierarchy, where psychology stands, and what to do when our ethics or professional standards seem to be in conflict with the way another professional is practicing.” She explained that there was already little training in supervision of other psychology students, but when she was expected to “supervise” (an

unclear role in itself) colleagues from other disciplines, she was very uncomfortable.

As the majority of students will complete internships in hospitals or health care settings, understanding the role of psychologists on multidisciplinary teams should be an essential issue addressed the first day on site, or even before starting internship. In order to build our confidence as skilled professionals – as well as understand the work of our colleagues – we need to more fully understand the roles of various disciplines, as well as more clearly define and develop the role of psychologists in health care settings. One of the primary goals of this Section is “To develop guidelines for psychologists working in multidisciplinary teams.” I would like to encourage students to stay abreast of this issue and request that doctoral programs and internships include this in their course curricula.

Some day I hope to be conducting internship interviews where students can proudly and clearly explain how their excellent training has prepared them to contribute in valuable ways to the multidisciplinary hospital team. Until then, we have a lot of work to do!

Leading Practices: TCOM (con't from page 1)

This outcomes management approach was more fully optimized in 2006, with research funding provided through the Centre of Excellence for Child and Youth Mental Health, as being consistent with the principles of Total Clinical Outcomes Management (TCOM) (Lyons, 2009).

A TCOM approach was implemented as a means to provide and manage inpatient mental health services that are grounded in a shared understanding of the needs and strengths of the children, youth and families receiving inpatient care. This clinical information drives decision-making at all levels of the system (patient, program, agency, network, full system), and allows for the seamless integration of outcome evaluation and research. The core tenets of TCOM are highly consistent with the philosophy of care for the Inpatient Psychiatry Program at CHEO, which embraces child/youth focused, family-centred care within an individualized and strengths-based approach.

The TCOM approach had not been applied to acute care inpatient mental health services prior to its adoption at CHEO. Both Accreditation Canada and the Ontario Hospital Association recently recognized this implementation as a [Leading Practice](#).

The goal of implementing a TCOM framework for the delivery and management of inpatient mental health ser-

vices was to demonstrate that these services could be provided effectively and responsibly while maintaining a shared and central focus on the needs and strengths of the children, youth and families receiving inpatient care. The use of standardized assessments to identify patient needs allows the interdisciplinary team to communicate clearly among team members and key partners (e.g., patients and families, community providers) and make treatment decisions that are individualized and based on appropriate levels of intensity. The assessment of acuity of psychiatric illness at admission and discharge for each patient allows for outcome evaluation at the individual and program levels. Gaining patient and family feedback after discharge is another important source of outcome data. At the program level, access to this rich information about clinical and process outcomes allows for regular monitoring of changing patterns and trends in the inpatient population over time, facilitating iterative decision-making (e.g., about group programming and staff training requirements) that is responsive and flexible. The evaluation and monitoring of these outcomes thus becomes an integral component of the model of care that drives decision-making, rather than a supplemental or post-hoc activity. This information is routinely shared with the team and administration, and when possible, with family representatives.

A key resource that is necessary for the implementation of this practice is key staff with dedicated time who are responsible for overseeing and monitoring the process. Training and education for staff members is essential to establish buy-in and for the reliable use of assessment tools. Personnel and infrastructure are required to manage, enter and analyze the data in real time. Finally, forums for sharing outcomes and a mechanism for review and decision-making at the program and hospital level, such as the leadership team or partnership council, are essential.

Having real-time access to this clinical information has been beneficial when we needed to have an understanding of certain phenomena, such as a recent unprecedented surge of admissions to the inpatient psychiatry program. By utilizing these data, program leadership and hospital administration were able to have a greater appreciation for some of the clinical characteristics of the population in addition to traditional data provided by the hospital decision support (i.e., numbers of admission, occupancy rates, length of stay). For example, over the last several years, CHEO has experienced dramatic year-over-year increases in mental health visits to the Emergency Department and subsequent admissions to the inpatient program. Using data obtained from our systematic inpatient assessments, we

have observed increases over this time in the acuity and severity of high risk behaviours related to suicide and self-injury, as well as symptoms of depression and anxiety. In addition, youth increasingly present with longstanding and pervasive mental health problems, and their parents and caregivers display increased needs related to their own health and level of involvement in their child's care. Over the past year in particular, we have observed notable increases in behaviours that contribute to volatile and unpredictable behaviour, such as substance use, impulsivity, and aggression. These data suggest that, in addition to a growing population that contributes to a greater number of admissions, the youth admitted are among the most high-risk in the region and require a crisis admission to maintain their safety and the safety of others.

Details of this practice and related outcomes research can be found in the following publications: Bisnaire & Greenham (2009) and Greenham & Bisnaire (2008).

Outcomes data have also been shared at various professional conferences (e.g., Canadian Psychological Association, CANS Conference, Canadian Academy of Child and Adolescent Psychiatry) and with the Ontario Network of Child and Adolescent Inpatient Psychiatry Services (ONCAIPS).



**Royal Ottawa
Mental Health
Centre**

17 Psychologists

Dr. Graff is the Head of Health Psychology Services in the Clinical Health Psychology Programme of the Winnipeg Regional Health Authority (WRHA); Dr. Scott is the Psychologist for the Centre for Metabolic and Bariatric Surgery within the WRHA.

Cross Country Check Up

The Women's Mental Health Program at The Royal Ottawa Mental Health Centre



Fotini Zachariades, Ph.D., C.Psych. & Susan Farrell, Ph.D.,

The Women's Mental Health Program (WMHP) at The Royal Ottawa Mental Health Centre (ROMHC) is a relatively new program offering gender-sensitive, gender-informed, and trauma-informed mental health care services to women presenting with a range of mental health, physical health, and social/interpersonal stressors. The development of the program's mental health care services and research has aimed to incorporate the unique biological, psychological, social, and cultural needs of women. Psychology has been part of an advisory group involved in the creation of this program, and a Psychologist has been involved in program development and planning on a full-time basis since February 2013. The Psychologist is involved in clinical service delivery, developing a program of research, education and will be involved in supervision of Psychology practicum students and residents. The first resident is scheduled to commence in September 2013. In addition to hospital-based services, development of partnerships is planned with community-based agencies (e.g., women's shelters) by collaborating with the Community Mental Health Program at the Royal. Areas of need that have emerged involve trauma, emotional regulation, substance use, depression, anxiety, interpersonal stressors, and comorbid physical health conditions. The program is currently offering group therapies, for example a Working With Emotions group (a DBT-informed skills training group), and an IPT/Interpersonal Process group. Additionally, the program aims to address the particular impact of trauma in women's lives, and its relationship to women's mental and physical health- this is reflected in education, research, and clinical activities including individual treatment and a Psycho-educational Trauma group.

Recommended Reading



Pre-surgical psychological screening: Understanding patients, improving outcomes. Andrew R. Block and David B. Sarwar (Eds). Washington, DC: American Psychological Association. 2013. 296 pages. (ISBN 978-1-4338-1242-2, \$69.95 US, Hardcover)

Reviewed by Lesley A. Graff & Aynsley Scott.

Clinical applications of health psychology have continued to develop and expand in recent years, particularly in the area of surgery and pre-surgical preparation. Technical success by the surgeon does not always translate to functional success for the patient, as there are multiple predictors of outcomes, including psychological factors such as mood and anxiety, coping strategies, and adherence issues. Given that surgical procedures can be costly, have inherent risks, and that elective surgery volumes are increasing in many areas, it is especially important that patients are

screened on all relevant grounds to facilitate optimal outcomes and to mitigate risks.

This book is a welcome addition to the clinical literature on psychological considerations for surgery. It is the first of its kind, compiling psychological screening information for multiple types of surgical procedures. The editors are both well-known for their work in this area. Dr. Block is an eminent psychologist and pioneer of pre-surgical psychological evaluation, with his work on psychological contraindications for spine surgery dating back to the 1980s. Dr. Sarwar also has significant clinical experience and

(con't p. 10)



Sick Kids
Toronto, ON
31 Psychologists



Toronto Western Hospital
13 Psychologists

Leading Practices: Bridging the Gaps for Obesity Management: Creation of a Transition Program between The Hospital for Sick Children and the Toronto Western Hospital

Marlene Taube-Schiff, Ph.D., C. Psych. & Elizabeth Dettmer, Ph.D., C. Psych

Nearly one-third of 5- to 17-year-olds in Canada are overweight or obese (Roberts, Shields, Grah, Aziz & Gilbert, 2012). In fact, childhood obesity has been reported to be the primary childhood health problem in developed nations such as Canada (Ebbeling, 2002). Obesity is associated with many negative physical, social and psychological consequences. Difficulties in psychosocial functioning that begin in childhood, as a result of obesity, often persist into adolescence. For example, it has been shown that obese youth experience greater behavioural and self-esteem difficulties than non-obese youth (Mustillo et al., 2003) and are at increased risk for developing chronic psychosocial and psychological difficulties in adulthood, such as depression and low self-esteem (Nammi et al., 2004).

Interventions for severe obesity (e.g., gastric bypass surgery) have been found to improve quality of life and psychosocial functioning in adolescents (Loux et al., 2008; Zeller et al., 2009). However, such interventions can be challenging as research has shown that youth (defined as individuals aged 15 to 25 years old by the World Health Organization) experience greater difficulty coping with medication compliance, making lifestyle changes, and adhering to healthy living practices compared to other age groups.

Transfer from pediatric to adult health care programs is often superimposed on top of this already confusing stage with sub-optimal results. Research shows that youth suffer significant physical and mental health complications during the transition process from pediatric hospitals to adult care hospitals (for a review of these issues in transplant patients, see Bell et al, 2008). Therefore, researchers and clinicians have begun to push for the creation of specific youth oriented transition programs that seek to improve coping, self management skills and independence, with the goal of enhancing mental health and medical outcomes.

Although research in the area of transition and transfer is relatively new, a handful of studies have been published looking at patients coping with different chronic medical conditions such as HIV, transplantation, congenital heart disease, and diabetes. Research has shown that young adults are four times more likely to lose their kidney grafts due to medication non-adherence than adults (Rianthavorn & Ettenger, 2005). Furthermore, loss of follow-up from pediatric to adult care centres has been reported at rates of 10 to 25% within one year of transfer in studies of adolescents with diabetes (Nakhla, et al. 2008). Research from both a developmental and psychosocial perspective has illustrated that youth

have specific needs that are often not addressed within our current healthcare system. Results from qualitative studies evaluating adolescents' perceptions of the transition process include requests to meet the adult team in advance of transfer, options of evening or weekend appointments, and opportunities to meet other young adults with similar medical diagnoses (Scott, et al., 2005). In line with these requests, a study that compared direct transfer to adult care versus meeting jointly with the adult and pediatric teams prior to actual transfer combined with a "young adult" clinic, resulted in lower loss to follow up and enhanced patient satisfaction (Kipps, et al., 2002).

The needs of youth experiencing obesity, obesity-related illnesses, and obesity management are, as yet, not well understood.

(Con't p. 8)



Leading Practices: Bridging the Gap (con't from page 7)

Transition Program Development

The Hospital for Sick Children Obesity Management Program (STOMP) was established in 2010 in order to provide obesity management strategies for individuals aged 14-18 years of age. Approximately 8 to 10 weight loss surgeries are performed at STOMP each year. All teens who undergo bariatric surgery must have met recommended guidelines for selection of surgical patients, have undergone an extensive lifestyle modification program, have received a psychological assessment and be receiving mental health support. Currently, STOMP is able to follow these patients for 2 years post surgery but transfer to an adult care bariatric centre (or shared care) will often need to happen much sooner. In addition, patients who participate in the STOMP program but turn 18 years of age before surgery are transferred to an adult care hospital for the actual surgery and follow-up care.

It is imperative that the transition process is carefully outlined to ensure quality care for these patients. For this reason, STOMP and the Toronto Western Hospital-Bariatric Surgery Program (TWH-BSP) joined together to form a specific transition program. It is the hope of this team that the successful implementation of a tailored transition program will allow for improved continuity of care and enhanced communication between STOMP and TWH-BSP for adolescents/young adults. We have begun to implement

resources at TWH-BSP that will target the specific needs of young adults (e.g. focus on university life, etc.), which are known to be different from an older adult population and can interfere with medical and mental health success. We hope to decrease the rate of “dropout” for those patients that are transferring from STOMP to TWH-BSP, allowing patients to receive critical follow-up psychosocial support, which will aid in maintaining successful long-term weight loss. We hope that enhanced patient engagement and services will increase the likelihood of a successful amount of weight loss (and no regain) following bariatric surgical intervention for these young adult patients.

In order for our transition program to be successful,

we believe that this process must begin prior to transfer and allow for seamless care throughout the transition process. Therefore, our teams have worked together to establish the following services (see the diagram below for a visual explanation of patient flow).

1. Coordinated Transfer Process: In order for patients to be considered for bariatric surgery at the TWH-BSP, they must be referred through the Ontario Bariatric Registry. Our teams worked closely with the Ontario Bariatric Network (OBN) to ensure that STOMP patients would be processed through this registry and sent directly to the TWH-BSP. This was an important administrative step, allowing for coordinated care between our hospitals and ensuring that patients were successfully transferred and not “lost to

coordinated care between our hospitals and ensuring that patients were successfully transferred and not “lost to follow-up”.

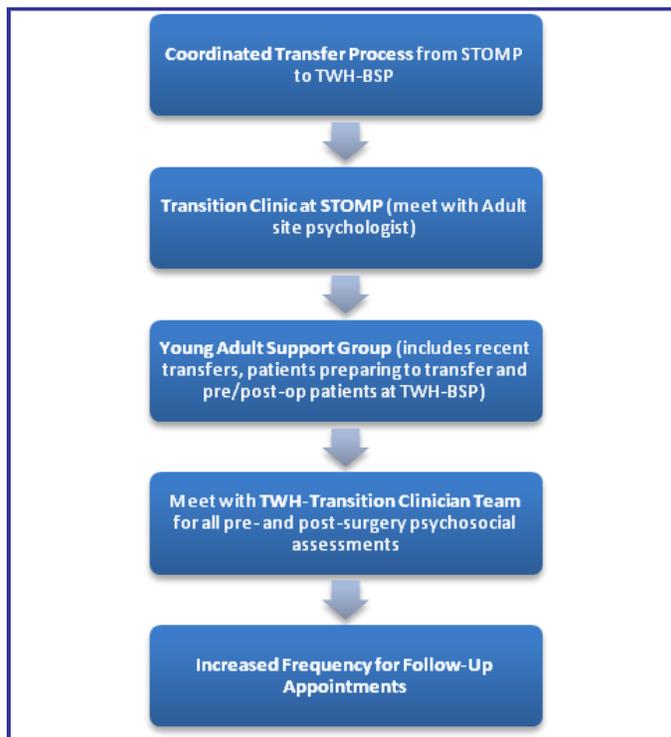
2) Transition Champions: In order to ensure that this program is continuing to develop and that patients are being transferred successfully we have identified transition champions at both STOMP (Dr. Dettmer) and TWH-BSP (Dr. Taube-Schiff).

3) Transition Taskforce: A taskforce was readily formed involving individuals from both the TWH-BSP and STOMP. This taskforce meets on a regular basis to ensure all aspects of the program are continuing to develop and run smoothly.

4) Clinical Transition Team: We also believe that continuity of care will be important for this age group once they transfer to ensure that they become readily familiar with their new hospital environment and have their unique needs paid attention to. Therefore, we have developed a TWH-BSP Clinical Transition Team. One professional from each discipline on the TWH Psychosocial Team was appointed to this team and these individuals will help run the monthly support, transition clinics as well as conduct the pre- and post-surgical assessments. The team currently consists of: Dr. Marlene Taube-Schiff (psychologist), Monica Chi (social worker), Mary Weiland (registered dietitian) and Patti Kastanais (nurse practitioner).

5) Young Adult Support Group: Members of the TWH-BSP Clinician Transition

(con't p. 9)



Flow of Patients from STOMP to TWH-BSP
(Transition Initiatives are in Bold)

Leading Practices: Bridging the Gap (con't from page 8)

team as well as representatives from the STOMP clinic facilitate a monthly bariatric surgery support group specifically for young adults (ages 17-25 years old).

6) Follow-up Care: The team has also successfully lobbied for and put in place increased follow-up care for youth in an attempt to decrease their typically high rates of medical noncompliance and drop out rates following transfer of care. Post-operative patients at the TWH-BSP are typically seen for follow-up appointments at 1, 3, and 6 months post-op and then annually every year until 5 years post-op. However, the young adult transfers will be seen every 6 months (as opposed to annually) following the 6 month post-surgical time point, up to 5 years post surgery or when they reach 25 years of age – whichever comes first. Patients that are transferred after 2 years post surgery will

be followed every 6 months up to 5 years post-op or until they reach 25 years of age.

7) Transition Resource Booklet: A resource booklet for these young adults, highlighting what to expect following transfer of care, along with supports that can be accessed at TWH-BSP and within their community has also been created.

8) Research: Finally, we are collecting data and developing additional studies to further understand the needs of this population of patients and their needs. We are currently in the process of evaluating patient satisfaction with the young adult support group and will soon be conducting a qualitative study to better understand the perceived psychosocial and resource needs of our young adult patients.

It is clear from the literature that youth and young adults have unique psychosocial

needs that, when not attended to, often in result in poor medical and mental health outcomes. Therefore, successful transfer of care involves well-developed transition programs that begin in pediatric care and continue on into the adult care setting. We have begun to implement these types of transition initiatives through collaborative teamwork between the STOMP and TWH-BSP programs. It is our hope that this program will continue to develop, grow and provide optimal patient care for this high-risk age group. We also hope that our program will serve as a model of care that can inform other transitional psychosocial programs. These services may assist youth during these key junctures of the healthcare system in other healthcare settings, allowing for improved mental health outcomes for a variety of chronic medical illnesses. (see references p. 16)



Newsletter contributions welcome– instructions to authors



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

open to other ideas. The following columns are available for contributions:

1) Open submissions: 500–1000 word column outlining a specific issue; historical review of a department; or any other topic of interest to the section.

2) Leading Practices: 500–1500 words Reports of psychological services that are considered leading practices, either as a result of recognition by accrediting bodies such as the Canadian Council on Health Services Accreditation (CCHSA:

“Accreditation Canada”) or similar organizations, or through outcome data that demonstrate the effectiveness of an innovation or an exemplary service model.
3) Recommended reading: 100–150 word summary of any article, book, website, journal, etc that would be of interest to the section
4) Cross country check up: 500–750 word article outlining an issue or experience that may apply across the country

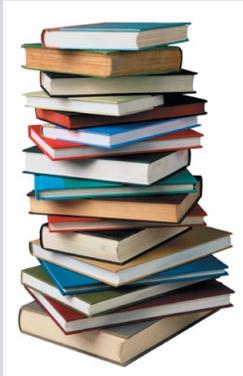
5) Student focus: 250–1000 word submission from a student member.

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

7) The back page Member profile: 250 word biography including picture of a member

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

Please send submissions to: Dr. Bob McIlwraith bmclilwraith@hsc.mb.ca



Recommended Reading con't from page 7)

research acumen in pre-surgical evaluation, specializing in the area of psychological screening for bariatric surgery.

The first 4 chapters of the book review areas where pre-surgical psychological screening has been most commonly incorporated, namely organ transplant, spine surgery, bariatric surgery, and pain control implants. The next 6 chapters describe areas in which psychological screening is being used with increasing frequency: bone marrow/stem cell transplant, deep brain stimulation for Parkinson's disease, oral surgery for temporomandibular disorder, reconstructive procedures, breast cancer surgery, and gynecological surgery. The book finishes with two developing areas of application: carpal tunnel surgery and cosmetic surgery. The chapters have a similar organizational structure, typically including background information regarding the surgery and/or the health issues, relevant psychological considerations, and suggested process and general content for psychological evaluation. Some chapters provide specific direction regarding commonly used assessment tools. Most chapters also include a case example that helps to illustrate the key points. Of note, the chapter on deep brain stimulation has a bit of a different emphasis for the role of psychological evaluation. The recommended evaluation is more neurocognitive in nature to establish pre-intervention baselines and

monitor changes with repeat assessments, for those who are good candidates to proceed.

While it can be difficult to include all current or emerging areas of pre-surgical psychological screening, there were two areas that in our opinion would have strengthened the comprehensive nature of the book had they been included: screening for joint replacement surgery, one of the rapidly expanding surgery volumes in North America, and screening for sexual reassignment surgery, a relatively uncommon surgery with significant implications for fundamental identity changes.

Overall, the book provides an excellent mix of empirically-based background information, and assessment recommendations, supported by research evidence where available, and by clinical experience. An important distinction is made between the ability to predict outcomes, which neither medical nor psychological evaluations can readily achieve, and the ability to assess risk, which is more in the scope of the pre-surgical psychological screening. The chapters are practical, efficient, and focussed, for the most part, on occasion straying to potentially more tangential information relative to the goal of the book. For the clinician intending to practice in this area, certainly more in-depth research and preparation would be required prior to beginning clinical service provision; however, for

those psychologists working in the area the book will no doubt provide useful validation of clinical approaches, and for those considering work of this nature, it provides a useful introduction with sufficient breadth to orient them to the important considerations of pre-surgical evaluation.

The compilation of the psychological screening information across these multiple clinical areas provides invaluable direction for psychological service development and planning in health care settings where these types of surgeries are offered. While the editors state the intended audience includes mental health practitioners, case managers (third-party payers) and surgeons, we suspect it is only individual chapters that might be of interest to the latter two. However, the book as a whole will be relevant for health psychologists and clinical students, in addition to psychology administrators. The introductory section is particularly useful for any potentially interested reader, as the editors provide a wide-ranging discussion of the 'what', 'why' and 'how' of pre-surgical screening along with a thoughtful consideration of bioethics.

In summary, the book provides a comprehensive overview of the usefulness and validity of pre-surgical psychological assessment, and is an important step towards improving the care for patients undergoing these surgical procedures.

Member Profile: Dr. Kim Corace

Thinking outside the building, city and region to grow Psychology Services

by Dr. Joyce D'Eon, Chief, Psychology, The Ottawa Hospital



Dr. Kim Corace is a Clinical Health Psychologist in the Viral Hepatitis Program at The Ottawa Hospital (TOH) as well as the Project Director of the Regional Opioid Intervention Service at The Royal Ottawa Mental Health Centre (ROMHC).

Does that sound like two jobs in two different organizations? On first glance it does. So how did this all start?

The Infectious Diseases (ID) Division, then led by ID physician Dr. Gary Garber, previously implemented a successful model of HIV multidisciplinary care and recognized how valuable a scientist-practitioner psychologist (Dr. Louise Balfour) was on their service. Given the complex addictions and mental health needs of the Hepatitis C (HCV) population, the ID Division began working with the Ontario Ministry of Health (MOH) Hepatitis C Secretariat to set up a pilot HCV multidisciplinary team, and Kim became an integral part of these discussions. This eventually led to the development of the HCV psychology position, and Kim took on this new role.

Next, in collaboration with ID physician Dr. Curtis Co-

per, they received funding to implement and evaluate a pilot psychosocial intervention for HCV treatment. This funding was itself a partnership between TOH's Academic Medical Organization and the Ministry of Health Innovation Fund. The outcomes of the evaluation were so clear that this influenced the provincial Hepatitis C Secretariat funding of the program at TOH – as well as 12 other multidisciplinary HCV teams in Ontario, one of which is the South Riverdale Community Health Centre (SRCHC).

Kim, in collaboration with Jason Altenberg of SRCHC, obtained MOH funding to provide training, education and mentorship for these Ontario multidisciplinary HCV teams. The specific goal is to enhance outcomes through team education geared to increase access to service and treatment adherence. Kim and Jason's partnership also led to the implementation and evaluation of interventions to reduce the compounded stigma experienced by people who use illicit drugs and are affected by HCV. This project supports community-academic partnerships in an anti-stigma intervention in both Toronto and Ottawa. While working in the Viral Hepatitis program, Kim noticed the gap in services for HCV patients struggling with concurrent addiction and mental health disorders. Opioids are one of the most common substances of abuse, and opioid addiction is on the rise in the last several years. Kim reached out to the ROMHC's Substance Use and Concurrent Disorders Program

(Dr. Melanie Willows, Clinical Director). Through their collaboration, they obtained funding to create an innovative program for people who had no service because they didn't 'belong' in any existing care system. In order to address the multifaceted needs of marginalized people with mental health and substance use co-morbidities, including those with HCV, they instituted a regional program that provides opioid detoxification and maintenance services alongside providing mental health services. The program is a collaborative, hub-and-spoke partnership between the ROMHC and a range of community agencies, hospital programs (including TOH), and family physicians throughout the Ottawa region.

These examples indicate how collaboration and partnership worked when no other approach had succeeded, by bringing together hospital and community programs, research and clinical services, to offer more people the benefit of psychology services that we know can enhance health outcomes for marginalized persons.

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CANADIAN
PSYCHOLOGICAL
ASSOCIATION



SOCIÉTÉ
CANADIENNE
DE PSYCHOLOGIE

WANTED: AUTHORS

Call for Submissions Special Feature on PSYCHOLOGY in SMALL HOSPITALS

We would welcome submissions (any length) that deal with providing psychological services in small hospitals, defined as small-town hospitals or community / neighbourhood hospitals (as opposed to large teaching hospitals or networks) - hospitals that may only have one or two psychologists on staff. Our readers and members would be interested in hearing about innovative ways of providing services in smaller facilities, inter-professional and “generalist” practice models, training for practice in smaller facilities, challenges and success stories.

Deadline for submissions is November 1, 2013

Canadian Psychological Association

Section on Psychologists in Hospital and Healthcare Centres (PHHC)

**Business Meeting Minutes
Friday June 14, 2013, 8:00-8:55 a.m.
Quebec City, Quebec**

Present:

Kerry Mothersill (Chair), Joyce D'Eon (Chair), Bob McIlwraith, Lorne Sexton, Vicky Veitch Wolfe, Andrea Piotrowski, Paul Greenman, Mary Pat McAndrews, Robin Adkins, Sharon Guger, Jessica P. Flores, Brent Hayman-Abello, Susan Jerrott, Jessica Furtado, Maxine Holmqvist; Sandy Klar, Theresa Newlove, Marilyn Ransby, Peggy O'Bryne.

1. Welcome and Introduction

Kerry Mothersill welcomed attendees to the first business meeting with a Section 'Happy Birthday' as it is one year to the day since the Section was formed.

2. Approval of the Agenda

The agenda was approved as circulated.

3. Approval of the Minutes of the June 14, 2012 Meeting

The minutes were approved as circulated.

Moved: Mary Pat McAndrews; Seconded: Theresa Newlove and passed unanimously, with no abstentions.

4. Chair's Report

Kerry Mothersill, PHHC Section Chair, noted that:

- There are now 417 members of the Section – the 2nd largest CPA Section. The dues were purposely kept low to help grow the Section and it has worked as there are many student members.
- The Section Executive have met through teleconference
- A fantastic newsletter has been produced and circulated by email.
- We have our first Section Award today and will review the policies and procedures for awards
- Two Executive positions need to be filled, one for member-at-large and the other is student member

5. Secretary Treasurer's Report

Joyce D'Eon, PHHC Section Secretary/Treasurer outlined the following meetings had taken place:

- June 14, 2012 (Formation Meeting, CPA, Halifax, Nova Scotia)
- 7 PHHC Executive Meetings held by teleconference
 - September 11, October 25, December 13, 2012;
 - February 4, March 18, April 29, June 4, 2013

In regard to Section finances:

- The Section now has a BMO Community Account
 - low-cost account for non-profit organizations
 - Deposit CPA: \$1,113.50
 - Expenditures: \$101.64 Award Plaque
 - Balance: \$1,011.86

Acceptance of the Secretary Treasurer's report was moved by Sharon Guger, seconded by Lorne Sexton and passed unanimously, with no abstentions.

6. Committee Reports:

Communications Committee

Members: Bob McIlwraith (Chair), Debbie Emberly, Mary Pat McAndrews, Dawn Phillips

Bob McIlwraith reported that the first Section newsletter was circulated in April.

- There is now a call out for leading practices for the August issue
- For the Fall issue there will be a call for articles from small hospitals.
- There is a contest looking for the best brief description of who psychologists are and what they do. It's important to be affirmative and have a brief response available whenever you may need it.
- This time next year we'll be looking for a Section Newsletter editor.

Guidelines Committee

Members: Kerry Mothersill (Chair), Camillia Clarke, Margaret DeCorte, Joyce D'Eon, Lorne Sexton

Kerry Mothersill reported on the committee's activities

- Development and Collection of Leading Psychology Practice Guidelines:
There are psychology practice guidelines and the Section Committee would like to have a compilation of leading practices in health care psychology documented and available to Section members. This will help identify pockets of excellence in Canada, facilitate advocacy for services, and foster the development and growth of services or new programs for both psychologists and administrators.
- Guideline collection and development:
The process by which we review and vet guidelines is being discussed as well as how to best standardize how they are presented.
- Partnering with other CPA Sections
Kerry Mothersill noted that at the last Sections meeting he talked to the Chairs of the Health and Clinical Sections about this initiative and they are interested in partnering around these guidelines.
- Psychology Guideline Fact Sheets
Lorne Sexton suggested that we develop guideline 'fact-sheets' similar to the Fact Sheets use for clinical services. These would be most useful for other professions and health care administrators.
- Model of how Psychology might best be organized in Hospitals. A document outlining what organizational model works best for the profession is being discussed.
- Manager's Psychology Handbook
This is a document that is in development and would be useful for all members working in settings where psychologists have a reporting relationship to non-psychologists.

Leadership Committee

Members: Vicky Vetch Wolfe (Chair), Peggy O'Bryne, Simone Kortsee

Vicky Vetch Wolfe reported that the Leadership Committee members met by teleconference and at the convention.

The goals of this Committee are to:

- Enhance systems of communication among Psychology Professional Practice Chiefs and Leaders
- Develop strategies to gather information on key issues related to psychology leadership practice and roles in hospitals (e.g., leadership structures, leadership roles and responsibilities, best practices for assuring strong psychology practice in hospitals and health centres; benchmarks for key areas of practice)
- Develop leadership capacity both within the discipline of psychology but also within other sectors in hospital settings (managers and directors, team leaders, in mental health, health, community services).

Progress has included:

- Developing list of current psychologists that hold leadership roles in health centers
- Establishment of a group to work on these issues
- Collecting documents related to leadership roles in health care centres

In regard to directions, the following are being considered:

- Develop educational and mentorship programs for psychologists in hospitals and health centres.
- A pre-conference workshop next year at CPA on this topic (e.g., a combination of a training session and a meeting of Psychology chiefs and leaders)
- Organize a full conference on leadership roles in Canadian health centres in the future, perhaps including other disciplines as well)
- Identify key responsibilities of psychology chiefs and leaders in hospitals and health centres (e.g., hiring; quality assurance);
- Identify the institutional supports needed so that psychology chiefs and leaders can successfully carry out our roles (e.g., budgets for continuing education, integral role in hiring processes).

Awards Committee

Members: Paul Greenman (Chair); Joyce D'Eon, Marcie Balch

Paul Greenman noted that the bulk of the work for this Committee has been to put together the policies and procedures.

Paul Greenman said he had the privilege and honour of presenting the first *Excellence in Hospital and Healthcare Psychology Award* to Dr. Ian Nicholson of the London Health Sciences Centre.

Paul outlined Ian's contributions to psychology in healthcare in Canada a teacher, administrator, supervisor, re-

searcher, mentor, colleague, and friend. Ian has held many public service and leadership roles with international, national and regional psychological associations, including APPIC, CPA, CCPPP, and OPA. He is renowned for the rigour and integrity of his work and for his ability to instil an understanding of, and appreciation for, the highest ethical standards of psychological practice. Ian continues to play a key role in the development of the profession and was applauded for his contributions leading to this Award.

As Ian Nicholson was unable to be at CPA his award will be brought to him by Brent Hayman-Abello. A photo will be taken with the award for the Section Newsletter.

Nominations for next year's award will be announced in the Section Newsletter.

7. **Adoption of Awards Policy and Procedures**

Below are the policies and procedures for the PHHC Excellence award:

Each year, the awards committee of the PHHC section of the Canadian Psychological Association will accept nominations for the *Excellence in Hospital and Healthcare Psychology Award*.

The award is to be bestowed upon a psychologist who has made significant contributions to psychology in hospitals and healthcare centres in Canada.

The award may not be given out every year.

Nomination Process

1) A call for nominations will appear in the Section Newsletter.

2) The call for nominations will specify that a letter from a section member is required, in which the member indicates the name and institutional affiliation of the nominee, along with details of the nominee's noteworthy contributions to the advancement of psychology in hospitals and healthcare settings.

The call for nominations will also indicate that two supporting letters from section members and a copy of the nominee's CV must be forwarded to the chair of the awards committee in order to consider the nominee for the award.

The Chair of the Awards Committee will receive 1 nominating letter, 2 letters of support, and 1 CV for each nominated candidate.

Selection Process

1) The Chair of the Awards Committee will forward copies of all nominating letters, letters of support, and CVs received to the other members of the awards committee.

2) The Chair of the Awards Committee will organize a meeting with the other members of the awards committee, during which the committee will select the award recipient based on one or more of the following criteria:

Significance of contributions for psychology as a profession

Impact of contributions on patient access to psychological services

Impact of contributions on the hiring and retention of psychologists

Creating new opportunities and developing positions for psychologists in healthcare service

Other significant contributions to hospitals and healthcare centres

3) The Chair of the Awards Committee will inform the Chair of the Section of the committee's choice.

4) The Chair of the Section will contact the nominee to inform him or her of the selection, and will invite the nominee to the section business meeting of the Canadian Psychological Association, where the award will be presented.

5) Psychologists who are nominated in a given year but who do not receive the award will automatically be considered for the following two years.

Acceptance of the Awards Policy and Procedure was moved by Andrea Piotrowski and seconded by Jessica Furtado, and passed unanimously, with no abstentions.

8. **Student Representative's Report – Marcie Balch**

In Marcie Balch's absence, Kerry Mothersill presented the student's report. Marcie Balch noted her role as Student Representative on the Executive has been to provide student-informed feedback to the direction and initiatives of the section. She noted that the section has 272 Student Affiliates (68% of the membership).

Student activities include:

- student articles in the Section Newsletter
- future workshop and/or symposium at the Convention addressing student concerns about working in a healthcare setting.
- recommendations to better prepare students for placements and employment in healthcare settings.

If anyone has any questions, comments or ideas please contact Marcie Balch at marcie.balch@gmail.com.

9. **Nomination and Election of Section Members to Executive Committee**

- Member-at-Large (two-year term)

Vicky Wolfe nominated Peggy O'Byrne, seconded Susan Jerrott, passed unanimously with no abstentions.

- Student Representative (one-year term)
The Student representative is renewable and Marcie Balch expressed an interest in renewing her term. Jessica Flores of BC Children's Hospital expressed interest in being the Student Representative. Kerry Mothersill noted that members of the Students section need to vote on nominations.

10. Proposed Survey

Kerry Mothersill noted that the Section would like to survey members and CPA may help run the survey. Areas to be covered include how psychology is structured in healthcare settings and evaluations of how well the structure is working. This could help support new leaders.

11. Other

Call for Committee Members:

Kerry Mothersill noted that members can help by being on one of the Section Committees. Please let Kerry know if you're interested.

CPA Demand and Supply Summit

Lorne Sexton noted that the CPA Demand and Supply summit is taking place in the fall to discuss meeting the needs of psychologists in the future. Andrea Petrowski will be attending the meeting.

A call for electronic dialogue around the issues for Section members was suggested and Kerry Mothersill noted that he would send out a request for input.

12. Adjournment:

Motion to adjourn Paul Greenman, seconded, Bob McIlwraith.
The meeting was adjourned at 8:55.

FROM PAGE 9 Bridging the Gaps for Obesity Management: Creation of a Transition Program between The Hospital for Sick Children and the Toronto Western Hospital

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