



PHHC Newsletter

Hospital Psychology

Fall 2015

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Message from the Chair:

Dr. Deanne Simms, C. Psych



I'm thrilled to be stepping into the Chair position for the Psychologists in Hospitals and Health Centres Section. As an early career psychologist working in a hospital setting, I am hopeful that I'll be able to contribute positively and build on the great work of those who have come before me.

Specifically, I would like to thank Dr. Bob McIlwraith, the Past-Chair of the Section, for his great leadership and encouragement over the course of my term as Chair-Elect. Bob has been a dedicated member of the Section since its inception at the Annual Convention in Halifax in 2012. His passion for the promotion of public sector psychology and his knowledge of the national landscape for the practice are remarkable and have made his presence in his time as Section Chair invaluable. We are fortunate to continue to benefit from Bob's participation in the Section's Executive Committee for the 2015-2016 year.

Another reason for my excitement is the Section's continued efforts in a number of areas. One important mandate of our Section is to contribute to policy pertaining to psychologists

working in hospitals and health centres. After a considerable amount of hard work and dedication, under the leadership of Dr. Kerry Mothersill, the Section's Guidelines Committee developed and disseminated "Guidelines for the Organization of Psychology in Hospitals and Health Centres" and a "Resource Guide for Managers of Psychologists". These important documents can be found on the Section's webpage (<http://cpa.ca/aboutcpa/cpasections/Hospitals/>) and can be used to support best practices and to advocate for psychological services in the public domain. Kerry will continue to head our Guidelines Committee in working to provide support and leadership for public sector psychologists.

Dr. Lara Hiseler, Chair of our Communication Committee, will continue to build on the Section's social media initiative. We are live on Facebook and Twitter (Psychologists in Hospitals and Health Centres – CPA and @cpa_phhc respectively) and we encourage all of our members (and prospective members) to follow us for relevant information and updates about the Section. Also, the Section continues to work on new and innovative ways to connect with and provide content to our members. Stay tuned for exciting new initiatives!

Following a very successful Preconvention Workshop at the 2015 Convention (Leadership in Hospital Psychology: A Call to

Serve), the Leadership Committee, chaired by our Chair-Elect Dr. Peggy O'Bryne, will focus effort on continuing to provide support and guidance for psychologists currently in or aspiring towards leadership positions in hospitals and health centre settings.

Finally, this year the Section will strive to provide additional content and opportunities specifically for our student members. Under the leadership of Fanie Collardeau, the Student Committee will enhance our student-specific initiatives (e.g., our Student Award for the best student submission to our Section) with opportunities to get involved with the Section both during and in addition to the Annual Convention.

On the heels of the recent Federal Election and amidst the current climate of change, this year promises to be an exciting one for the Section! I encourage our members to become involved in the Section in a number of ways including contributing to our Section newsletter, following us on social media, and considering the PHHC Section as the endorsing Section for convention submissions. I am looking forward to beginning, and continuing dialogues with our Section members about the issues that matter most to psychologists working in hospitals and health centres. Feel free to contact me directly (Deanne.simms@iwk.nshealth.ca) to share your thoughts or to discuss opportunities to become involved with the Section!



CPA Convention 2015: A recap from the section symposium on CBT- Psychosis in the Public Sector

Dr. Amy Burns - University of British Columbia
 Dr. Dave Erickson - Fraser Health Authority
 Dr. Mahesh Menon - Vancouver Coastal Health



Treatment guidelines in Canada, Europe, and Australia call for the availability of cognitive behavioural therapy for psychosis (CBT-P). While CBT-P qualifies as an evidence-based treatment (Wykes et al., 2008), the guidelines do not provide specific indications for its use. This symposium addressed three issues related to the implementation of CBT-P in the public sector.

First, Amy Burns from the UBC Psychology Department addressed the evidence for the specificity and timing of CBT-P. For example, she noted that the largest body of evidence for CBT-P comes from its use with clients with refractory symptoms, i.e. where symptoms are still present after at least two adequate trials of medication (Burns et al. 2014). She also noted that CBT-P for hallucinations is slightly more often effective, and has a larger effect size, than CBT-P for delusions (Van der Gaag et al. 2014a) among these patients. Another paradigm that has been frequently studied is whether CBT-P can prevent psychosis in high-risk individuals beginning to experience symptoms. Here, two meta-analyses conclude that CBT-based interventions can cut in half the risk of transition to a first lifetime episode of psychosis (relative risk = 0.52), although the large number needed-to-treat of 13-20 (Hutton & Taylor, 2014; van der Gaag, 2014b) means CBT for prodromal symptoms is not normally possible in the public sector. CBT-P has also been modified to incorporate other strategies such as motivational interviewing, mindfulness, and metacognition, where early results are encouraging but do not yet qualify as evidence-based interventions.

The second presentation in this symposium

addressed implementation and dissemination of CBT-P. Dave Erickson, from the Fraser Health Authority in Greater Vancouver, described a new program for refractory psychosis that has recently added CBT-Psychosis to its repertoire. The Psychosis Treatment Optimization Program (PTOP) is a specialty out-patient team in Fraser Health that uses evidence-based treatments to reduce the severity of refractory symptoms and improve functioning, and hence reduce hospital bed-days, emergency department visits, and polypharmacy. In the past year, PTOPTOP has begun to increase capacity for CBT-P by training skilled nurses. The training includes three steps: 1) a two-day workshop in CBT for psychosis; 2) a 12-week seminar where nurses learned cognitive & behavioural techniques; and 3) a 6-month individual supervision where each nurse observes the supervisor with one case, and the supervisor observes each nurse with 2 cases. Erickson's preliminary data on the outcome of CBT in PTOPTOP showed that both positive and negative symptoms were significantly reduced from baseline to 3 months. This study is ongoing, and we are continuing with follow-up at 6- and 12-months.

In the third presentation Dr. Mahesh Menon from the Vancouver Coastal Health Authority described Metacognitive Training (MCT), which is a newer CBT-based group intervention that aims to reduce the positive symptoms of psychosis. MCT originated as a knowledge translation exercise, aimed at helping consumers of mental health services and their families understand the cognitive biases associated with delusions and hallucinations in psychosis. Based on the feedback from those initial presentations, MCT was developed (Moritz & Wood-

ward, 2006). Metacognitive Training uses a less direct approach than most CBT-Psychosis protocols. MCT presents clients with a series of semi-didactic modules, where participants learn about various cognitive biases and cognitive processes associated with belief formation, delusions and hallucinations. Through a series of interactive exercises, they are then invited to consider the role of these processes in their symptomatology, rather than directly discussing their specific beliefs and experiences. MCT has also been used as an individual approach, and found to be efficacious in group and individual forms (Moritz et al, 2013; Balzan et al, 2013; Menon et al, in press).

In conclusion, it is encouraging that evidence-based psychological interventions such as CBT-P are available for patients to help reduce the distress and symptoms associated with refractory psychosis. Further, the preliminary data from Fraser Health's PTOPTOP Program suggest that skilled nurses, with training and individual supervision, can help clients reduce their symptom severity. And we await further evidence regarding an exciting new variation on CBT-P, i.e. group-based MCT, to see whether it can be implemented in the public sector.

Call for CPA 2016 Convention

This year the annual CPA convention will be in Victoria, British Columbia from June 9 - 11, 2016. This year's conference promises to be an exciting one full of even more section-sponsored events! Our section continues to grow so attending the conference is a great way to network and meet other members with similar interests and passions. We encourage submissions to the Section of Psychologists in Hospitals and Health Centres, to help all of our members stay abreast of all the hard work members are doing across Canada. Remember, submissions are due December 1st, 2015 so be sure to get yours in on time!

<http://www.cpa.ca/Convention/callforsubmissions/>



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Psychologists in Hospitals and Health Centres – CPA

Predoctoral Residency Training in Health and Rehabilitation Psychology

Gregory Tippin & Laura Katz, Psychology Residents Health/Rehabilitation Track



Despite the increased awareness and intervention to address the burden of various chronic illnesses, the rate of morbidity and mortality due to chronic illness continues to grow (World Health Organization, 2009). Given the importance of psychosocial factors to the development and adjustment to chronic illness, Health and Rehabilitation Psychologists play a vital role in helping Canadians prevent the onset of chronic conditions, and strive to maximize adjustment and quality of life following the onset of chronic illness.

Health Psychology and Rehabilitation Psychology are distinct competencies within psychological practice in Canada (e.g., College of Psychologists of Ontario [CPO], 2015) and America (American Psychological Association [APA], 2015). For trainees, these competencies require students to obtain a doctoral degree from a psychology program and specialization in health and/or rehabilitation aspects of psychological practice, through coursework, practica, and predoctoral residency experiences. Several internship sites throughout Canada offer focused training in health and rehabilitation psychology (e.g., London Clinical Psychology Residency Consortium).

Health Psychology

Health Psychology is defined as “the application of psychological knowledge and skills to the promotion and maintenance of health, the prevention and treatment of illness, and the identification of determinants of health and illness” (CPO, 2015, p. 38). Intervention may occur in the context of addressing preventative health behaviours (e.g., weight, adherence to treatment), acute health difficulties (e.g., surgery, transplant), or adjustment to chronic illness (e.g., chronic pain). Clinical health psychologists use a broad array of procedures including assessment, diagnosis consultation with the health care team including family, and various psychotherapeutic approaches and techniques in the context of physical illness and health promotion (APA, 2015).

Rehabilitation Psychology

Rehabilitation Psychology is defined as the assessment and treatment of cognitive, emotional, and functional aspects of chronic disability that results from injury or illness (APA, 2015). A core feature of Rehabilitation Psychology is striving to help patients and their families adapt to chronic disability, toward increasing engagement in life activities. As in Health Psychology, students practicing in Rehabilitation Psychology setting can gain experience working as member of an interprofessional team, earning valuable experience understanding the fluid and dynamic roles of each profession on a given health service. Rehabilitation Psychology offers opportunities to provide care in various medical settings, such as acquired brain injury, stroke, spinal cord injury, or chronic pain, among others (APA, 2015).

Health versus Rehabilitation Psychology

While Health and Rehabilitation Psychology are conceptualized as distinct specializations, they frequently overlap in actual practice. Psychologists working in both settings often provide intervention in hospital settings addressing the psychosocial sequelae for patients presenting with medical issues. In general, Health Psychology and Rehabilitation Psychology can differ temporally, based on the time and purpose of intervention: while Rehabilitation Psychology typically helps patients with adjustment and adaptation *following* the onset of chronic illness, Health Psychology may operate in more of a proactive role toward health promotion and prevention (e.g., smoking cessation; APA, 2015).

In practice, however, the line between health and rehabilitation is often blurred as a natural consequence of the treatment setting, where psychologists collaborate with a team of professionals to provide patient-centred care within a medical context. For example, a health/rehabilitation clinical psychologist might be a member of an interprofessional team on a pain management service where a patient is seeking treatment to cope with pain, loss of role-functioning and depression following a work-related accident resulting in chronic back pain. A health/rehabilitation clinical psychologist might help the individual maximize adjustment and quality of life post-accident (e.g., re-engage with important life roles such as work/parenthood), as well as preventing any future issues that might arise (e.g., pain and stress management, maintenance of weight and physical functioning and learning to garner social support in adaptive ways). particular type of psychologist or training background.

Predoctoral Residency Training in Health and Rehabilitation Psychology (cond't)

The differentiation in treatment and patient-related health/rehabilitation goals often depends more on the actual location within the healthcare setting (e.g., bariatric weight loss clinic vs. spinal cord rehabilitation), rather than a particular type of psychologist or training background.

Finally, relative to Psychologists working in a general mental health setting, Health/Rehabilitation Psychologists typically work within the context of a medical team. While a proportion of health/rehabilitation psychological care revolves around typical activities aimed at encouraging health behaviours (e.g., treatment adherence/compliance, weight loss), much of our care often revolves around treating associated suffering and mental health difficulties, such as depression, anxiety, and trauma, within the context of comorbid chronic medical conditions such as cancer, cardiac disease and diabetes.

Final Thoughts

For students, training in Health or Rehabilitation Psychology offers a unique experience of the demands and challenges of providing psychological services within the limitations of

Canadian healthcare. In addition to the resource limitations inherent in a publically funded system, students are faced with a variety of ethical challenges unique to a medical health context. Given the wide range of potential healthcare settings, clinicians working in health/rehabilitation settings commit to a lifelong learning process (Belar, 2008).

The future of health and rehabilitation psychology within Canadian healthcare settings is uncertain. In the drive for cost-effectiveness and patient turnover, there is a risk that the evidence-based services provided by Health and Rehabilitation Psychologists in medical settings could be devalued; however, there are numerous factors that can contribute to the ongoing growth and development the fields of Health and Rehabilitation Psychology. At the core, the scientist-practitioner foundation of clinical psychology continues to represent the unique and evidence-based value that the profession adds to any healthcare setting, especially within the context of medical teams. Furthermore, as the Canadian population continues to age, individuals are living longer, albeit with debilitating chronic conditions. As

such, there is growing need for the support and management of mental health within the context of coping with medical symptoms, pain, and disability, in order to maximize adjustment to chronic illness, improve quality of life, and decrease disability in Canada's aging population. Finally, advocating for the role of psychology in health and rehabilitation settings will remain an important consideration for students interested in these challenging and rewarding areas of practice, in order to demonstrate the important contributions the profession makes in improving the lives of patients across all health settings.

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Victoria Hospital - London, Ontario

Mobilizing Minds Research Group: Informed choices about treatments for depression

John Walker, Ph.D., Department of Clinical Health Psychology, University of Manitoba

Major depression is one of the most common mental health problems in the community. About one in six Canadians will have an episode of depression during their lifetime. The first episode of depression is often seen in the late teen or early adult years and the highest prevalence of depression is seen during the young adult years. Depression is even more common among people coping with chronic health problems. Many people with depression do not seek help or delay the decision to seek help. One factor here is a lack of information about effective treatments.

A key challenge is that we have not had good information about what people want to know about treatment choices. The Mobilizing Minds Research Group has gathered information from young adults about their information needs and preferences – using individual interviews, focus groups, and surveys. We found that young adults had many questions about treatments for depression and some misconceptions about treatment choices that could serve as barriers to seeking help. Recently our surveys have found that adults across the age range have similar information needs and preferences.

Our team also studied information for the public available on the Web to see how well the public's questions are addressed. We found that while existing websites provide good descriptive information about depression and about some of the treatments available they did not answer many questions about depression. In response to this problem, we developed evidence-based information in plain, easy-to-understand language to answer the questions the public identified as being most important. The content was developed by specialists in mental health and vetted by a wide range of health professionals. It has been evaluated by young adults in the community, including young adults with personal experience in dealing with depression. Content is available in both English and French.

This information is now freely available to the public through our website and Factsheets (PDFs) about all topics. These Factsheets may be downloaded, printed and distributed by professionals, or posted on organization/program websites free of charge. There is also a business card giving the website location that may be distributed by professionals.

The information answers questions including:

- What happens to depression with no treatment?
- What are the treatment options and how effective are they including psychological (counselling) or medication treatments, exercise, self-help programs, herbal medicines, light therapy, diet supplements, meditation.
- Who provides treatment? What is the cost?
- How long does treatment continue?
- What happens when treatment stops?
- How to manage the cost of treatment?
- How to find help for yourself, a family member, or a friend?

Clients look to psychologists for information concerning treatment choices. This information may also help you to provide high quality resources to patients when they are considering changes in treatment such as starting or stopping medication or trying an alternative treatment.

For more information, please visit the website (downloadable Fact Sheets are in the resources section). For information about hosting the factsheets on your website contact: John Walker, Ph.D., Department of Clinical Health Psychology, University of Manitoba at John.Walker@umanitoba.ca.



To Fund or Not To Fund: Psychology Internships in Nova Scotia

Jennifer Richards, Clinical Psychology PhD Student, Dalhousie University, Student Representative, Association of Psychologists of Nova Scotia (APNS)

On August 14, 2015, the CBC reported that Nova Scotia's Department of Health and Wellness had axed \$220,000.00 of funding which had been spread across three psychology internship programs that offered training in child and adult mental health and addictions across sites located in the Annapolis Valley, Halifax, and Dartmouth. This effectively eliminated funding for eight internship positions across these three sites – the highest number of internship training opportunities in all of the Maritime Provinces. These cuts represented a major loss of training opportunities in the Maritimes and a substantial blow to Nova Scotia's ability to recruit psychologists.

The funding cut was met with criticism from the mental health community and a public outcry to reinstate funding. On August 25, 2015 a press release from Health and Wellness Minister Leo Glavine's office stated that the provincial government would continue to fund Nova Scotia psychology internship positions for the subsequent year, and that long-term funding for the program would be discussed during the next budget talks. In an ambiguous comment, Glavine stated that, "Contrary to media reports, the program was never cut and it will continue." Thus, while the Department reported that it was always their intention to continue the program, at some point a decision was made to terminate the funding required to support the internships. This funding debacle pointed a spotlight on two important points for Nova Scotia: (1) a lack of prioritization of mental health care in the province, and (2) a lack of communication pertaining to funding decisions regarding mental health services.

Regarding the first point, the (seemingly) hasty decision to axe funding for three accredited psychology internship programs begged the question: where do Nova Scotia's

mental health priorities lie? In the 1990s, the Department of Health offered funding for psychology internships as a recruitment and retention strategy. Indeed, in August 2015, health authority spokesman, Everton McLean, was quoted saying, "Psychologists, as you may or may not know, are hard to recruit in various locations.... The internship [sic] program, as we've seen it, has been an integral part of (our ability) to recruit and train psychologists". This recruitment strategy has been successful, in part, because it has offered funding (albeit, below the national average). This funding helps Nova Scotia competitively recruit excellent trainees to the province. Subsequently, psychology interns help meet the need for mental health care. From a dollars-and-cents perspective, as highly trained students, interns are cost-effective: they provide a valuable service at roughly 1/3 of the cost of a registered psychologist. By removing positions for eight mental health trainees, service provision decreases, and wait times increase, thus making it increasingly difficult for Nova Scotians to access mental health resources in a timely fashion. Removing funding for these positions - even temporarily - strongly indicated that the Nova Scotia government was not prioritizing access to mental health care.

Regarding the second point, it should give us pause that major decisions pertaining to mental health funding occurred without consulting the mental health professionals most directly affected by the decision. The Association of Psychologists of Nova Scotia (APNS) was not invited to discuss the value of the internship programs with the Department of Health and Wellness. To date, the context around the funding cuts (e.g., key decision makers responsible for cutting and/or reinstating funding) remains unknown to many psychologists, including APNS. Furthermore, hospital policies pre-

vent those who have information to share this information with the broader community, making it challenging to understand the decision-making process behind the original funding cuts. The lack of transparent communication makes it difficult to appreciate how these decisions impact hospital-based psychologists in the province. Regardless of whether or not psychologists are working in the hospital system, without transparency, it is challenging for psychologists to advocate for their training, their profession, and for their hospital-based colleagues. It also makes it difficult for psychologists in the province to advocate on behalf of their patients for timely, accessible, and evidence-based mental health care.

Psychologists need a voice when decisions pertaining to mental health services are made. During a recent meeting with the President, Past-President, and Executive Director of APNS, the Minister and the Deputy Minister of Health and Wellness reassured APNS about their understanding of the importance of internships and agreed to consult with APNS about such issues in the future. This is a positive step for psychologists in Nova Scotia. As a profession, we need to advocate for a seat at the table with key stakeholders when actions that directly impact our profession are decided. This funding fiasco sheds a light on the importance of professional advocacy by psychologists and psychologists-in-training. Advocacy is needed to ensure that psychology students can complete their compulsory training. Likewise, advocacy is needed to recruit and retain psychologists to Nova Scotia. Consequently, advocacy is needed in order to meet the demand for mental health services. Sadly, this type of advocacy is almost impossible if we do not have basic information about decision-making at governmental and institutional levels. Thus, we need a voice at the table. It's time for psychologists to pull up a chair, and speak up.



IWK Health Center - Halifax, Nova Scotia

Student Column

Fanie Collardeau, PHHC Executive Student Representative



Greetings student members!

My name is Fanie Collardeau; I am the new student representative for the Psychologists in Hospitals and Health Care Centres (PHHC) section. I was involved in the section's Student Committee last year and I am excited to continue representing students on this rapidly growing and dynamic section of the CPA.

I am enrolled in the graduate program in Clinical Psychology at the University of Victoria. I completed my undergraduate degree at the American University of Paris, in France. Being a trainee both in France and

in Canada allowed me to understand better the multiple ways in which public services can be organized and mental health defined. I am hoping to stay in Canada after I graduate.

A few things of interest:

As I am writing abstract submissions are underway for CPA Convention 2016, June 9 to 11th, which will take place in Victoria. I am hoping we will see more student submission to the section this year!

The PHHC section has many strengths, and here are a few reasons why you should consider becoming more involved with us, and be for the look out at CPA for events sponsored by our section:

- Hospitals encompass a wide breadth of clinical populations, as well as diverse patient demographics, numerous cultural groups and social economic strata. With the wide array of relevant topics, there is a high chance what is of interest to you, is also of interest to us!
- Consider how current research/practice can be translated to these settings and learn about some exciting practice guidelines, services and treat-

ments that are being launched or tested across Canada!

- Professionals of the section often need to advocate for our profession at their institutions and work in interdisciplinary teams. Benefit from their leadership skills and knowledge!
- Students' work is showcased this year with the first Graduate Student Symposium of the PHHC section. Come support your peers and learn about the exciting research and insights graduate students have on treatment options and other domains relevant to psychologists working in mental health centers and hospitals.

In addition, we are pleased to let you know our section now has a Facebook page (Psychologists in Hospitals and Health Centres – CPA : <https://www.facebook.com/Psychologists-in-Hospitals-and-Health-Centres-Section-CPA-794760023917773/>) and a twitter account (@cpa_phhc). Follow us on social media and stay tuned !

Feel free to contact me with your comments and feedback ! I look forward to meeting some of you in Victoria !

Fanie Collardeau (faniecol@uvic.ca)

A Short Snapper from the Ottawa Hospital: Psychology Consultation Services for Inpatients (PCSI)

Amanda Pontefract, Ph.D., C.Psych., Acting Chief of Psychology

The Ottawa Hospital is an acute care, academic health sciences centre. During recent budgetary challenges, we asked ourselves how we could offer psychological services to our patients most in need. This required a shift from justifying what we were offering to what our stakeholders were telling us they were struggling with the most. In other words, we needed to distinguish ourselves in terms of filling a gap in service. We learned that our assistance was highly valued for patients with adherence, addictions, behavioural or complex mental health issues that interfered with care and health outcomes.

In order to build capacity, this meant spreading some of our specialty inpatient services to more general services; prioritizing based on acuity rather than by program. It also involved discussions with directors to reallocate relatively small portions of psychology outpatient resources to our inpatient services. So far, we have provid-

ed care to 22 inpatients, prior to the launch date. The feedback shared with senior management has been overwhelmingly positive.



The Ottawa Hospital - Ottawa, ON

PSYCHOLOGISTS IN HOSPITALS AND HEALTH CARE CENTRES

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Newsletter Contributions Welcome – Instructions to Authors

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

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

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

2) Leading Practices: 500-1500 words Reports of psychological services that are

considered leading practices, either as a result of recognition by accrediting bodies such as the Canadian Council on Health Services Accreditation (CCHSA: “Accreditation Canada”) or similar organizations, or through outcome data that demonstrate the effectiveness of an innovation or an exemplary service model.

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

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

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

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

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

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

Please send submissions to:

Dr. Lara Hiseler
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Psychologists in Hospitals and Health Centres – CPA

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