Improving Lives Through Excellence

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Rapport

Editorial

Dr Ester Cole

As we begin a new year, CRHSP's Board of Directors extends its thanks to the membership for your valuable support and contributions!

The last Rapport highlighted the Mental Health Commission of Canada's report (www.mentalhealth comission.ca). The included recommendations and strategies will unfold in the years to come, and will involve psychologists in promoting prevention and evidence-based intervention services across the country. In addition to our registrants' advocacy at the local and provincial levels, we invite you to share your efforts in promoting well-being for all Canadians by publishing an article in this Newsletter during 2013.

Several included articles highlight the importance of professional development, knowledge sharing and translation, and the importance of effective multidisciplinary coordinated mental health teams.

- Dr. Michael Vallis' paper "Professional Psychology and Health: Times They Are A-Changing", concerns professional role development and the significance of psychological services to society.
- Dr. Myles Genest follows from the previous newsletter with the theme "Continuing Education Highlights (or Opportunity?)".
- Dr. Ester Cole shares a handout with a framework for "Effective Multidisciplinary Teams".

CRHSPP members are encouraged to provide feedback, and share their publications in future issues. Please send your papers (in English or French) to ester.cole@sympatico.ca.

Continuing Education Highlight (or Opportunity?)

Myles Genest, Ph.D.
CRHSP Registrant and Board Vice-President

On behalf of our Registrants, CRHSP has negotiated an excellent opportunity to participate without charge in the online Continuing Education that is offered by our U.S. counterpart, the National Register of Health Service Providers in Psychology. As a service, we will highlight some of these offerings in this and upcoming newsletters.

For many years, one-third to half of my therapeutic work has been with couples, yet I continue to be amazed at the ability marital and common-law partners have to challenge me with ethical problems. As with other therapeutic endeavours, issues of confidentiality remain central, and are frequently complex.

Nicole Pukay-Martin's CE offering, "Ethical Considerations in Working with Couples: Confidentiality Within the Couple," highlights various ways in which ways in which the requirements for privacy, confidentiality and therapeutic benefit intersect and may present the psychologist with competing demands.

Her offering is relatively brief, and it provides a good review of the complexities related to confidentiality that arise in couples therapy.

Under the headings of: **Defining the Client; Individual Sessions; Secrets**, Ms. Pukay-Martin identifies problems that can arise, and discusses them with reference to the APA Ethical Principles and Code of Conduct (2002).

The APA Code is much more specific and prescriptive than its Canadian counterpart. Nonetheless, as Ms. Pukay-Martin notes, it is rare that the APA guidelines offer clear answers in the face of the multiple responsibilities facing the psychologist in couples' work. Instead of providing simplistic solutions, she alerts the reader to relevant principles and raises awareness of how actions concerning sharing or not sharing information with one or both parties can have an impact on individuals and relationships–both the couple's relationship, and their relationship with the therapist. She also highlights how decisions concerning confidentiality within this work may affect safety, trust, and the transparency of the therapist's relationship with the couple and each individual.

Her discussion thus resonates for the Canadian Psychologist's code of ethics, with its reference to principles and problem-solving, rather than rule-governed decision-making. In the end, the therapist must balance competing responsibilities. The potential for harm is reduced by the therapist's awareness of how things can go wrong and by his or her taking steps to address some of the issues beforehand, such as in early discussion with the couple of how "secrets" will be handled. Although Ms. Pukay-Martin notes that different therapists find different solutions, careful consideration of the issues she raises can help prevent missteps and reduce the likelihood that one is taken by surprise in the midst of therapy.

This is a worthwhile, brief refresher for therapists who work routinely with couples, and it is a good introduction for those beginning such work.

Through our agreement with the National Register, CRHSP provides Registrants with access to many educational resources on a wide range of practice-related topics. The selection is regularly updated with new content. CE credits can be obtained by passing an online exam. Scoring feedback is immediate and certificates can then be printed online. As a supplement to in-person continuing educational opportunities, these online sources are an excellent resource in continuing professional development. See http://www.crhspp.ca/registrant-benefits/continuing-education/.

EFFECTIVE MULTIDISCIPLINARY TEAMS

Dr. Ester Cole

Handout for Multidisciplinary Service Providers

Multidisciplinary Teams can offer an effective mechanism for knowledge transfer and translation efforts in a range of systems providing coordinated mental health services. Table 1 presents an organizer of Team characteristics discussed in the literature. Enhancing and inhibiting factors relate to the clarity of the Team's goals and roles; leadership support; effective planning of regular and efficient meetings; the composition of its membership, and the Team's performance.

Table 1

CHARACTERISTICS OF TEAMS

Enhancing Factors	Inhibiting Factors
1. Goals and Roles	
• Goals and roles are clearly defined for Team members and invited participants. • Professionals are appraised about the rationale for a particular service model. • Team members have a sense of ownership, and are committed to multidisciplinary services. • Summary forms are developed by the Team.	• Team goals and members' roles are unclear to the professionals and the participants. • Different professionals are unclear about the Team model. • Staff members do not feel supported by their Team. • New members do not receive appropriate orientation.
2. Leadership Support	
• Shared leadership or democratic leadership results in an inclusive atmosphere, and following of guidelines. • Administrative support results in a larger number of consulting relationships which evolve among participants. • Release time for in-service training is provided. • Invited members are included on an as needed basis.	• Leaderless group results in inefficient decision-making, and a lack of focus for activities. • Administrative lack of commitment to the Team, results in uncertainty and mistrust. • Meetings are held infrequently and shared decision-making is not promoted. • Clarification of issues is not encouraged, and implementation procedures are fragmented.
3. Regular and Efficient Meetings	
• Frequent and scheduled meetings allow for a broad range of services. • Goals are discussed and agendas are set by Team members. • Individual and group needs are addressed, and multiple recommendations are considered. • Advance preparation time for staff is supported. • Discussions are focused and needed documents are available for meetings.	• Infrequently held meetings result in crisis interventions, and address only urgent matters. • Little time is allotted for discussion about group processes or issues of concern. • Meetings focus on reactive agendas. • Communication regarding Team dates and agendas are not shared ahead of time. • Discussions are rushed and problems remain unresolved.
4. Team Membership	
• Team membership varies according to the objectives it is trying to achieve. • Referring staff are key participants in the appropriate phases of consultation. • Translators/interpreters are arranged as appropriate.	• Core membership varies throughout the year because of poor planning. • Core participants do not include referring sources when appropriate. • Multilingual participants are not invited and/or translators not provided.
5. Team Performance	
• Effective Teams ensure democratic and equal participation in the consultation process. • Group dynamics are evaluated, and members review their own role and those of other Team participants. • Proper in-service is provided in order to develop skills including: communication, prevention strategies, cross-cultural consultation and collaborative problem-solving. • All members are viewed as bringing different skills and knowledge to the Team.	• Cross- disciplinary exchange is not the norm, and conflicts are unresolved. • Lack of proper in-service training leads to ineffective operations, resistance to change and poor utilization of resources. • Meeting formats are unstable and consensual plans are not achieved. • Poor verbal and non-verbal communication results in negative emotional reactions and lack of monitoring of recommendations. • Some Team members are not engaged as active participants, and are less satisfied with the Team process.

Professional Psychology and Health: Times They Are A-Changing

Dr. Michael Vallis
Associate Professor, Dalhousie University

This article concerns professional role development and the value to society of psychological services. First, a context is required. Most professional psychologists practicing in Canada have been well-trained in psychological assessment, treatment and consultation. The modal professional psychologist sits in an office managing a clinical caseload. You know the drill; a referral arrives, an individual session is offered in the near, mid-term or (if you work within a healthcare organization) the long-term future. You then begin the intensive process of understanding current mental status, history, alliance potential, responses to trial interventions, obtaining psychometrics when relevant. Next you provide feedback, generally guided by the DSM-IV-TR1 structure, and negotiate a treatment plan. If all goes well, the individual returns multiple times to benefit from your skill. This is a tried and true method of practicing professional psychology that has made a core, valuable contribution to society. That said, if we stick solely to this model of practice we might run the risk of going the way of the do-do bird! Or if not extinct, is rare. And rare means inaccessible, hidden, underutilized and in overtaken by others with less training. Let me explain and illustrate my points through the lens of diabetes/obesity.

Let's talk numbers. Imagine seeing 30 individuals weekly and following individuals for 10 bi-weekly sessions. Using a 50 week year you can provide service to 150 individuals and wow, are you working hard! But, what is your contribution to society? It all depends on the number of people who could benefit from your services. But what if our potential target group is huge?

Let me tell you a little about type 1 and 2 diabetes (see www.diabetes.ca). Type 1 diabetes (15% of those with diabetes) results from an auto-immune reaction that destroys pancreatic beta cells (which produce insulin - a hormone that binds with glucose in the blood stream to transpose this glucose into the cells for energy) and renders the individual dependent on insulin for survival. Type 2 diabetes (85% of those with diabetes) is due to insulin resistance often followed by insulin insufficiency. Insulin resistance is mediated by excess fat cells interfering with insulin action. Insulin insufficiency is reduced production associated with duration of diabetes and aging. So the main risk factors for type 2 diabetes are age and obesity. Oh my! Obesity is of epidemic proportions in all of the industrialized nations of the world (http://www.who.int/features/factfiles/obesity/en/) and the first of the baby boomers (born between 1945 and 1965) turn 67 this year. Type 2 diabetes is the fastest growing disease on the planet, labeled by the World Health Organization as a world epidemic. The Heart and Stroke Society of Canada uses the term “The Perfect Storm” to describe the future health of Canadians2.

What do these medical diseases have to do with psychologists? Well, health behaviours and psychosocial functioning have become recognized as critical to successful management of diabetes and obesity. Mainstream healthcare has discovered behaviour. Lifestyle interventions are all the rage. Health services are hiring a variety of professionals with job titles such as wellness navigators, health coaches, self-management support clinicians, as well as engaging with expert patients and lay leaders. The skill sets of these professional are motivational interviewing, goal-setting and action plans, stress management and communication skills. I wonder where we fit on these Teams?

Let's go back to numbers; remember we see 150 separate individuals/per year in our traditional practice model. How does this stack up relevant to the numbers of individuals with diabetes and obesity. Using Halifax (population 400,000) as an example, there are 34,000 with diabetes (8.5% prevalence; http://diabetescare.nshealth.ca) and 96,000 living with obesity (24% prevalence3). Assuming that 50% of these people would benefit from our skills there would need to be, between 113 and 320, of us available in Halifax. Not going to happen.

But do we need to conduct an intensive assessment and implement personalized services with all whom we see? Is it possible that we could make a valuable contribution and yet not even know who the patient is? Consider the following: you are talking to a dietitian who expresses her belief that “patients rarely change”. She (or he) goes on to justify her belief - a patient seen for weight loss to manage diabetes. She tells you that she worked very hard; told the patient all about the Canada Food Guide, instructed the patient to start eating breakfast, to stop eating snacks at night, to be sure to select items from multiple food groups at each meal, and to carefully read food labels to identify hidden salt, count carbs, and determine percent of calories from fat. All evidence-based healthy eating principles; none of it worked, despite her best efforts. Surprised? Do you think you might have a few suggestions that could help? Suggestions that do not require you to crack the cover of the DSM, or know about the individual's early life experiences, or even see the patient. I wonder how many people you could help if you supported this dietitian in understanding about goal setting, behaviour shaping, and readiness assessment, emotional eating, or establishing a relationship with the patient based on listening and understanding more so than education?

There is evidence that non-psychologists can be effective in supporting behaviour change4-6 and accumulating evidence that models guided by stepped collaborative care7, or Glasgow’s RE-AIM framework8 (Reach, Efficacy, Adoption, Implementation, Maintenance) or those taking advantage of contemporary e-learning platforms might increase the impact of psychological expertise9. So maybe we could start thinking about how we could partner with others in the healthcare system to help guide the implementation of psychological principles into primary care and chronic disease management services.

Let’s look at how we might help with diabetes, where the main symptom, hyperglycemia (elevated blood sugar levels), is asymptomatic. How do you know if your blood sugar is high? You test it. How do you reduce the burden associated with living with diabetes? You avoid testing and go by how you feel; you feel fine (at least until the complications set in – micro-vascular complications such as blindness and amputation and macro-vascular complications such as stroke and heart disease). So it is understandable why someone with diabetes would be non-adherent. With diabetes the better in control sugars are the more work the person is doing. Work that takes time, effort, distress tolerance (imagine always choosing an apple over apple pie) and money (each testing strip costs $1). The tasks of diabetes include medication adherence, self-monitoring blood glucose, foot-care, medical follow up, constant diet adjustment and physical activity. Diabetes can be overwhelming (in the number of tasks required for good glucose control), complex (the interrelatedness of self-care activities - e.g., what should I do about my insulin on the mornings I exercise before breakfast?), constant, unforgiving (even high levels of self-care do not necessarily prevent complications), and is plagued by uncertainty. Is it any wonder the burden of living with diabetes is high.

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Diabetes specific issues include diabetes distress (a concept for which data are gathering that suggests it is an independent construct from depression), fear of hypoglycemia, needle phobias, eating disorders associated with insulin omission, psychological insulin resistance, interpersonal distress associated with diabetes self-management, as well as motivation, health beliefs, and self-efficacy. Non-diabetes specific issues include depression and anxiety disorders, social support, life stress and family conflict.

Diabetes is managed through primary care practices and diabetes education centers. The potential for psychologists to consult to these groups for the benefit of the patients is extremely high. Yet, evidence suggests that access to psychological resources is rare, which is unfortunate, given that it is seen as essential by those working in diabetes centers . Clearly, our diabetes colleagues see the need for psychosocial issues to be addressed within their clinical practice settings.

Imagine the following practice model. You work within a primary care network charged with managing chronic disease using the self-management model . You develop a self-report screening tool to identify distress. These people are then provided with print and on-line tools to manage distress. Further, you train and support your primary care colleagues in psychosocial screening and how to help patients use these tools. You also train a group of your colleagues to competency criteria in behaviour change, stress management, and role adjustment so they can both integrate these skills into their competencies and provide structured group-based sessions that you oversee and support. In addition you offer consultation and intervention for those individuals who either do not respond to the above interventions or do not fit. You also spend some of your time responding to on-line discussion boards on health related issues and provide regular public sessions on health promotion to the local community. I wonder how many people would be positively impacted by this practice model.

Thanks for reading this contribution. I think I have made my point. As someone who has worked within the medical field for the past 28 years I have witnessed an overwhelmingly positive response from the medical community to the potential value of psychosocial expertise. All good, except any compliment expressed about our field is quickly followed up with something to the effect of "it's just that there are no psychologists in my area who do this kind of work". I see this as a problem that needs to be addressed by us. I hope this discussion has encouraged you to consider how we can use our skills to benefit health outcomes at a population level.

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Helpful Websites

Several ADHD related websites are available for general information across age ranges. Those include, among others:
ADHD Canada www.adhdcanada.com; Canadian ADHD Resource Alliance www.CADDRA.ca;
Teach ADHD www.teachadhd.ca; at the Hospital for Sick Kids www.sickkids.ca/healthinfocus/adhd/index.html;
National Institute of Mental Health www.nimh.nih.gov/health/publications;
Children and Adults with Attention Deficit/Hyperactivity Disorder www.chadd.org; www.russellbarkley.org; and
National Resource Centre for ADHD www.help4adhd.org.

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