In the Matter Of:

Re: Barbara Wand Seminar

December 11, 2019

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neesons
A VERITEXT COMPANY
77 King Street West, Suite 2020
Toronto, ON M5K 1A2
1.888.525.6666 | 416.413.7755

RE: BARBARA WAND SEMINAR - DEC 11, 2019,
December 11, 2019.
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PREPARED BY:
EVELIENE SYMONDS
NEESONS, A VERITEXT COMPANY
77 KING STREET WEST, SUITE 2020
TORONTO, ONTARIO M5K 1A2

TEL. 416.413.7755

---Upon commencing:

BARRY GANG: Welcome to all of you who are here live in Toronto and also to the many people who are out there listening in -- in the rest of Ontario.

We have approximately 2,300 people with us this morning, and I'm very pleased to say many of you are in groups, which is something that we encourage. I understand the biggest group out there is about 60 people. Maybe the next biggest is about 45 people.

So some -- the message really is -- is working that doing your professional development together is a really great thing to do.

For those of you who joined the profession less than 30 years ago, some of you may not know who Barbara Wand is. Barbara -- Dr. Wand was the Registrar between 1976 and 1991. So she really was a -- a force and a leader of the profession. And the seminars were instituted when she retired in 1991 in recognition of her vast contribution to the profession of psychology.

I should have mentioned, I'm Barry Gang. I'm the Deputy Registrar, the Director of Professional Affairs. I know I've corresponded

with many of you on our practice advice line and hope to get to know all of you eventually.

Before we get into the formal program, I'd like to invite Dr. Michael Grand to come and formally welcome you to the Barbara Wand Symposium.

MICHAEL GRAND: Good morning, everyone. As president of the council, I'm so pleased to welcome you to the Barbara Wand Seminar.

You know, as an academic of 43 years, I'm not used to speaking for under an hour and a half at a time. And I had my comments ready, but because we had technical delay today, I'm going to keep my comments to a very short brief set of words.

I just wanted to -- to reiterate that the mandate of our College is the protection of the public. And as such, we have a responsibility to ensure that we deliver the best service we can to the public that's also of a very strong ethical nature. And I hope and I know that this morning, you will find the comments of our two presenters reflective of that mandate.

So welcome again, and we look forward to a very stimulating morning together. Thank you.

BARRY GANG: Thanks, Michael. So a

tiny bit of business before we get started. I know I'm speaking quickly. It's kind of like my daughter listening to her lectures at one and a half speed, so I apologise for that. If you need me to slow down, just wave or something. I just want to make sure that you get to hear Rick and John.

So the numbers are very exciting, and we want to encourage people to ask questions. But we found in the past because of the number of people online and the time lag, addressing questions live has been virtually impossible and frustrating, I think, to everybody.

So because of this, questions from online participants will be answered after the seminar. Those of you who are online already have the address to send questions to. Those of you who have questions that you think of after today are also welcome to e-mail us with the questions. It's not up on the screen right now, but I'm happy to give it to anybody later. It's BWSBarbaraWandSeminarquestions@cpo.on.ca.

And --

AUDIENCE MEMBER: (Indiscernible).

BARRY GANG: Pardon me?

AUDIENCE MEMBER: (Indiscernible).

BARRY GANG: Go down one slide. I'm afraid I'm going to mess this up. It's fine. We'll do that after. Barbara. No. I'm not -- I feel much better that it didn't work for you either.

BWSquestions@CPO.on.ca. If you're having any technical problems, those of you out there online, Stephanie will have sent you instructions about how to get help. If for any reason that fails, Stephanie can be reached at SMorton@CPO.on.ca, which she's also, I think, given you.

But instead of joining the queue, if you're having serious problems, we found in the past the instructions that really do help most people are to exit and reload the webcast, try a different browser, refresh your screen.

Worst case scenario, this will all be available online on the College website probably within a day or so. But it should be no longer than a week, depending on how the technicalities work their way through.

The other big question that we get is how many points of CPD credit can you get for this?

We're always happy to answer those questions. But for those of you who are taking note now, those of you who are watching either live -- well, who are watching live, either here or online with other people and interacting, you get one credit for that plus a credit per hour, so three hours in Category 2.

Documentation, that's the other question. If you're watching with other people and you haven't signed up and have an e-mail trail, just some trail of the communication with whoever has registered will be fine.

So I'm going to introduce Dr. Morris, Rick Morris, the Registrar and the Executive Director of the College. Many of you know him, but some of you are new. Before coming to work at the College, Rick worked for many years in children's mental health both as a direct service provider and in senior clinical administrative positions.

He frequently makes presentations to both member and non member groups in Ontario and beyond on a variety of professional practice issues. He is the former chair of the Association of Canadian Psychology Regulatory Organisations, has served on many committees for the International

Association of State and Provincial Psychology Boards, and is actually also a fellow of that organisation. As well, he's a recipient of the OPA, Barbara Wand award for excellence in the area of professional ethics and standards.

So here is Rick.

(APPLAUSE)

RICK MORRIS: Okay. So this didn't work for Barry, but it has to work. Otherwise, I'm an idiot. Ahh, there we are.

There's the address that Barry was referring to. If you can see it, it's right down at the bottom. That was the -- okay.

So as tends to be my thing, I'm going to do some tricky issues today. I've prepared a number of them, and we'll get through as many as we can and the remainder of them all right up in the next issue and bulletin.

Because of the time we have, I'm not going to spend time going through my rules, although many of you already know what the rules are. But I did want to point out the consideration at the bottom of the screen. It's just to ask you whether or not you're going to be able to do as well as university ethics classes that I presented

to. I've done four or five over the past three or four weeks, and they did really well. So we'll see how the rest of the -- pardon?

AUDIENCE MEMBER: That's a threat.

RICK MORRIS: That's a threat. I want to see how the rest of the membership does as compared to those people that are being trained to join us in the profession.

So, okay. The first one, true or false. And we don't have wireless mics. We're trying to get wireless mics. So if you have a question, please say it loudly enough for me to hear, and then I'm going to have to repeat it to the people that are viewing online. Okay.

So, true or false. One must not accept an invitation to a current client's wedding, as this would constitute establishing a prohibited dual relationship. True or false?

AUDIENCE MEMBER: False.

RICK MORRIS: True? False? Well, at least there's participation, which is what I wanted in terms of my first rule. The first rule is interactive participation.

So, show of hands in the room, how many people think that it is true, can't go, it's a

prohibited dual relationship?

And how many people like false? All right.

Let me just see how I have this worded here. I'm going to go with you're allowed to do it. Sometimes I put double and triple negatives in these things here, so they become more difficult for me to remember whether if it's true or false.

Anyways, there is -- it would be a dual relationship, obviously, if you went from your therapeutic relationship to -- to your client's wedding. But dual relationships aren't prohibited. They're discouraged, but then you have to take them one at a time. You have to take them as looking at each case by case and each client by client.

And there's no reason why, if you can justify it and it makes clinical sense for you to not attend the wedding of a client. Most of us, I think, immediately say no, feels kind of funny. I'm not sure if I want to get into that, and that's okay. Doesn't mean that you can't make that decision. But the important thing is you could make the decision to attend if you really felt that that was the right thing to do, the clinically appropriate thing to do. Okay?

I'm going to have to rely on the people here in the room, if you have any questions as we go along, and then I'll repeat them for the people that are in the -- watching by the webinar who are not able to ask questions.

Okay. Next one. One may use a collection agency or take a former client to small claims court if necessary to collect unpaid fees. True or false?

AUDIENCE MEMBER: True.

RICK MORRIS: Oh, that was unanimous true. Yes. Sometimes people look at that and say, well, really, that doesn't feel very good. And obviously it doesn't feel very good. We're in this helping profession. Our job is to help people and not to cause additional stress and problems around anxiety. But also for those of you in a private practice, you have a business of being in private practice. And depending on the number of unpaid fees that you might have, you can only stay in private practice for a certain period of time before your own bills are going to mount up.

So, yes. One can use a collection agency. Certainly all of the -- the things like proper notice and making sure that people

understand that this is the step that's going to be taken and making sure people get reasonable opportunity to pay their fees or to work on some kind of a fee schedule with you in advance.

Okay. It would be unreasonable and unfair -- yes?

AUDIENCE MEMBER: (Indiscernible).

RICK MORRIS: I don't know of anything that you need to do other than the only thing that you're going to be providing is name and amount. And you wouldn't be talking about anything clinical.

So it's really in the same category as using an accountant. I mean, you have an accountant. Your accountant is going to have names of clients.

In a sense, that's sort of the way it is. There -- it wouldn't be reasonable to -- for -- for a prior practitioner to run a business and not be able to have some access to some of these methods for collecting fees, if necessary. But obviously it's an if necessary kind of thing, and hopefully we don't run into it all that often.

Yes, question?

AUDIENCE MEMBER: (Indiscernible).

RICK MORRIS: So the question is whether or not this is something that should go into the limits of confidentiality that one does at the beginning. And I guess, for me, I'm not sure that that would be the way that you want to start your relationship, by explaining -- there's enough limits. I'm not sure that the relationship -- starting the relationship with, and, oh, by the way, if you don't pay me, you know, then I'm going to do all of these nasty things.

I think a lot of that might depend on your practice and what your experience is. I mean, if, for whatever reason in your practice you have a lot of unfortunate experiences, then maybe you decide I want to give people prior notice. But I think, generally, most of us wouldn't -- wouldn't do it at that point.

Yes?

AUDIENCE MEMBER: Just to let you know, when I first went into private practice -- oh, thank you -- I won a case in small claims court. And the sheriff went to the address and was so frightened that he wouldn't collect the money.

RICK MORRIS: Oh. Interesting. Okay. All right.

AUDIENCE MEMBER: (Indiscernible).

RICK MORRIS: Right. Right. Okay.

How about this one? It would be unreasonable and unfair to exercise your mandatory reporting obligations unless you've made the client aware of the potential limits of confidentiality. True or false?

AUDIENCE MEMBER: False.

RICK MORRIS: Oh, good. So child abuse reporting, mandatory reporting of sexual abuse, those kinds of things. Hopefully we've covered all of those things in advance.

But if for some reason we missed one or forgot one, that doesn't -- this doesn't get us off the hook in terms of having to provide -- to exercise our mandatory reporting obligation.

If one is terminated, suspended, or disciplined as a result of the unauthorised collection, use, disclosure, retention, or disposal of personal health information, your employer must notify the College. True or false?

AUDIENCE MEMBER: True.

AUDIENCE MEMBER: False.

RICK MORRIS: Hmm. Actually, this is a fairly new piece that's in PHIPA, and it is true.

It's true. So if you do something that results in unauthorised collection of information or you use information improperly, dispose of it improperly, that's one of the things that has to be reported to the College. There's becoming an increasing list of things that one has to report to the College.

I think it was last year's Barbara Wand, I went through a whole series of, you know, which of these do you have to report, and it was quite a number of them.

Okay. And the last one of these. To safeguard the integrity of the client file, PHIPA requires that one maintain the paper record for at least one year after it's scanned into electronic files. True or false?

AUDIENCE MEMBER: False.

RICK MORRIS: Anybody want to say true? Okay. Is that because there is nobody who thinks it's true or because of the peer pressure of everybody else said false and you're afraid to sort of - --

AUDIENCE MEMBER: True.

RICK MORRIS: -- say true? Yes. And that is -- that's certainly the case. There's -- there's no time limit once one has converted their

paper file to an electronic file. There's no longer a need to keep the paper file. You just want to make sure that you've verified that what it is that you put in the scan -- you've scanned is an exact copy. And then, under the law, your original -- your electronic copy becomes your original, so you can get rid of the paper.

One of the things that we're doing -- I'd like to tell the story. One of the things we're doing at the College is we're converting all of our registration files to digital files, because we have, you know, file cabinets after file cabinets of my file and John's file and all of your files, and we're trying to minimise the amount of storage space.

And one of the very unpleasant jobs -- I can't think of any other way to say it -- that staff at the College are doing is photocopying or scanning in the file and then comes the job of having the file on your computer screen, having the paper file in front and saying Page 1. Yeah. Page 1. Flip the page. Page 2? Yes, that's Page 2. And going through the whole file to verify that it's an exact copy.

So it really is a time consuming, mind

numbing kind of thing. But it really is important, especially if you think about various files that you'll receive, some are single sided, some are double sided. You can't just put it on a scanner and let it go, because you might end up with Pages 1, 3, 5, and 7, as opposed to the whole thing. So there's no requirement that you keep it for any length of time once you're satisfied that what you have is an exact copy.

Okay. Let's go on to this scenario. You received a letter from a lawyer who is representing the family of a client you saw briefly about 11 years ago. The letter indicates that the former client has died, and the family is suing the facility where she had been treated most recently. The lawyer, at the request of the client's adult daughter, is gathering all of the information he can in preparation for the court action.

As is your practice, you had shredded the clinical file at the ten year mark. When you tell the lawyer this, he asks you to provide a brief statement based on your recollection, describing what you could of the client 's difficulties and the progress the client made in therapy.

Which of the following best describes your actions?

Okay. Would you -- since informed consent cannot be obtained from the client, the lawyer must obtain the Court Order compelling you to provide a brief statement or write a brief statement and release it to the lawyer upon receiving a satisfactory documentation showing that the adult daughter is the Estate Trustee, refuse to provide a report since you no longer have the file and one is not permitted to prepare a report based solely on 11 year old memories, agree to speak with the lawyer about your recollections but refuse to put these into a written statement, or release the brief report to the lawyer on the agreement that he'll not use it in court because you're really unsure of your recollections.

Does that mean you don't like my Number 5? Is that what that means? Okay. So I'll take that as saying that we have 1, 2, 3, or maybe 4 as opposed to 1, 2, 3, 4, and 5. What do you think? 3?

AUDIENCE MEMBER: Yeah.

RICK MORRIS: A lot of people are saying 3?

AUDIENCE MEMBER: 1.

RICK MORRIS: We have a 1.

AUDIENCE MEMBER: 2 over here.

RICK MORRIS: 2. 2 over there. 1, 2, 3. 4? Question?

AUDIENCE MEMBER: (Indiscernible).

RICK MORRIS: That could probably be Number 6 on all of my slides. You know. Get legal advice. Certainly the College that, if you're unsure about any of these kinds of things, to seek legal advice. That's always a good thing to do.

AUDIENCE MEMBER: (Indiscernible). The insurance company that we have --

RICK MORRIS: Right.

AUDIENCE MEMBER: -- makes it very easy for us to obtain a legal opinion.

RICK MORRIS: Sure. There is the pro bono legal service available, and so certainly if you're unsure about any of these kinds of things related to responsibilities or obligations, I would certainly agree that getting a legal opinion is a good idea.

So I think we've had, like, 1, 2, 3. Anybody say 4? Nobody said 4. And that's good, because 4 doesn't work, because there's no

difference under PHIPA between an oral record and a written record. It's still the record, it's still a file. It's still a report.

So a statement in writing or a statement that you make is not -- there's no difference under the law.

So we have people with 1, 2, 3, and 4. I would probably go with -- personally, Number 2 is actually the best option.

Number 1 is a very safe option. It's a safe option in terms of you would then not be releasing the report in any way voluntarily. You would be compelled by the courts to release it.

The risk you're taking is you could end up finding yourself being ordered to pay court costs. The reason for that being -- is that the legislation is quite clear that the estate trustee or some other such decision-maker with respect to a deceased individual has the same rights to provide -- or to access information as the client for whom they are the substitute.

The law is very clear about that, and the judge could decide that since you have, in a sense, unnecessarily required this individual to hire a lawyer to go to court and go through all

that whole process, that you're going to be penalised for that as opposed to the client. So it's not a wrong thing to do. Just be aware. And that's where -- certainly where you would want to get legal advice.

Number 2 is fine. As we say, the estate trustee or the legal representative of the estate does have the right to provide consent and to access information.

Denise, you had a question?

AUDIENCE MEMBER: I was just going to say, shouldn't that Statement Number 2 include a requirement that the adult daughter would provide informed consent before you proceed to release the information to the -- to the lawyer?

RICK MORRIS: Well, the responsibilities for that would really be the same. The adult daughter or -- with the adult daughter or the client are -- responsibilities in terms of consent remain the same.

Number 3. Number 3 is too strongly worded. There's no reason why you -- there's nothing that says you have to refuse, that it's not permitted.

Yes. Question?

AUDIENCE MEMBER: (Indiscernible).

RICK MORRIS: Combination of 2 or 3. So your combination would say something like, yes, I'll release it to you, but...

AUDIENCE MEMBER: (Indiscernible).

RICK MORRIS: Right. But be very -- please understand that these are just my recollections. They may or may not be accurate. That -- that kind of thing. Right. So you're releasing some information based on Number 2, the right of the individual to get it. But then you're also making it really clear that you can't be 100 percent sure, because these are 11-year-old recollections, and you may or may not remember the client. Some of us remember clients really well that we saw many, many years ago, and others are obviously just a blur.

Question behind you, Stephanie?

AUDIENCE MEMBER: What about relevance? Do they need to show that it's relevant information that's 11 years old?

RICK MORRIS: Do they have to show it's relevant? I don't believe that's one of the requirements under the law that it has to be relevant. Because in this kind of a situation, it

would really be up to the courts and the Court to decide in this suit -- case that I made up, suing the facility, whether or not it's relevant. It wouldn't be up to us to say, well, we don't think this information is relevant and related to whatever your case is, so we don't want to provide it. So, really there you may have that conversation. You may want to get consent to speak to the lawyer and have a conversation about whether it's relevant or not, but that isn't enough reason for us to -- to deny.

Okay. So that's been through all of them. So, you know, the adult daughter has the -- the authority to sign off on the report. But we -- if we're going to prepare a report, we would want to make sure that we were really qualifying it quite heavily, because it's so -- it's so old.

But then, after struggling with the situation that we just talked about, you recall -- you discover you actually still do have the file, lo and behold. The lawyer is now requesting your full clinical record. You now know that the client's adult daughter is able to authorise this request.

In reviewing the file, however, you

discover some highly sensitive and secret information about the family, information you feel could result in serious emotional harm to a number of family members. Okay?

So the -- what are we going to do? The adult daughter has the authority, so what are we going to do with this one? Are we going to release the information to the lawyer on an agreement that he not share the information with the family? Release the file to the lawyer as requested, since you've received proper authorisation from the legal representative of the estate? Since the mandatory retention period has passed, shred the file and lie like you thought you had so that it's no longer a problem? Release the file but withhold the sensitive information, as you believe it's likely to result in serious physical or psychological harm to family members or others? Require the lawyer to go to court and get a Court Order, similar to what we said before? In this case, it's because of the harmful information it contains. Review your practices for shredding files to determine how this one was missed, contrary to information discretion policy?

What are you going to do now? And this

is not necessarily an usual circumstance in terms of information that you might have about a client. And it may be information that the family doesn't know. And it may be information about the family that is very sensitive, personal, potentially damaging information. What are we going to do? 1, 2, 3, 4, 5, 6?

Okay. Let's see. Do people like Number 1?

AUDIENCE MEMBER: No.

RICK MORRIS: No. I don't like Number 1 either. I mean, the lawyer is working for the family. That's just not going to work.

What about Number 2? You have the authority from the legal representative of the estate, so...

AUDIENCE MEMBER: Yes.

RICK MORRIS: Yes? It's good? Okay. What about Number 3? Let's take care of the problem.

AUDIENCE MEMBER: Yes. Yes.

RICK MORRIS: You know. Let's just not mention it to the lawyer that, oops, found it.

Okay. Number 4?

AUDIENCE MEMBER: No.

RICK MORRIS: No? Yes? No?

AUDIENCE MEMBER: (Indiscernible).

RICK MORRIS: 4 in combination with 5? 4 in combination with 5, I heard. Okay.

What about 6? Yeah, 6 is probably a good idea. I mean, if your policy is and you want to be able to confidently tell a lawyer or the courts at the end of 10 years, according to the College, I shred my files, you don't want to then find that, oh-oh, this one's here, and this one's there. That's not good for your credibility if you ever had to sort of say, yes, for sure this is what I do with files.

All right. So, actually, just in running through these quickly, I mean, you could do Number 5, but once again, you're into -- you possibly are into some difficult territory. Yes?

AUDIENCE MEMBER: Once you've shred your files after the 10 years, do you have to keep any information at all? Like the name of the client or anything?

RICK MORRIS: What we usually recommend is keeping the name, maybe the date of birth as an identifier if you have people with similar names and the date that the file was shredded. Some

people have the date of initial contact and the date it was shredded, but at least you have a list of who your -- who your clients were, so if you're asked, did you ever see so and so, you can say, well, I don't remember, but let me check. And you can look through, and you can see that, yes, they were a client, but I no longer have information about them as opposed to, I have no idea if I ever saw them or not. So that tends to be what recommended practice.

Okay. Actually, any of you that said Number 4 is actually correct. PHIPA does permit the withholding of information if you believe it's going to cause serious harm, physical or emotional, to some other person. It -- it fits with a deceased client. It also fits with a non -- a living client that we have that -- the authority to withhold that information.

Now, when we do that, you have to indicate that you have withheld some information and what the reason was. It's a good chance that's going to trigger curiosity more than anything else. It's not going to be the end of it.

But there is a process within PHIPA, and it involves the privacy commissioner where the

individual can then go to the privacy commissioner and lodge a complaint that you've withheld information that you feel -- that I, as the adult daughter in this case, feel is necessary and that I want.

The privacy commissioner then has the authority to review the file and decide whether or not the reason I withheld it was good enough. And so then say that's fine, and not take it any further. Or tell me -- order me to release that information. But there is that appeal process available to the family.

But, initially, if we're that concerned about information that's in there, we have the -- have the authority under PHIPA to withhold it and make that extra step -- or force that extra step to happen.

Question?

AUDIENCE MEMBER: One over here.

RICK MORRIS: Okay.

AUDIENCE MEMBER: Rick, I'm wondering if you would kind of do the equivalent of that but do it ahead of time. So call the adult daughter, say, look it. You know, I'm happy to release the file. And, you know there's some sensitive

information here that I think may be hurtful. Do I have your permission to withhold that for now?

Or, you know, if it's possible, do I have your permission to just put it kind of in a sealed envelope in the file, and, you know, if you want to open Pandora's Box, go ahead, but this how I have kind of decided the information, you know, could be managed? And see if you get their consent that way as opposed to just making that call yourself and then having them appeal it?

RICK MORRIS: Right. Certainly the first part, indicating to them that you're going to withhold some information and you just want to let them know so when they get this file that has a bunch of redacted stuff, that they aren't totally surprised.

The second one, I'm not sure about. I guess it would depend on how concerned you are about the information.

The example I like to use, and some of you have -- some people have heard me say this, so if you've seen an adult female client and what you find out is that somewhere along the line, she had an affair, and the three daughters -- and actually this daughter that's the adult who is the legal

representative of the estate is actually not the daughter of the father that she thinks she is. They thought there were three sisters in the family, all sisters. Actually, one of them had a different father. But nobody knows. You and the client are the only ones that know that. Nobody has any -- nobody else has any information like that. Not sure you want to just sort of say, well, there's some secret stuff in this envelope. Open it at your -- at your peril.

So, I mean, that -- I tried to think of something really, really dramatic, and that was the best I could come up with. But that might be enough for me to say, I don't feel that I'm going to just share this information with the family, because that could be explosive for a lot of people in that family. I'm going to require that -- I'm going to withhold it as per PHIPA, and I'm going require something else take place before I -- and I'm going to be sort of compelled to and let the privacy commissioner take a look at it.

Question over there?

AUDIENCE MEMBER: So what happens if the file discloses information about somebody else? What about their privacy?

RICK MORRIS: For example? Like?

AUDIENCE MEMBER: Like if there was sexual abuse and it's named somebody and it's not public knowledge.

RICK MORRIS: I think -- I mean, it doesn't have to be about the family. You get to decide. You make a clinical judgment as to the volatility of the information. And you could then say, you know, no.

I mean, think about this person is operating as -- as the client. Now, if it was the client asking for release of information, this information, you would have a conversation with them about, okay, I hope you remember that back on Session 5, we talked about all of this stuff. Are you sure that you want that released?

This way, we don't have the client to be able to have that conversation. We can't have that conversation with one of the people involved in this situation in terms of explaining what the issue might be. So there is the -- the way in which we can handle it under the law without having to -- to sort of say, whoa, I really don't want to do this, but here it is.

AUDIENCE MEMBER: Sorry. I might have

missed it. But in submitting the file that you withheld certain information, do you have to make a note explicitly that you withheld some information, or are you just --

RICK MORRIS: You have to let the person who is requesting it know that there is some information has been withheld.

AUDIENCE MEMBER: Okay.

RICK MORRIS: Yes.

AUDIENCE MEMBER: Just wondering how relevance, Rick, factors into our discussion, relevance of the information.

RICK MORRIS: It depends on -- I mean, I don't think -- as I said before, relevance isn't really part of it, and so it's not really our job to decide whether this is relevant to the case. I mean, a client can ask for a copy of their file. And we might think their reason for it is really a bad reason, but if they're a capable adult, they get to decide. And so it may not be relevant to case, but it's really up to the family and the family's lawyer to determine the relevance as opposed to us determining that.

Dan?

AUDIENCE MEMBER: Yeah, that may be. I

was just going to say something the same, Rick.

Often the first thing I'll do if they get a request is to talk to the lawyer and ask why the information -- what information they need and why they're asking. Sometimes that can leave you open to problem solving and saying just to get around some of these tricky issues.

RICK MORRIS: Sure. You can certainly speak with the lawyer and see whether or not you can get around it without having to send a redacted file, just providing certain information. But it may not be this kind of a case. It could be that a family, after a suicide in the family, wants the file. They want a file, because they need to get some answers. Like, what happened? What's going on? We're sort of so, you know, shaken by this thing. And they want to get the clinical file just to see if there's something there that will help them get some closure or answer some questions they might have.

And in that case, you know, it could be that there was information about the family that you don't feel -- not that you don't want to share, but you don't feel you should share given the volatile sensitive nature of it.

All right. Barry's giving me the signal here.

Barry? Okay.

So as you have -- in terms of the handout, there's probably -- there's two or three more scenarios. Watch for the next bulletin, and I will go through them in the next bulletin and give you an explanation. If you have any questions about it, please write me and let me know. And if there's any questions come up about any of these things after the fact, I'm happy to try and answer them.

(APPLAUSE)

BARRY GANG: Thank you, Rick.

One of the least pleasant parts of my job is interpreting Dr. Morris' tricky issues. It's something everybody loves, and we can never get enough of it. So apologies for that. We've cut into about 20 minutes of Dr. Hunsley's time, and he's got a lot of information to share with us that is really valuable.

Dr. Hunsley, many of you who have been members of the profession for a while know or at least know of.

He's a professor of psychology and

director of clinical psychology doctoral program at the University of Ottawa.

He's authored over 140 articles, chapters, and books on assessment, intervention, professional issues and evidence-based psychological practice.

He's a fellow of the association of state and professional psychology boards, the CPA, the CPA clinic psychology section. He's also a recipient of the CPA award for distinguished contributions to education and training in psychology.

He consults with health care organisations and professional psychology associations, presents workshops on evidence-based psychological practice and has a private practice focussed on the assessment and treatment of mood, anxiety, and related disorders.

As if that's not enough, he's also very generous with his time to the College, and in the couple of decades now that I've had the privilege of meeting with John and seeing him on -- on a committee level, I'm always very impressed by his thoughtful contributions and always felt this is a person really to listen to.

So having said that, I'd like to ask John to come up.

JOHN HUNSLEY: Okay. Thank you.

Thank you, Barry. And it's quite an honour to be here. I was doing okay until I heard there was 2,000 people watching, so no pressure. No pressure at all.

The fact that you have the slides already, I think, will be quite important, because I will take questions. I'll break at certain points. But given the time crunch that we're under, you already know what I'm going to talk about. So you can prepare yourselves if you do have questions or make notes on the handouts, so when I do stop occasionally, I'd certainly like to have questions from you.

So knowing that -- it works. Knowing that you know everything already, here's what I'll be talking about this morning.

Starting off with a little bit about why evidence-based practice is needed, at least perhaps from a different perspective than you're used to hearing about this, and then talk about the whole gamut of what's involved in evidence-based practice, assessment, treatment, and therapy

relationships. And then hopefully have considerable time to also talk about what you can do with all of this in your efforts to continually enhance your practice and your skills.

The issues around evidence-based practice have probably been going on for at least 25 years. I've been contributing to that in some way for probably two decades.

And I think we're at a rather interesting point right now, and I say that for at least three reasons.

One is compared to what it was like 20 years, 15 years ago, the heat has really gone out of the arguments. I think that indicates that we're coming to a much more comfortable position for most of us in psychology, recognising what evidence-based practice is and isn't. And some of the extreme positions for and against this seem to have faded away largely because we found ways to come up with ensuring that our clients get the best from science in a way that works for, hopefully, the majority, if not all of us, as practitioners.

I also see that there's been a change in terms of the incoming classes that I teach in the first year in a clinical program. It's now the

case and has been for a number of years when you make the statement. And in our program, you know, we focus on evidence-based practice, and this means this, this, and the other thing. And the students sit there blankly. And I ask many questions: What's your lack of reaction about? And the typical response is, yeah, of course. This is the way it should be. That certainly was not the way it was 30 plus years ago when I started at Ottawa.

The final thing that I would say that gets us to where we are now where I think most of us are comfortable with the idea of evidence-based practice is that consistent with the scientist practitioner model that most of us have been trained in, we're actually using all the evidence, not just randomised control trials. We're using information about assessment, yes, about treatment outcome, but also about therapy relationships. And I think that gives us a much more accurate rounded picture about what evidence-based practice can be and should be.

So with that as my overview, let me move on a little bit to talk about why at least I think evidence-based practice is quite important for our clients.

And what it really comes down to for me is, no surprise to any of you there, we're all human beings. We make mistakes. We are vulnerable to the same kind of cognitive errors, decision-making errors, biases that everyone else on this planet is going to make.

So we know, for example, and as you'll see in just about every slide, any time I make a statement that comes from the research literature, I've included the reference. So you can check up on me, if you wish. Sometimes I got a bit squished for space, so I don't have the full APA style reference, but you should be able to find it.

So we know we're like other people. We make errors in our decision-making a lot, just like everyone else. We're not very good at self assessment, just like most people. We're not even that aware of our biases or, if we are aware, one of my favourite biases is called the spotlight bias, which is we know human beings make errors, cognitive biases, they're everywhere, but not for me. You know, I'm different. Okay. We can all fall back on that one and continue to make as many errors as everyone else in the world. We simply know all of this from decades of research. We know

that we -- we'll make mistakes in our clinical work.

If we move specifically to look at certain aspects of psychological service provision, we also know that this does have the potential to impact our clients.

So, for example, we're not very good at being able to detect clients who are not going to do well with our services, at least not early on in the service provision where we could make some modification to treatment plans in order to -- to help them achieve what they're hoping to achieve.

The second point strikes home for me, because this is a study I did at our training clinic. We looked at clinical files, rated why people ended services, and after treatment ended, we actually contacted clients to talk about why did you end services? Did you get what you wanted?

What we know from that study at least -- and this may hold for your other clinics where you work -- we're not very good at detecting successes. We have a pretty high standard for what counts as a success.

You know, the analogy is you take your car in for service to get the oil changed, and the

mechanic says, yes, you need all these other things. And you say, no, I'm the client; I just want an oil change.

Well, in this context, we're the mechanic. We can see all the other things that, in an ideal world, we could help the person with. But that's not always what the person wants.

In addition, when we went through the files, and these were files completed by trainees under the supervision of registered psychologists, we couldn't find any statement in any file where the client said they stopped, because things were getting worse for them. No statement at all to indicate that the clinician, trainee clinician, and the supervising psychologist were aware of that. They may have been, but it didn't go in the file.

So we're not good, I would suggest, at detecting failures, potential failures, and all of the successes that our clients have.

The final one for any of you who had to do reference letters or evaluations for anyone will ring true. In a research study when you ask therapists to rate how good they are, everyone -- almost everyone is in the top 25 percent. Okay? Can't be that way. But you know that.

In the last decade or so, there have been several initiatives in North America to develop practice research networks where, essentially, often dozens or hundreds of clinicians work together to gather data from their day-to-day work on important research issues generated by the clinicians who are providing the services. One of the studies that I think is quite important to know about comes from Pennsylvania, where there were data collected from over 6,000 patients, clients.

Most of the therapists were social workers or mental health counsellors. So if you stay with the safety of being -- using your cognitive biases, you can always say, well, that's not us. Probably is too. And they simply were asked to rate at the beginning of services how their clients were functioning on a number of dimensions, as you can see in the slide. And, again, at the end, to rate how the clients were doing.

What was learned in this study is that not everyone improves. We know that. But most importantly, I think, most clients were helped by -- let me put it the other way.

Most therapists were able to help the

majority of their clients make changes in certain areas, hopefully the areas that were most relevant to the client.

However, there were certainly a number of therapists who, in the study, were described as harmful in that a number of their clients -- not just one or two -- but routinely got worse on certain dimensions.

These were not primarily psychologists. Nonetheless, they have the same kind of ethical approach, I'm sure, and the same set of values that we have. They don't want to do this, but that's what's happening. Inadvertently perhaps or through inattention that they may not have been adapting their services when something external to treatment occurred that started to lead the client down the road to deterioration.

I don't know if any of you read this article when it came out a few years ago in American Psychologist, but I think it created quite a storm, because if you had to pick authors who had written most of their careers in support of the importance of the therapeutic relationship, trusting therapists, developing therapist skills, it would have been the authors of this article in

American Psychologist.

And, therefore, I think a lot of people paid attention to their conclusions, which were essentially that years of being registered, for example, don't make you better. Put another way, simply not having complaints brought against you and being struck off the record, if you will, is no indication that you're doing well.

In fact, there are studies that have been done recently tracking therapists over a short period, five-year period. Most therapists get a little bit less helpful with their clients over time unless they're actively doing things to keep their competence high.

One of the reasons that this becomes a problem for us is that although experience, per se, is not associated with helping clients, experience is related to our self confidence in our own abilities, and that's what we're going to act on. We think we know what to do, and we think we know where we're competent.

What they've argued and what has led to some efforts recently and some that you may know about is to develop strategies to engage in deliberate practice. That is, what's missing? Why

do these clinicians who want to help their clients -- what's stopping them?

And what the authors concluded is, really, there are two things. One is we don't collect enough data in our clinical practices to know how we're doing session by session. Or over the course of a number of clients where we need to make improvements, the clients are not improving the way we would like to see. And we rely on cognitive biases like, I think I'm doing well. I'm in the top 25 percent of therapists, so it's got to be those clients who don't want to change.

So the effort that's now being developed -- and probably some of you will be reading the books or even taking some of the workshops in the coming decade -- is to engage in deliberate practice, to identify things based on ongoing assessment feedback from your clients where you need to improve, and making that a focus of your, I don't know, maybe every two-year self assessment for the College.

So I've mentioned cognitive biases, cognitive factors a number of times, and that's really where I'm coming from in this, that I want to emphasise that it's not that we're bad people.

It's just that we're people. We have all the cognitive errors possible that everyone else has.

And that's just part of being human. If anyone's read any Kahneman's book or any of his research, he talks a lot about two cognitive systems. There's a fast system, System 1 for lack of a more colourful name, which really is automatic. It's based on, you know, your biology, your experience. It happens immediately.

System 2 is much more thoughtful, rational. You weigh the evidence, you think about things. And as Kahneman writes and as we all know, each of these systems have their value in certain situations.

So, for example, I'm going to stay car focussed. Having wandered the streets of Toronto last night, that became quite important. The System 1 -- the fast one, automatic, no thinking involved -- is really good if you're crossing a street appropriately with the walk sign, and a car comes at you. You're not going to stop and think, what's the probability of this driver with that kind of car -- because it was a Volvo, so it's a safe driver. What -- you're going to jump out of the way. Right? System 1 is going to save you

there.

On the other hand, you've checked to find the new car, that safe Volvo, on your browser. And for the next three weeks, those ads pop up all to the time in every site you go to.

Well, relying on System 1 would say oh, geez, everyone thinks Volvo is good. I should buy that Volvo.

System 2 hopefully comes into play, and you think about the costs, the alternatives, you weigh things out. Each system has its own place.

And part of the problem that we have as clinicians is relying too frequently on System 1. It has its place at times with clients but not engaging enough with System 2 to get us into trouble.

One of the other things that Kahneman talks about in his book is we're story tellers as human beings. We tell stories about ourselves, about everyone. That's how we understand the world. And in his research, he found that if you can tell a really good story about something, you'll believe it. You really will believe it. It affects your confidence in your story. And what makes a story a high quality confidence-inspiring

but probably inaccurate story? Personal details.

I had a former classmate come up to me just before the talk saying when did I get gray? Well, given that I'm gray, I pay attention to retirement things. So being in Toronto, I thought I should choose an example from The Globe and Mail -- it was from last year -- about why so many people when they have gray hair and are thinking about retirement hold -- do not hold off on taking their Canada pension. People take it far too soon.

If you look at longevity of Canadians and the fact that you get more CPP the longer you wait to take it, people on average are taking it far too soon, saving the government hundreds of millions but taking it far too soon. Why?

Well, according to at least one journalist, it's because knowing one person close to you who died young is more compelling than knowing all the mortality statistics. We're influenced by stories, and the plural of case examples is not data. Knowing one or two people who died early, unfortunately, does not mean you should take your pension early.

These heuristics and biases that I've been alluding to feed into making a story

compelling, and here is one of the best examples I've ever encountered from many, many years ago.

You all recall from probably intro psych a serial position effect, that if you're given a list of whatever, you'll tend to remember the first and the last more than the things in between.

Well, bear that in mind when I tell you the story from one of Nisbett Wilson studies many decades ago. They went out into a store, set up a little -- I guess we'd call it a pop-up shop now to ask people to rate different products, laid out identical -- whether they were nightgowns or nylons -- bear with me. That was the language from the study. Okay. Nightgowns and nylons. They were all the same. And between participants, they would switch them around.

You know, there was no difference. It was the same whether it was a nightgown or a nylon. The majority of the participants thought the last one that they looked at, touched, considered was the highest quality, was the best one. When the researcher said, you know, why was that? Well, it was the best. Well, is it because it's the last one in the row? And they looked at the researcher

kind of strangely. No, it's the best one.

So clearly we had a serial position affect going on. Participants had no knowledge of it, but they told a great story about it being the highest quality nightgown, and they were convinced that's why it was the best one.

So to take you from a nightgown to something hopefully a little bit more clinically relevant with the warning that I'm going to use personal details to try to convince you of the importance of what I'm about to say. Okay. So you've been warned about that. I'm going to try to tell you a good story with personal details. All right.

For those of you who have never seen an image like this -- I'm trying to avoid any problems with using copyrighted images -- there is a card on the thematic apperception test, if you've ever seen those, with a male figure who may or may not have clothes on climbing up or down a rope. Okay.

Well, that's the closest I can get without being sued.

And so this was in the first assessment I did as a graduate student. We had learned the mighty battery of the WAIS-R -- tells you how long

that ago this was -- the TAT, and the Rorschach.

And so we were doing an assessment. I was doing this assessment under supervision, of course. And the client was a mid-30s male who had recently been divorced, having panic attacks, was depressed, using alcohol to self medicate, and his physician was quite concerned.

So through the assessment, using those instruments, came to the conclusion that, yes, he had a number of problems, but a number of strengths. And the supervising psychologist turned to the story from this naked man climbing up or down the rope card saying that really represented this client's strengths, 'cause it was about this person -- there was a story the client told -- who was fighting to save his family, that a fire had happened, and he was climbing down to get his children -- he didn't have custody of the children in his life -- and he was going to look after him -- them.

And the supervisor -- my supervisor said, well, that's really an indication of his strengths, and that's also like with panic attacks. Because with panic attacks, you're fighting to breathe. You're fighting for air. And this guy is

a fighter, and that's going to serve him well.

So, yes, in our report, we concluded there were some concerns, but, overall, this strength would see him through. Okay.

Now, a number of years later, I'm preparing to teach a course. And at the time when I did the assessment, panic disorder had just recently shown up in the DSM. We didn't know much about it at all.

I was horrified when I read this article several years later preparing a course where having panic attacks actually greatly increased your risk of suicide, even taking all the other factors into account.

Now, hopefully we did what was necessary with the assessment and the person is fine even to this day. Hopefully. But this one really hit home to me, that we didn't know this evidence at that time of the assessment. But potentially, boy, did we -- I -- get it wrong. Okay?

So personal story. I'm sure that you can all find some of your own that map onto that where you find out something from the research later that maybe wasn't available or maybe you

should have checked, and it makes you concerned about what you did. This for me -- this collection of issues around cognitive biases is why evidence-based practice is so important, because you keep relying on the evidence not just from published studies but from what the clients are telling you. You keep going back to that and making sure you're on track with your clients.

So evidence-based practice, to get to the point of this, is really about providing the right services that have the greatest chance of working based on the evidence that the client needs. And being accountable, being as efficient as possible for both the client and any other payor of the services.

Of course, you don't just take the research evidence and run with it, applying it willy nilly to all clients. You have to take what you know about the client and find the appropriate balance to make it work for the client.

So you should be asking your questions like the following when you're doing evidence-based practice. I know this about the research for someone with the characteristics, diagnosis, personality characteristics, whatever.

I know what the research says, but for my client, is my client so different from the participants in those studies that the evidence really doesn't apply? Maybe it is, but more often than not, it probably is the case that your client is not that different.

If the evidence applies, do I have to adapt it in some way to make it really work, fit for the client? And given that the nature of the setting in which I'm working, are there others ways that we have to adapt it?

So, for example, if the research suggests that the optimal approach would be have the person in both individual and group treatments, do I actually have access to those in the service setting that I'm in?

Those are the kinds of questions that I think you need to ask yourself at the outset with the client in order to start the process of doing evidence-based practice and minimising -- reducing the likelihood of your cognitive biases entering into the service you provide.

Let me stop at this point and just see quickly if there are any questions. We will be having a break, so don't worry. That's going to

come up soon.

Okay. So you've all seen these kinds of models before about what goes into evidence-based practice, the evidence, client/patient preferences, your experience, and where they intersect is supposed to be evidence-based practice. I just need to put that up, because I like things flying in from the side of the screen. But that's what it's supposed to be all about. Hopefully for most of us, the intersection of those three circles is a little bit bigger than what I've put there. But that's the idea.

And that's true, whether we're talking about psychology, social work, nursing, medicine. The same model is used across health care disciplines.

For those of you who have been around for a while, you will recall the early days back in the -- probably '93 as a start, where the movement towards evidence-based practice actually started with a very different initiative that was called empirically validated initially and then empirically supported treatments. That's not evidence-based practice. It can be a component of

it, but it's not the same thing.

The evidence -- the empirically supported treatment and approaches, some of which continue today, are relevant in terms of setting some standard for how much research evidence do you need in order to be confident that a treatment is likely to be helpful for a certain problem?

That can be useful information, but that's not the only way of looking at treatment outcomes. And what evidence-based practice tends to do is not use a standard cut-off of at least two RCTs, but you try to use the services for your client that have the strongest evidence. And it may be that whatever has the strongest evidence has far more than two RCTs, or it may be the kind of problem you're dealing with is so unusual, so rare, that there really is only one or two case reports. If that's all there is, then that's probably what you're going to go with, even if there's no RCT.

Okay. So I just want to emphasise that for those of you who remember empirically validated or empirically supported treatments, evidence-based treatments and evidence-based practice is a much broader way of looking at using research evidence.

What I will be looking at with you this

morning, as I've said already, is looking at assessment, treatment, and therapy relationships altogether. I think those are the ones that have to come together for us to really be using the best evidence available.

And, again, going back to some of my initial comments, I think we're at a point where most professionals now see these three components as being maybe not equally important but all important. Whereas, initially, all that was available was guidelines or evidence on treatment outcome, per se, we now have a lot more on assessment and certainly a lot more on therapy relationships.

So I am going to go in the order that's listed here, and I'll talk more about that when I get to the therapy parts. Let me start with the assessment.

So nothing earth shattering here, I don't think, around assessment. We should be using research and theory to guide how we assess our clients both at the outset and throughout our service provision. We should be considering the kind of methods and measures that are most appropriate for the assessment. Can we simply use

self-report measures for clients? Do we need performance measures of some type? Do we need to get informant information from teachers, parents, family members? What does the research say about that?

And the research can often be surprising. I mean, there's -- there's some reviews, for example, in the ADHD literature suggesting that you don't need a huge range of informant data, but you need informants from a -- an informant from school, an informant from home. You need the different context, but you don't need multiple informants on each one, which can save a lot of time and money for your clients and also perhaps allow more time to be devoted for treatment services if you cut back on assessment.

You also need to think about in evidence-based practice how you put all of this together. I've just given the example of multi informant data. Anyone who does collect clinical information from parents, teachers, or family members, spouse, you'll know that they never fit together. I mean, almost never. And the correlation in reports is typically very low. That's to be expected.

But there is something about the context in which the person sees the client or the relationship with the client that's important to pick up on the discrepancies between informants. All of these kinds of things need to be considered in evidence-based assessment.

When we move to talk about treatment, I'm going to strongly suggest that what is the way to approach evidence-based practice is looking at an initial evaluation of the problems the client has, the clients have, as a way to not only help you understand the client but to help you have an entry point into the research literature about treatment options.

That's not where you stop, though, of course. You have to work with the client to develop treatment goals. You have to make sure that the treatment is being implemented successfully, by which I mean, of course, that the client is getting better, as you're hoping. And you need to be strongly considering that as you're monitoring your client throughout treatment, to not just look at how the problems are being addressed but if there are other issues that you want to monitor as well, such as your alliance with the

client.

Skipping ahead, as we know in your handouts, we'll be talking about therapeutic alliance, and you all know that there's a fairly robust correlation without. So attending to that throughout treatment, there's a lot of merit for considering that.

When you go to select measures, it's pretty common -- and I can tell you this from sitting on many dissertation committees over the year -- for at least students and maybe some of you in the audience to select a measure based on the fact that everyone else uses it or the name. You know, well, I want to measure adult depression. Everyone uses the BDI for depression, so that's what I should use. Maybe.

You actually need to look at what the research data are and whether it's relevant for your client. And you need to factor into this kind of decision-making a number of issues. What do the psychometrics look like? And as this is usually the point where people tune out, because it's psychometrics and it's boring, I'm just going to give you a couple of examples that my colleague Eric Nash (phonetic) and I use in our assessment,

that workbook.

You need to have appropriate norms for the measure. And we've tried to come up with a classification system that's really simple: adequate, good, and excellent. You can see it there for norms. I'm not going to repeat it, but I am going to explain why I've underlined relevant.

A student I supervised a few years ago for her dissertation, Zoey Tevien (phonetic), focussed on anxiety measures used with older adults. And in the systematic review that we did, we were astonished to find that the commonly used anxiety measures with older adults, I think two of about a dozen had norms for older adults, and those two were developed specifically for older adults.

The majority of the measures used clinically and in research context for older adults assessing anxiety, there were no norms for that age group. That's a problem.

Internal consistency, usually psychometricians don't want to give values, and they'll say things like, well, how long is a ladder? It depends what you're going to use it for. I can't tell you how long your ladder should be. Well, for clinical purposes, I'm telling you

the length of your ladder. Okay? This is what most test and measurement people would say would be appropriate.

Likewise for overall construct validity, again, I'm not going to go into details, but you need to have evidence that the measure does what it's supposed to do for the kind of populations you work with and that it's relevant for your client.

Now, about this point, the issue always comes up: But they're so expensive. I mentioned the BDI. Hope I don't get sued, but it is expensive. Okay? There are lots of alternatives. In fact, in the most -- the second edition of the Assessments That Work book, Jackie Person's chapter on measures for adult depression, they made a decision to only review measures that were free. They didn't include the BDI. And this is from a pretty prominent person in depression treatment. There are a lot of measures that are free and short and easy to use and have good psychometrics and good norms.

There's always concerns too that if we assess clients, they're going to -- that's somehow going to have a negative impact on the alliance,

especially if we're assessing them session after session. There isn't a huge amount of research on this, but what there is suggests that's not actually a problem for the majority of clients. They think it makes sense to monitor how they're doing. That's what's coming out of the progress monitoring literature.

And even going beyond that in situations where clients are actively involved in writing notes into the file, the collaborative documentation, clients like that. So it really isn't an issue that clients are upset by filling out some measures or being asked how they're doing routinely.

What we do have to be careful of, though, is that we don't have a lot of evidence that the measures we've developed in psychology necessarily have clinical value. Good psychometrics, sure. But do they make a difference clinically?

And so the example I want to give you is the MMPI-2. This was an experiment at a training clinic. All the clients completed the MMPI-2. Half the clinicians got feedback on that, half didn't. All the clients could get feedback on

their own, to be ethical about it, but not from the treating clinician.

And then they looked at treatment outcome. Did the clinician having the MMPI-2 results make a difference? Essentially, no, even though there is at least one scale on the MMPI-2 that's directly keyed towards appropriateness for a readiness for treatment.

Let me stop there, see if there are any questions.

So I'm not going to say anything more about assessment. And in a couple of minutes, we'll have a break.

So any questions at this point?

AUDIENCE MEMBER: Yes. Thank you very much. And basically in putting together the -- the puzzle called an assessment is a baseline and the derivation of the monitoring. Two components, and this is that because of the very frequent turnaround of psychometrics that are now available on the market, the issue of self-report questionnaires in general. So this is one component. And the -- even if the norming -- the baseline was very good.

And the other one is an increasingly

multi-lingual or multi-cultural community, self-report is in the eye of the beholder, not only in the eye of the feeler of -- of what is reported. So if you could, in two seconds or less, talk about it?

JOHN HUNSLEY: Sure.

AUDIENCE MEMBER: Thank you.

JOHN HUNSLEY: Well, in fact, the language of a measure is incredibly important, because simply because you have a translated measure doesn't mean that the psychometrics for that measure are what they should be. I will be showing you -- or, no. I will be discussing in the second half some sites you can go on to, and there are validated, psychometrically sound measures in literally dozens of languages. So for any of you who use the -- you know, who want a short anxiety screener or a depression screener, the GAD7, the PHQ9, there's a link in the website to -- again, you can download for free multiple language versions all with good psychometrics.

So that helps, but it's not going to deal with everything. And I think the bigger issue is, as clinicians, we know that a lot of factors go into a client's self-report.

There are a lot of reasons why a client might exaggerate or minimise, and I think good clinical practice means that you use that score as one source of data, but you're looking for consistency in how the client interacts with you, reports on his or her daily life. That becomes very important too, especially if you take into account why the assessment is being done. If there's some potential benefit to the client, you always have to have that as a hypothesis to consider.

We probably have time for one more.

AUDIENCE MEMBER: I have some -- some difficulties with the MMPI-2. Quite often, I would find the psychologist is saying that this is the gold standard, and the reliability and -- and validity, I think, is completely off.

For example, I've gone to Vietnam, in different places in Vietnam, whether it's north or south. They're both two different countries. They are trying to make them into one, but they're very different. And yet still the research will say, well, we -- we did an assessment of Vietnam. But there's no such thing as -- as a Vietnam . There's a place Phu Quôc, which is tail end of Vietnam from

south of Vietnam, and then you have the northeast coast and -- from Hanoi. And it is very different.

Or one of the very worst things they can day, we have done a study on the west Indians. There's no such thing as west Indians. There's west Indian islands, but the culture is very different even from -- from, let's say, Trinidad, from Port of Spain, which is the capital, to Lebrai, which is the south, they're very different. The language is very different. Their idioms are very different. And yet still we will have psychologists saying, oh, this is the gold standard, and it's the only test which are being used. I'm thoroughly against it. Thank you.

JOHN HUNSLEY: I think the one takeaway from evidence-based practice is you probably should not ever have a gold standard for anything, that, depending on the issue involved, there may be something that has more evidence than other measures, for example. But that does not make it a gold standard.

Additionally, as with any measure, there are going to be times where it's not an appropriate choice for a client because of culture, because of language. And I think our professional

obligation is to use the measures that we think are most appropriate, but then in our reports, to indicate our -- any reservations we have about the appropriateness of the measure.

So, yes, I can fully support what you're saying. You have to use everything you know in determining how to select a measure and how to interpret it, not just because everyone else uses the measure.

So let me stop there.

BARRY GANG: So we're going to be really rigorous about time, because there are all kinds of people outside of the room. We're scheduled to start again at 11:00. I was going to say we should cut the break to 10 minutes, but I think we already have, so we'll see you back here at exactly 11:00.

(ADJOURNMENT)

JOHN HUNSLEY: Okay. We need to start up again. Sorry for the shorter break, but I hope you're all enjoying your coffee and cookies and whatever else Rick has. Yogurt. Yogurt. Okay .

I am aware of the time because of some of the challenges we had with starting, so I'll try -- we'll definitely get through the material,

but I won't be as -- elaborating as much as I have so far.

That being said, I'm just going to contradict what I just stated, because I want to take a moment now when we move into the treatment side for evidence-based practice. I am going to start by looking at evidence-based treatments first and then evidence-based therapy relationships. To me, they're both critical. You have to have both.

But I'm well aware that in the field, there have been many debates and probably continue to be -- will continue to be many debates about which one is more important. And I really don't think it's an either/or. It's combining them using the best treatment evidence we have available in developing a plan -- treatment plan for a client along with what we know about the therapy relationships.

And there are a number of ways you can look at this. So one possibility is thinking about if you go to any plays in Toronto or Stratford. You know, there's a script, but there's also the actor's skill. And at one point, I was thinking there's this wonderful clip from a charity presentation in the UK where very famous British

actors are doing the, "To be or not to be, that is the question. Whether it is nobler in..." That one. And they changed the emphasis by one word and get a very different effect.

So we don't have time for that, but I can -- if you come up afterwards, I can tell you where to find that on YouTube, just to be or not to be, Judy Dench, Benedict Cumberbatch, Prince Charles. You'll find it. Okay.

But the point is you have a script, you have the treatment, but the delivery makes a huge difference. You want to get the script that matches, if I stay with the analogy, what the client needs, but it's your acting skills that are going to bring that script alive. So I think you really need both. Likewise, there's a lot of research on which accounts for most variance. Is it the treatment or is it all the relationship factors?

And, yes, at some level, you can run those analyses. But to me, it's kind of like taking a really good chocolate cake, and you can make it gluten free or vegan, but a really good chocolate cake, okay, whatever it is for you, and trying to deconstruct what made it so good, because

you've got different ingredients, you've got different quantities of ingredients, you've got what you mix in first, you've got the temperature of the oven. But at the end, you've got a cake. I don't know how you can deconstruct it to determine what's the most important set of ingredients or processes.

So that's what I would invite you to bear in mind as I talk about things today, that we need both the treatment literature and the therapy relations literature. And although I think, statistically, you can artificially pull them apart, I don't think that represents our reality.

And I don't even know why you would want to. Why wouldn't you just want to capitalise on the best of everything for your client? So that's my perspective that we'll be going into for the next several slides.

Okay. We're into evidence-based treatments. And you've all seen, I'm sure, this kind of pyramid talking about the quality of evidence that ideally you want to be selecting as the starting point for treatment planning with your client, a treatment that's as high up that pyramid as possible. Expert opinion doesn't cut it. Case

studies, okay, if there's nothing else.

Ideally, you want to be relying on accumulated aggregated research and systematic reviews and meta-analysis. But, again, that's true across all health care disciplines when you talk about evidence-based practice.

With any luck, you've seen this kind of modification to that pyramid from the CPA task force on evidence-based treatments. Essentially, you still want to be higher up the pyramid, but we tried to also incorporate the fact that qualitative research sometimes plays a role. It doesn't just have to be meta analysis, but it's -- it's looking at, overall, the internal and external validity of the aggregate studies that becomes important.

And then the important addition is the box about treatment and the arrows, that we think it's in that task force, thought it was very important that you keep assessing, you keep drawing upon the client feedback, because you might need to go back to your pyramid and modify your treatment and find something else to do that's going to help your client more or in addition to what you're doing.

So I'm now going to take the stance of

telling you why evidence-based treatments should be considered for use with your clients. I'll soften it a bit in a few slides, but I'm going to start with the stronger version now.

We know that when clients receive evidence-based treatments through RCTs, that about two-thirds will improve or recover in different indices. And using the same kind of index of recovery or improvement, studies have been published with very large samples of real world practice environments showing that those improvement rates in the real world don't hit the two-thirds that you often will get in the RCTs.

So it looks like, from this research, that there's a gap, that the RCTs can bring something possibly that real world practice at least as -- and, see, I'm already waffling -- as indicated back at the early part of this century was doing.

That was based on adult research. The same kind of thing shows up with youth interventions, that we know that compared to treatment as usual, the effect size is about .3 for evidence-based treatments . In other words, about a third of a standard deviation greater improvement

if you received evidence-based treatment than treatment as usual.

Now, the issue is often what does a third of a standard deviation or a D of .3 really mean? Well, I've tried two different ways to depict what it means, that the average youth getting an evidence-based treatment was better off after treatment than 62 percent of those getting treatment as usual.

Or that the number needed to treat how many clients would have to get, in this case, the evidence-based treatment in order to get one more successful outcome compared to what would have happened if they had the treatment as usual.

In this case, it's six. Six clients getting evidence-based treatment to get one more successful outcome than would have happened with the treatment as usual.

The numbers for NNTs, you'll see that a lot in medicine. Usually anything under -- certainly under 10, under 15 seems pretty powerful.

At some point, I may need some help here. My screen just disappeared. So I'll look at the -- over here, because my monitor has gone out.

Another example -- and, again, I'll

briefly -- just briefly describe this. A training clinic in --

No. The monitor has just died here. I'll just look here, so thank you.

A training clinic in Florida where they changed their procedures for providing services that, in 1998, they changed to a situation where all services provided had to be evidence-based, and that actually expanded the scope of clients they could work with. They turned away before, for example, people with personality disorders and a history of suicide attempts. After this, they were able to provide services.

But what they did was compared the outcome of clients prior to this when it was essentially treatment as usual to the time when it had to be an evidence-based treatment. And what they found consistently is much greater improvement compared to what they had been providing before. In other words, the switch to providing only evidence-based treatments not only expanded the range of clients they served but also led to better outcomes for the majority of clients.

Okay. Here's where I soften things a bit. Remember at the outset I said one of the

weaknesses we have as clinicians is that we're people and we make mistakes? One of our strengths is that we're people and we learn. So I think it's important to recognise that what was treatment as usual in the 1990s and even in the early part of this century -- millennium, probably -- isn't the treatment as usual anymore.

That even if someone isn't fully adopting evidence-based practice approaches, there's probably been an incorporation of a lot of evidence-based elements in treatment as usual. And there's some indication to suggest that this may be the case.

So you've probably all heard of the initiative for improving access to psychological therapies to try to deal with treatments to start off with for adults with depression. Well, the first maybe controversial point was that people got training -- clinicians got training only in CBT. And the developers were very clear; we have to start somewhere. I'm going to start with CBT, and then we'll add other things. Well, they've added other things.

And one of the things they've added is a form of person-centred counselling based on the

research about what we know about depression and what works in treatment for depression that is not CBT. And it has comparable effects to CBT in this very large country-wide -- or two country-wide project.

Now, that's a win. Even though I do CBT, that's a win. Not everyone wants to provide CBT. It doesn't fit, if you will, for all clinicians. But to have multiple approaches that work, what could be better?

Likewise, there have been studies coming out more recently in training clinics showing treatment as usual is getting better. Or I shouldn't say that, because there isn't the pre/post. Is -- appears to be more effective than it was 10, 15, certainly 20 years ago. And I think that's probably due to the fact that there's more and more elements that evidence-based treatments creeping into, informing, infusing -- choose the word you want -- regular treatment.

So just to give you an idea, if you took that pyramid and looked at what's at the top four conditions -- so I'm going to focus primarily on mental disorders, but you'll see some others later.

If you look at what we have treatments for -- and I'm not going to go into what orientation, what flavour. Just we have treatments that look like they work fairly well. Let's start with kids.

For all of those, doesn't mean every client is going to improve, but we have pretty good research evidence about treatments that should be used for those kinds of problems. For any of you who work with youth, you won't be surprised at all -- well, you definitely won't be surprised. You've got the outline already. There are more on the list for adults. Right? That's always the case.

Doesn't mean the treatments are close to as effective as we would like them to be, especially when I look at things like substance related disorders and eating disorders. But we have treatments that are pretty effective compared to other alternatives like medication.

Sorry. Should go back. I was too fast.

And it's not just disorders. There's a lot of other conditions we have affective treatments for . Again, not perfect, but we know

that they'll help -- have the potential to help a lot of people.

And the assessment person in me just needs to point out at the bottom that for all of those conditions, all of the disorders, we have psychometrically strong assessment measures that are available -- most of them are free -- to assess those things.

Continuing with the good news, if you will, about the IPT in the United Kingdom, we have multiple treatment options that are known to work well for a number of conditions. Probably the best example is adult depression. Again, it's not everyone who is going to benefit from therapy. We've still got a lot of work to do. But we have a lot of different treatments when provided appropriately that we know work.

Same as with PTSD. That used to be what we would talk about trauma focus and other -- well, that terminology seems to be used less frequently, which is why I've gotten past focus and the present focus. But there are different approaches that work.

That doesn't mean we have that multiple option approach for every disorder.

We don't have many for OCD that tend to be in the cognitive behavioural camp. But as -- I think CBT has had a head start for decades, because it's part of the model that you collect data. You do the research. As that's adopted more and more by clinicians and researchers from other orientations, we're getting more evidence. So I don't see it as problematic. This is a win. There are multiple approaches that can be of benefit. That's good.

What becomes important is for us to learn how to do not every one of them but some of them. I'll never learn how to do short-term psychodynamic, but I can do multiple forms of CBT for depression. Apply that to yourself. That's what's important.

We all know that there are transdiagnostic approaches that are emerging, and that's important for a couple of reasons. One is based on the psychopathology research. We know that there are some common elements that underlie a lot of at least the internalising disorders in children and adults.

So what I've described here for you is David Barlow's unified protocol for dealing with

mood disorders, anxiety disorders. And the evidence seems to be coming out that it's as effective in treating those specific disorders as a treatment developed specifically for that disorder. And it's still early days, but the evidence seems like this is working well.

And the second reason why transdiagnostic approaches are important, you can apply this one treatment model to a range of presenting problems. You don't have to know -- again, the data continued to show this -- that it works as well as, say, panic control treatment for panic disorder. You don't have to know multiple disorder-specific treatments. You can get an awful lot of benefit for your clients with this. That's -- Barlow's isn't the only one, but it's probably the one most researched.

On the child side, it's taken a different approach. Not so much transdiagnostic, although the unified protocol is now being developed for work with adolescents, but it's been much more focussed on identifying common elements that, for example, Bruce Chorpita has done looking at treatments that work for kids and seeing what are the components that seem to be salient and then

mapping those components like problem solving, like relaxation, like interpersonal skills training.

On to discrete client problems. So if you've never gone to his company -- and it is a company, -- his website PracticeWise, I would strongly encourage you to take a look. It is absolutely amazing. For an annual subscription, you get -- and, again, I have no -- I have no horse in this race or no shares in this either. But you get handouts for clients. You get -- you can enter in your client's presenting problems, age, gender, ethnicity, and it will search the literature for you and tell you the kinds of elements that you might want to consider for treatment. It has an assessment dashboard that tracks progress for you across the session. It's -- it's a very nice package.

The question often comes up -- probably less than it used to -- are evidence-based treatments -- sure, they're effective, but it's only for those who are really not that badly off to begin with.

That's not what the evidence suggests. In fact, there are studies showing that the participants who are included in RCTs for these

kinds of treatments often have more severe symptoms, psychopathology, than would be seen in some clinics. They'd be turned away from clinics, maybe having to go to specialty clinics.

And it's not just the case that you try to get just a pure depression, for example, whatever that might be, if anyone has ever seen that, no other problems. And all you have to do is look at the NIMH collaborative study 30 years ago. Yes, it was a treatment of depression study, but almost all the clients had a Axis II -- as it was known at the time -- personality disorder. They weren't screened out. So these are real clients being taken into these trials.

So, again, because of time, I'm not going to go into the details. You've got my notes there.

We're now in a situation where I think we have RCTs on most common disorders. The starting point for some of what Chorpita did with PracticeWise goes back to when he was at University of Hawaii, and there was a legal case that was brought in Hawaii from parents of a child who didn't get appropriate services. It basically led to evidence-based treatments being mandated for all

youth in the State of Hawaii.

And then they -- when researchers looked into who was receiving services, what their problems were, there was a pretty good mapping on to whether or not evidence-based treatments were available. Not perfect, by any means. But, again, this is 13 -- some 20 years ago, this would have been conducted. It's pretty good at the time, and I'm sure it's gotten even better.

We know that if you take those RCTs and look at how successful they are and then look at the literature of when they're implemented in real world clinics, they do pretty well. At least potentially, they do pretty well. Lots of things can go wrong, but if implemented appropriately, the success rates you see for RCTs can be replicated in real world clinics, real world settings for adult and youth problems.

So let me stop there before I go into the therapy relationships part. Any questions or reactions so far? There's one hand back there.

AUDIENCE MEMBER: So I am really glad to see that you differentiate the evidence-based treatment from evidence-based practice, because they are different.

So I read a statement from a -- a psychotherapy networker, which I agreed, that they say when lots of people saying evidence whatever or practice or treatment knowledge based, a lot of time, they're actually saying manual-less treatment. So I wonder, what do you think about that?

JOHN HUNSLEY: From what you're saying, that would imply that manualised treatment is a bad thing. Should I conclude that?

AUDIENCE MEMBER: Well, it's not necessarily a bad thing. It's just -- like you said, it's just part of the component of the entire practice.

JOHN HUNSLEY: It certainly is in a treatment study. However, do we have people who are trained -- I'm going to pick -- just I'm not going to go with CBT.

Anyone trained in doing emotion-focussed couples work or individual work?

Do you follow a manual, roughly speaking, in private practice? There are nods. Right? A manual is not a straight jacket. It's -- it's the script. It's a guide. And you can improvise -- staying with the acting -- based on

what the client needs and what's happening. So it's not a straightjacket. I think most evidence-based treatments will start with a manual, suggesting these are things that you need to cover, but the sequencing and how much you devote time to one topic versus another is going to be a matter of your clinical judgment.

So, yes, they're probably based on manuals, but I don't think manuals are necessarily a bad thing if applied appropriately.

AUDIENCE MEMBER: Thank you.

JOHN HUNSLEY: Probably need to move on. That's -- sorry. Just aware of the time. I want to make sure we have time to do the third important component of evidence-based treatment. And that's evidence-based therapy relationships.

And probably one of the strongest proponents of this has been John Norcross over the years. He's now making far more money on his books than I am, because he's got a two volume set from Oxford for evidence-based therapy relationships. But it's a -- I highly recommend it, even though it's two volumes, to buy the two volumes. It's very well done.

If you don't want to do that and you

have access to e-journals, condensed versions of all the chapters were published in 2018 in Journal of Clinical Psychology and in Psychotherapy. So you can find them without having to buy the book and giving John royalties. I also have a picture of John in a wet suit when we were in South Africa shark diving, but I decided you didn't need to see that. We'll just go with this.

So this work from Norcross and now colleagues both Mike Lambert and Bruce Wampold has really developed nicely over the years, building a case with very strong meta-analysis for the importance of a range of therapeutic relationship factors.

And if you want to get into the politics of this, there still is an either/or. I mean, it's APA's clinical division that promotes the evidence-based treatments and the same with the child and adolescent division. It's the psychotherapy and counselling psychology division that's promoting the relationships. But people do talk to each other and increasingly attend the same conferences. So there is much more cross fertilisation occurring.

Anyway, to get to the point about

what's -- what we know from the research evidence that really makes a difference in terms of therapy relationships, they had a ranking system based on the strength of the evidence. So I am presenting here first it's just demonstrably effective. It's really the pay attention category. There's a lot of evidence.

So we know that alliance, therapeutic alliance, is a strong predictor, usually at the correlation of about .25-ish. So is goal consensus and collaboration. I've put them up in the same bullet point, because many of the commonly used measures of alliance actually have subscales of goal consensus and collaboration. So I don't see them as separate things.

Cohesion and group therapy, empathy, who is going to argue with that? And there's a lot of evidence that empathy is important. Positive regard, affirmation, being congruent and genuine, and collecting and delivering client feedback. And I'm going to spend some time on that in a few minutes.

So those are the relationship factors in terms of things you can change. You can adapt your treatment and your style. Paying attention to

the client's culture, religion, spirituality, and preferences makes a difference.

Less evidence that reactant stages of change or coping style makes a difference, but some.

And certainly when Norcross talks about these things, what his recommendation is, the ones that are demonstrably effective, choose three or four to focus on and intentionally try to improve on that. One isn't necessarily more important than the other, but you can't do all of them all the time and still pay attention to your client. Try to work on improving your skills with your client in a small number of these.

So to cut to the chase, what the task force suggested are the following. To be optimal -- optimally helpful to clients, use both the therapy relationships -- evidence-based relationships and evidence-based treatments -- that are adapted as appropriate to clients.

So it's not a fight between evidence-based treatment and evidence-based therapy relationships. Use them both. Remember that the alliance is important.

And, again, for me, I do CBT work.

It's pretty easy to train people about the important of the alliance when you're doing exposure work. You're going to ask the client to face things that they are most frightened of in the world. If you don't have a good alliance, it ain't going to happen. No. Pay attention to client characteristics and adapt your treatment appropriately.

Assess, assess, assess both how the client is doing and how you or the two of you are doing on these dimensions. For many years in our training clinic when I was supervising there, at the end of every session, the trainees would have the clients I was supervising complete a therapeutic alliance measure. And if necessary, that would be brought up as an item to discuss at the next session if something had gone wrong, basically. It doesn't take long, and you can build it easily into treatment.

Now, for those who are critical of evidence-based therapy relationships, these are the things that Norcross and colleagues bring up. Yeah, a lot of these are not based on experimental designs. It's correlational. But the evidence is pretty consistent and strong. We don't know a lot

about how disorder-specific effects might influence these characteristics. And, of course, you know, being genuine, being empathic, having a good alliance, those are not individual, separate ingredients. They're related to each other. But why not try to maximise as much as you can?

Okay. This one I'm going to have to do fairly quickly so we can be respectful of time. But delivering -- or collecting and delivering client feedback is really quite a central part of what comes out in the therapy relationships literature in contrast to how clinicians usually see it. So a colleague of mine, George Tasca, developed a practice research network in Ottawa a number of years ago, and one of the things that we did was a larger survey across North America of clinicians about what your research priorities would be.

Of the 41 priorities we surveyed on, getting more research on treatment monitoring was ranked Number 38. No one really cared. They could care less. But as you'll see in just a couple of minutes, the effect of using this treatment feedback is as powerful as choosing whether or not to do an evidence-based treatment or paying

attention to the alliance. We know that a few Canadian psychologists are using this, although those getting training now, probably the majority have heard of them and may be trained to use these measures.

Different terms are used, different names are there. I'm going to flip between progress monitoring, treatment monitoring. But these are all the kinds of terms that get used to referring to collecting data on a regular basis on the -- how the client's doing, how the relationship is doing. There are different measures.

The outcome questionnaire from Mike Lambert, it does cost a little bit to use this. But depending on the size of your practice, it's pretty minimal. I mean, I'm talking about less than a dollar a client. There's a lot of evidence early on using just minimal, almost like a -- sorry. Getting stuck in French. (FOREIGN LANGUAGE) Staples. A Staples intervention.

Clients completed the feedback, but all the therapist got was on the outside of the client file a sticker from Staples: red, yellow, green; red meaning the client is not improving, may be deteriorating; yellow means some progress, but not

what you would expect; green means you're on track.

Based on that little evidence, just getting that feedback compared to getting no feedback led to greater client rates of improvement and lower rates of deterioration. Since then, Lambert's gone on to actually let clinicians read the feedback and use it, not just have the stickers.

So, overall, it looks like there is an effect for feedback that's important, especially for clients that are identified as not doing well, and those are the clients that, if you remember at the start of my talk, were not good at identifying those who will not benefit from treatment.

The OQ is not the only game in town. The PCOMs is available. Again, a slight cost, but it comes with the opportunity as the DOQ to provide this to clients on a digital -- on an online form. And you can summarise your data for your client and for your practice. And, again, very similar kinds of effect sizes. It makes a difference if you use this greater client improvement. The same is true for other systems when used with youth services.

So it doesn't cost much to do this. It doesn't take long to do. At our training clinic,

when we did a small survey of clients, most of them were quite comfortable completing this.

The one issue that I can say we don't have a good answer for from the research literature or the implementation literature is there are clinicians who rightly or wrongly are concerned that this might be used to evaluate their performance. And that will be an issue that has to be sorted out in your clinic and your systems of care, because that, in all likelihood, is not an appropriate use of these kinds of data, because it doesn't take into account case mix. You may be the person who gets all the difficult to treat clients, whether based on personality characteristics or presenting problems. But for these others, doesn't cost much, fast to do, clients don't mind it.

Even when the studies show that it hasn't had much effect on treatment outcome, a Dutch study found that it actually led to more efficient services. Which meant not only did it save the client or the health care system money, the client got better sooner. Which is a great thing. We can all agree.

So this is just pitting one thing against another. If you look at the effect size

for collecting and using ongoing progress monitoring data, the effect size for using an evidence-based treatment compared to treatment as usual, and the effect size for the alliance, they're not hugely different. But the important thing is you don't have to choose. You can do all of them. Focus on the alliance. Base your treatment on an evidence-based treatment that's likely to work for the client and monitor progress.

Let me stop there for a question maybe before I get on to what was going to be a longer part. But as Barry had said, you can send questions in. They will answer them, I will answer them.

AUDIENCE MEMBER: (Indiscernible).

JOHN HUNSLEY: Yeah.

AUDIENCE MEMBER: (Indiscernible).

JOHN HUNSLEY: Yeah. Yeah. I'm not sure if the microphone was working, so I don't know if everyone else heard that. But the issue is the importance of actually assessing the alliance so that we don't assume things about the alliance that may not be true. Okay.

So let me continue to the last section of my presentation, and that is so, obviously,

you're fully convinced that you need to do all of these things. How do you go about it? And I just have a few suggestions for you. One involves keeping up to date, which you're all doing anyways, especially with our super ego sitting over here, making sure that we're saying the right things.

It also means building up a library of measures that you can use for the kind of clients you see, emphasising therapy relationships in the context of evidence-based treatments, monitoring client progress, reviewing your practice to see how you're doing and where you may need to improve, and on the basis of that, refining your skills.

So Paul Kelly was kind enough to give me a printout, because he uses the PCOMs. Does anyone else use the PCOM system? Okay. So as part of the software, you track how the client's doing. And then you push a few more buttons, and suddenly you see how your practice is doing. And you have -- what was it? How many years of data did you say? 10 years of data on how many clients? 12,000 clients. That's pretty good data for seeing how you're doing with different types of clients and setting up your goals, which I'm sure Paul has done for his every two year quality assurance

activities and where to focus efforts on learning to do things better.

So one of the things that is a challenge for many of us is you can't use books and articles anymore. They're just not going to be up to date. Things are changing too quickly.

You have to look at guidelines and websites. And the books can be useful, but you really are going to have to learn how to search through a lot of websites. And I'll include some in the following slides.

What this does mean is putting a lot of upfront investment. And, frankly, it doesn't have to be done all at once. You can take time when you're not at work, down time devoted to cat videos on YouTube and just going on to one of these websites and searching around. That's really the best way to do it, just kind of looking what happens when you push links. That's what most of us are not good at. Most of us learned how to use Psych Info or med line. They're not going to give you the kind of information you need. They're not what helps for you to implement things clinically.

So there are books that are out there about evidence-based practice, strengths,

weaknesses, how to implement. There are things around assessment, treatment, and the relationships that work.

But there's an awful lot of websites. So do people know NICE? Have you gone to NICE? Not NICE (FOREIGN LANGUAGE) but NICE. Okay. So some people.

It is a -- here's what -- if you learn nothing else today, you'll learn what a QUANGO is. A QUANGO is a quasi non-governmental organisation. And NICE is a QUANGO that's set up separate from the government, but it sets standards for the National Health Service to follow in England and Wales.

They have amazing information on how to assess and treat at different levels of severity and different steps of intervention, most of the disorders that we will see in our client base.

The Cochrane library provides systematic reviews of the evidence. Evidence-based behavioural practice gives you an overview of how to understand evidence-based practice and how to search the evidence yourself.

And there's a McGill website with lots of these links. Go and try them. See what you can

find. Lots of little short videos describing how to implement, for example, progress monitoring.

If you're really going to do evidence-based assessment, you are going to, as I say, have to develop your library of measures that are relevant and that have appropriate psychometrics. They're free, the majority of them. You just have to look around.

For example, all of those except for PracticeWise are free. The promise measures on the top, there are literally -- well, not literally. There are scores. It's well over 100 different measures across age groups, Spanish, English -- I'm not sure other languages. All psychometrically sound and free to use. You can either print them out, you can have them delivered online to clients.

If you're doing PTSD work, you can get free self-report measures, semi-structured interviews. The depression and anxiety screeners, all free.

There are a number of systems currently available. Green Space is one that I know some people are using where they either come with some of these measures built in or you can have the measures added in .

And, again, your clients can complete these online before they come to the clinic. In our training clinic, they sit in the waiting room with an iPad and fill it out before the session. The client -- we're not using Green Space yet, but we will be. But the OQ is completed before the session. It's on the computer. So the trainee sees that before the session starts and knows if there are things that need to be dealt with immediately from the OQ symptom responses.

I focussed an awful lot on psychometric nomothetic measures, but there's an awful lot to be said for idiographic measurement. And this is an example of something that John Weiss uses in his research and in their treatment. Even though they have people fill out the You Self Report or other versions of the child behaviour checklist, they found that that didn't necessarily capture well what the clients, the youth, or the parents wanted in treatment.

So what they did was to ask what are the top three problems that you're having that you would like to have dealt with in therapy? And my example is worrying about really bad things happening. And you just track how that's going

every session.

What Weiss found was that although many of the items did map onto the child behaviour checklist if you know the measure, it didn't always show up in subscales that were at the clinical cutoff. So you might not have paid attention to them. But they were issues that were centrally important to the clients or their parents. So consider using idiographic individually oriented measures, not just the nomothetic ones.

As I said a bit earlier, think about the relationship factor elements and make some conscious decisions about what you want to try to improve. Do some reading, talk to colleagues, consult, and focus on doing that for a period of time and hopefully assess things with your client to see what impact they're having.

You can also -- if you track how your clients are doing with some kind of monitoring system, you can also look at how your practice fares compared to those benchmarks from the RCTs that I showed earlier. If there isn't a good fit, you're not achieving what you think you should, the evidence says you might be able to, that may be an area to target for skill improvement.

And that all feeds back into the College activities. We know that if you're going to declare a new area of competence or a new practice area, a new population, you need to do a training plan, you need to see a certain number of cases under consultation/supervision. You can do the same for yourself here, that if it turns out that you've learned with certain types of clients, you don't have the level of effect that you're hoping to have and you haven't kept up with the research literature on this, you might decide that you need to learn a new form of treatment. You go to the two-day workshop, you get a sense, you read the book, but then you can arrange with a colleague, sometimes informally, sometimes formally through the training clinics, training centres, to be supervised or get consultation to improve your skills. That's what we're supposed to do if we add areas to our declaration of competence. There's no reason you can't do it for yourself if you self-identify some limitations.

A few more examples of books you can consult, websites that have lists of treatments. At one point, I thought I'm going to show you all these tabs, all the websites, but you can do that

yourself. You can copy and paste.

So the big challenge, I think, for all of us in trying to be evidence-based practitioners is it can -- it's a lot of work, and it will take us out of our comfort zones, because you have to keep questioning yourself. And as we tell our clients all the time, change is difficult. Difficult for us too. It takes time. You have to be self-critical. You have to think about what you want to be good at. We know from a lot of literature on health care delivery that the way to get good at something is by doing a lot of it with feedback, which may mean it's hard to be a generalist. Which may be especially challenging in areas where you may be the only psychologist or the mental health provider for a very long distance.

So there can be realistic limitations on how much you can learn or specialise in a treatment of any kind of problem, but you at least need to ask yourself these questions. What do I need to do to improve, and how does that fit in with where I'm working? And the last point, what does that mean for my income for many of us?

So evidence-based practice, to sum up, is about using all the best evidence to benefit our

clients, to make sure we're delivering on the service that we say we're going to deliver that's science-based and to help us and our students, trainees become better at helping clients.

It really is not about a competition between orientations between clinicians and researchers. This has got to be about clients. That's why we're here. That's why we're doing what we're doing. And I hope this can help you.

So thank you very much for your patience. I think we have time for a couple of questions, but thank you.

(APPLAUSE)

JOHN HUNSLEY: So there's one back here.

AUDIENCE MEMBER: I'm sorry to take more of your time, but there's one thing which I just want to summarise what you're saying is that we seldom get stuck between therapy and therapeutic intervention. I can go to the best therapist in the world, and he prescribes or she prescribes therapy. It isn't worth a damn thing to me. I can go to a barber and tell him all my problems, and he listens, and he carefully listens. And that becomes therapeutic. And that's where the problems

sometime comes with psychologists. They don't know the difference between therapy and when the therapeutic intervention takes place.

JOHN HUNSLEY: M-hm.

AUDIENCE MEMBER: And we are concerned about that.

JOHN HUNSLEY: So let me just take what you're saying and ask you all to think about what you do when someone says to you, a close friend or a family member, I have some difficulties. Can you recommend a psychologist? If you're like me, the first thing I do is try to find out a little bit about the problem so I know in my mind who I can scroll through who's trained to do that. That's the first step.

The second step is based on what I know about my family member or friend, I then think about who might be a good match interpersonally.

So hopefully it captures both those things, the kinds of things that you're alluding to. It's not just being able to do the treatment, it's being able to do the treatment in a humane, interpersonally appropriate way and hopefully better than the barber.

AUDIENCE MEMBER: (Indiscernible).

JOHN HUNSLEY: Yes. You've got to have the relationships there. Has to.

One more.

AUDIENCE MEMBER: One thing that you said really stuck with me is the notion that there is no gold standard treatment. And obviously evidence evolves. A lot of the talk, which I found excellent, was about clinicians, considerations to follow evidence-based practice.

Do you have any recommendations at, like, an organisational level what can be done, particularly if there is an effort to adopt evidence-based practices and then, you know, five years later, three years later, what should organisations be doing to consider the evolution in evidence?

JOHN HUNSLEY: Sure. So at a systems level, I think psychologists need to be involved in a number of ways.

One is you have to be a very strong proponent, advocate, for appropriate implementation of evidence-based treatments, 'cause sometimes, as we all know, that simply means what can we do that's going to be the fastest and cheapest to do? And you really need to be able to make a case to

the administrators at the agency or system about here is what the evidence suggests, not just in the short-term but the long term.

And then I think it also -- then the next step is moving into the whole knowledge dissemination phase. How do you implement? How do you train people? And then what happens? How do you maintain competence? Is it a train the trainer approach that, you know, once you're trained, you can teach other people to do it? Or do you have to bring in others?

But I think the -- the overall message of what I think needs to be conveyed to the administrators is this is not a one-time decision. You've got to keep revisiting it. You've got to keep evaluating not just what the literature on the best practices say but your own services. Are we doing what we thought we would be doing with the service? Or do we need to do something different?

So I think psychologists in the training we get around consultation and how to understand research play a central -- very central role.

I think we need to wrap up so everyone can have lunch and get on with their day. Thank

you very much. It's been wonderful.

(APPLAUSE)

BARRY GANG: So thank you very much, John, from helping move us along from external super ego to hopefully a more integrated ego institutionally.

I appreciate that you have been able to catch up on the time, even without a working monitor. It's really impressive. You've given us a lot of really relevant information about how to be deliberate and actively reflect on what we're doing and to use objective information to decide where to go next and even point us to some of that. And it's been tremendously helpful.

As always, thank you to Rick, whose tricky issues are really actually very tricky today and inspiring. To the staff who have really worked hard, particularly Stephanie and Caitlin (phonetic), who -- who put a tremendous amount of work into getting these events off the ground, one of which is to have organised having a survey that's probably in your mailboxes already, and especially after today, but always we pay a lot of attention to your survey information.

One of the things I find most valuable

in looking right away is to see about how to plan the next one and what people are really interested in finding out. And hopefully we'll see you all again in about six months or so. So thank you very much.

(APPLAUSE)

---Whereupon audio recording concludes.

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