

In the Matter Of:  
Re: Barbara Wand Seminar

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December 11, 2019

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Toronto, ON M5K 1A2  
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RE: BARBARA WAND SEMINAR - DEC 11, 2019,  
December 11, 2019.

DURATION: 2:21:38

PREPARED BY:  
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TEL. 416.413.7755

1 ---Upon commencing:

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

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

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

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

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

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

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

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

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

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

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

25 BARRY GANG: Thanks, Michael. So a

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

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

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

23 And --

24 AUDIENCE MEMBER: (Indiscernible).

25 BARRY GANG: Pardon me?

1 AUDIENCE MEMBER: (Indiscernible).

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

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

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

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

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

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

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

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

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



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

6 So here is Rick.

7 (APPLAUSE)

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

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

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

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

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

4 AUDIENCE MEMBER: That's a threat.

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

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

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

19 AUDIENCE MEMBER: False.

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

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

1 prohibited dual relationship?

2 And how many people like false? All  
3 right.

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

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

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

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

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

10 AUDIENCE MEMBER: True.

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

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

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

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

7 AUDIENCE MEMBER: (Indiscernible).

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

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

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

24 Yes, question?

25 AUDIENCE MEMBER: (Indiscernible).

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

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

18 Yes?

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

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

1 AUDIENCE MEMBER: (Indiscernible).

2 RICK MORRIS: Right. Right. Okay.

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

8 AUDIENCE MEMBER: False.

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

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

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

22 AUDIENCE MEMBER: True.

23 AUDIENCE MEMBER: False.

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

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

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

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

16                       AUDIENCE MEMBER: False.

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

22                       AUDIENCE MEMBER: True.

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



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

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

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

25 So it really is a time consuming, mind

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

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

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

1 Which of the following best describes  
2 your actions?

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

18 Does that mean you don't like my Number  
19 5? Is that what that means? Okay. So I'll take  
20 that as saying that we have 1, 2, 3, or maybe 4 as  
21 opposed to 1, 2, 3, 4, and 5. What do you think?  
22 3?

23 AUDIENCE MEMBER: Yeah.

24 RICK MORRIS: A lot of people are  
25 saying 3?

1 AUDIENCE MEMBER: 1.

2 RICK MORRIS: We have a 1.

3 AUDIENCE MEMBER: 2 over here.

4 RICK MORRIS: 2. 2 over there. 1, 2,  
5 3. 4? Question?

6 AUDIENCE MEMBER: (Indiscernible).

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

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

14 RICK MORRIS: Right.

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

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

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

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

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

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

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

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

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

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

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

10                        Denise, you had a question?

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

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

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

25                        Yes. Question?

1 AUDIENCE MEMBER: (Indiscernible).

2 RICK MORRIS: Combination of 2 or 3.

3 So your combination would say something like, yes,  
4 I'll release it to you, but...

5 AUDIENCE MEMBER: (Indiscernible).

6 RICK MORRIS: Right. But be very --  
7 please understand that these are just my  
8 recollections. They may or may not be accurate.  
9 That -- that kind of thing. Right. So you're  
10 releasing some information based on Number 2, the  
11 right of the individual to get it. But then you're  
12 also making it really clear that you can't be  
13 100 percent sure, because these are 11-year-old  
14 recollections, and you may or may not remember the  
15 client. Some of us remember clients really well  
16 that we saw many, many years ago, and others are  
17 obviously just a blur.

18 Question behind you, Stephanie?

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

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

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

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

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

25 In reviewing the file, however, you



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

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

25 What are you going to do now? And this

1 is not necessarily an usual circumstance in terms  
2 of information that you might have about a client.  
3 And it may be information that the family doesn't  
4 know. And it may be information about the family  
5 that is very sensitive, personal, potentially  
6 damaging information. What are we going to do? 1,  
7 2, 3, 4, 5, 6?

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

10 AUDIENCE MEMBER: No.

11 RICK MORRIS: No. I don't like Number  
12 1 either. I mean, the lawyer is working for the  
13 family. That's just not going to work.

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

17 AUDIENCE MEMBER: Yes.

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

21 AUDIENCE MEMBER: Yes. Yes.

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

24 Okay. Number 4?

25 AUDIENCE MEMBER: No.

1 RICK MORRIS: No? Yes? No?

2 AUDIENCE MEMBER: (Indiscernible).

3 RICK MORRIS: 4 in combination with 5?

4 4 in combination with 5, I heard. Okay.

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

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

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

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

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

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

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

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

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

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

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

18 Question?

19 AUDIENCE MEMBER: One over here.

20 RICK MORRIS: Okay.

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

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

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

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

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

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

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

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

22 Question over there?

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

1 RICK MORRIS: For example? Like?

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

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

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

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

25 AUDIENCE MEMBER: Sorry. I might have



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

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

8 AUDIENCE MEMBER: Okay.

9 RICK MORRIS: Yes.

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

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

24 Dan?

25 AUDIENCE MEMBER: Yeah, that may be. I

1 was just going to say something the same, Rick.

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

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

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

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

3 Barry? Okay.

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

13 (APPLAUSE)

14 BARRY GANG: Thank you, Rick.

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

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

25 He's a professor of psychology and

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

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

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

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

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

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

3                   JOHN HUNSLEY: Okay. Thank you.

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

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

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

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

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

5 The issues around evidence-based  
6 practice have probably been going on for at least  
7 25 years. I've been contributing to that in some  
8 way for probably two decades.

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

25                  Most therapists were able to help the

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

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

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

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

1 American Psychologist.

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

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

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

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

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

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

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

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

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

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

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

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

1           there.

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

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

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

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

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



1 but probably inaccurate story? Personal details.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1           come up soon.

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

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

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



1           it, but it's not the same thing.

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

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

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

25                      What I will be looking at with you this

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

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

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

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

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

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

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

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

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

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

1 client.

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

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

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

1           that workbook.

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

14                        So any questions at this point?

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

25                        And the other one is an increasingly

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

6 JOHN HUNSLEY: Sure.

7 AUDIENCE MEMBER: Thank you.

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

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

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

12                  We probably have time for one more.

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

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

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

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

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

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

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

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

10 So let me stop there.

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

18 (ADJOURNMENT)

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

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

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

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

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

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

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

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

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

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

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

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

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

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



1 studies, okay, if there's nothing else.

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

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

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

25 So I'm now going to take the stance of

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

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

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

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

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

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

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

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

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

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

25 Another example -- and, again, I'll

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21                  Sorry. Should go back. I was too  
22                  fast.

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 youth in the State of Hawaii.

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

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

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

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

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

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

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

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

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

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

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

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

11                        AUDIENCE MEMBER: Thank you.

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

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

25                        If you don't want to do that and you

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

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

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

25 Anyway, to get to the point about



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 AUDIENCE MEMBER: (Indiscernible).

16 JOHN HUNSLEY: Yeah.

17 AUDIENCE MEMBER: (Indiscernible).

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

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



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

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

14                        So Paul Kelly was kind enough to give  
15          me a printout, because he uses the PCOMs. Does  
16          anyone else use the PCOM system? Okay. So as part  
17          of the software, you track how the client's doing.  
18          And then you push a few more buttons, and suddenly  
19          you see how your practice is doing. And you  
20          have -- what was it? How many years of data did  
21          you say? 10 years of data on how many clients?  
22          12,000 clients. That's pretty good data for seeing  
23          how you're doing with different types of clients  
24          and setting up your goals, which I'm sure Paul has  
25          done for his every two year quality assurance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 every session.

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

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

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



1           yourself. You can copy and paste.

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

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

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



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

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

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

13 (APPLAUSE)

14 JOHN HUNSLEY: So there's one back  
15 here.

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

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

4                           JOHN HUNSLEY: M-hm.

5                           AUDIENCE MEMBER: And we are concerned  
6           about that.

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

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

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

25                          AUDIENCE MEMBER: (Indiscernible).

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

3 One more.

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

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

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

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

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

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

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

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

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





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