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Psychotherapy progress and outcome monitoring in the real world of private practice

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Abstract

The Canadian Psychological Association (CPA) Task Force on Outcome and Progress Monitoring (OPM) in Psychotherapy recently issued a lengthy report recommending widespread implementation of OPM in publicly and privately funded psychotherapy practices and urging the CPA to change its Canadian Code of Ethics for Psychologists to require psychologists to give progress monitoring testing procedures weekly. This recommendation also extends to all practising psychotherapists. Although the Task Force offers many valid arguments for why OPM is important in certain clinical contexts, it fails to take into account psychologists and psychotherapists who are in private practice, including those whose training, experience, and expertise directly challenges such sweeping generalisations. In addition, it is largely out of touch with clients' needs and preferences, as well as the diversity of therapies they seek and require. It ignores practical, financial, and ethical parameters for such mandates and fails to note how the therapeutic relationship, frame, and quality of treatment could be drastically transformed by technocratic impositions. Finally, it appears to be motivated by political considerations rather than optimal treatment standards in private practice environments. I address many problems linked to the Task Force's directives and broad oversimplifications, arguing that current practices show more

fidelity to the real world of private practice and privilege the right to maintain independence in clinical judgement rather than follow a superimposed, prescriptive model governing psychotherapeutic praxis.

KEYWORDS
Canadian Code of Ethics for Psychologists, ethical practice, outcomes, private practice, progress monitoring, psychotherapy, third-party funding

1 | INTRODUCTION

The Canadian Psychological Association (CPA) Task Force on Outcome and Progress Monitoring (OPM) in Psychotherapy (Tasca et al., 2019) recently issued a lengthy report with recommendations that have profound implications for professional psychology and psychotherapy in Canada, as well as potential implications for other countries who may adopt these practices. With international implementations in public healthcare sectors adopting excessive managerialism, cost-efficiency standards, and hyper-regulation of psychotherapeutic praxis, the United Kingdom, Australia, New Zealand, and the United States could be equally in danger of becoming increasingly institutionalised. The OPM Task Force recommends widespread implementation of OPM in publicly and privately funded psychotherapy practices and urges the CPA to change its Canadian Code of Ethics for Psychologists to *require* psychologists and psychotherapists to adopt OPM procedures—but those of a certain kind. The Task Force specifically wants all practitioners of psychotherapy, regardless of background, training, and educational models, to use a variety of psychometrically sound tests and measures to monitor patient progress and outcomes on a 'weekly or bi-weekly' basis (Tasca et al., 2019, p. 167) that should become a central part of the treatment and be employed in a conscientious and systematic manner.

Although the Task Force offers many valid arguments for why OPM is important in certain clinical contexts, such as accountability to third-party payers in health facilities and its value in clinical training curriculums, it (a) fails to consider how these recommendations dismiss the real world conditions of independent private practice; (b) ignores the vast pluralism of psychotherapeutic training models, theoretical orientations, forms of therapy, praxis methodology, and technical considerations; (c) assumes all patients are to be treated as the same, when this violates individual patient needs, differences, and the diversity of clinical populations served, as well as their cultural and linguistic contexts; (d) glosses over biases in test construction and lack of generalisability to non-Anglo audiences, especially when tests are not culturally specific, lack appropriate ethnic norms, and are not available in people's native languages; (e) presumes OPM is integral to the principles of therapeutic action; and (f) contradicts major findings from psychotherapy research that make the therapy relationship the fulcrum of successful therapeutic work and outcome rather than following sanitised, prescriptive procedures in clinical practice. If the CPA begins to instruct all psychologists to adopt these practices regardless of the professional environment in which they work, which would likely be accepted by most, if not all, provincial registration bodies that regulate the practice of psychology, then I am concerned it will damage the profession and public image of psychology in Canada and internationally.

It should be noted that all members of the CPA Task Force on Outcome and Progress Monitoring in Psychotherapy are primarily academics employed in a department or school of psychology in a university setting or public health agency in Canada. In addition, the reader should be informed that Canadian mental healthcare is a physician-funded system. There are very few resources available for free in the Medicare system, and most services for psychological and psychotherapeutic services are only accessed through private-pay services. Canadian citizens are largely without access to mental healthcare, and when they do have access it is generally through their family

physicians, who are not trained in talk therapy and merely prescribe psychotropic medication to purportedly 'treat' psychological symptoms (see Mills, 2017).

2 | A DIFFERENCE OF VALUES

When the OPM Task Force makes such specific yet universal recommendations for all clinical contexts, 'whether in independent practice or part of an agency or institution', where psychologists and psychotherapists must 'routinely obtain outcome data on patients they are treating by using psychometrically sound scales' (Tasca et al., 2019, p. 172), they may be viewed as conflating the role and goals of a researcher or administrator with those of a clinical practitioner. This conflation presupposes a shared vision of the purpose, breadth, and parameters of service delivery, theoretical orientation, the structure and function of the therapeutic milieu, the actual nature of treatment, and the values that practising psychologists and psychotherapists share with other colleagues in the field. This decree ignores the circumstances, clinical reality, and professional values of many psychotherapists in independent practice who do not share these views and standards, and find the suggestion of such an imposition highly paternalistic and unjustified, because it fails to consider the contexts and contingencies of professional intervention.

Implementing progress and outcome monitoring in such doctrinaire ways foists a certain model of practice *in toto* on *all* clinical contexts, when, in fact, this diktat commits the fallacy of *petitio principii*: the proposition is assumed to be self-evident and true from the start—not to mention being encouraged—thus simply begging the question and deflecting the need for serious debate. The Task Force appears to be more concerned with changing practice policy based on selected empirical studies friendly to its vision rather than on what actually transpires *in vivo* in therapy with patients, the priority of their phenomenal needs and actual conditions, the subjective qualia of their lived experience, their having meaningful conversation with their therapists, and the interpersonal nature of the therapy dyad and the treatment relationship, not to mention the mechanical, if not adversative, trespass this proposed requirement can have on clients who could not care less about such formal monitoring test activities. Furthermore, the Task Force selectively ignores studies that challenge the value and legitimacy of routine progress and outcome monitoring measures including iatrogenic abuses of implementation, flaws in standardisation, test construction bias, and the politics of research (Ashcroft, 2017; Boswell, Kraus, Miller, & Lambert, 2015; Miller, Hubble, Chow, & Seidel, 2015; Rodgers, 2017; Wolpert, 2014).

Psychotherapy is not medicine. Let's not pretend that it is. It does not need to measure the patient's thoughts and attitudes quantitatively through paper-and-pencil, computerised, or online self-report tests as if they were blood work being collected, examined, and analysed in a lab. That is not what psychotherapy is about. The mere suggestion that every clinician should practise in such a circumscribed, rote, and perfunctory fashion misses the basic fact that therapy is not conducted by a technician in a workroom (Miller et al., 2015; Mills, 2005). This rendition of homogenous standardised practice further delegitimises the value of talk therapy, as if the intimate process of what a patient and therapist are engaged in were suspect and in need of inquest. This type of prescriptivism, motivated by emulating a medical model based on the ideology of a so-called 'scientific method' superimposed on the real conditions clinicians face in treating those who suffer, cannot be applied to psychotherapy practitioners in such a wholesale fashion. This directive interposes and meddles with what talk therapy is really all about, namely, verbally exploring the most intimate aspects of people's lives with a caring professional whom they trust and have developed a safe and meaningful relationship with. This mandate also puts the clinician into a sectarian box, as though therapy should be conducted following inflexible uniform procedures. These are not therapeutic values that take into consideration the reality of genuine professional practice; rather they appear to be designed by those who have other political motivations, partisan agendas, and conflicts of perspective between different stakeholders.

3 | POLITICAL AGENDAS INHERENT IN ADVOCATING FOR CHANGES IN PROFESSIONAL PRACTICE POLICY

Tasca et al. (2019) argued that OPM should be mandated in order to enhance 'accountability' vis-à-vis 'public funders and third-party payers' (p. 166). The Task Force assumes that there will be government-funded psychotherapy in Canada and OPM is necessary in order to provide accountability for treatment interventions. Even if government funding becomes a possibility in the future, this does not mean that all psychologists and psychotherapists will sign up to work under such a system. Many will choose to remain in independent practice for a number of reasons, including the need to maintain professional autonomy, the issue of compensation (Drapeau & Bradley, 2019), concerns over client privacy and patient–therapist privilege, and the need not to be accountable to extraneous parties except the clients themselves and the provincial bodies that regulate professional practice.

When the spectre of third-party politics is invoked and OPM is instructed to be practised in order to justify paying for treatment, these agendas are not synonymous with patients' needs or the reasons why they seek out treatment. When the argument for accountability is used to collect progress and outcome data in order to provide so-called 'evidence-based' healthcare, this places third-party stakeholder self-interest over the needs of patients and further opens up avenues for abuse of process, including denial or termination of treatment services where blame could be allocated to (a) the client, (b) the therapist, (c) the type of therapy delivered or (d) failure to deliver a type of therapy, especially when a specific form is prescribed and another is deemed ineffective, unscientific, or not evidence-based, and/or (e) a combination of any of these variables. We may already witness this in the motor-vehicle accident (MVA) industry, where insurers use the results of psychometric measures in both initial assessments, progress reports, and outcome/discharge reports to deny treatment to a patient, halt an ongoing treatment because the patient is accused of not needing the treatment, is not getting better, is malingering for secondary (financial) gain, or, instead, the therapist is blamed for either being incompetent or not delivering the so-called 'right' type of therapy the patient purportedly really requires (Mills, 2011). This abuse of process is further determined by other authorities under the politics of evidence-based treatments (EBTs)—also sometimes called empirically supported therapies (ESTs) or evidence-based practice (EBP)—rather than based on clients' and therapists' wishes, values, preferences, and predilections.

It is worth noting that not only do insurers request outcome data measures in the form of progress reports, they also ask for the intimate details of individual therapy sessions that are recorded in the therapist's clinical session notes. This has become a standard requirement by many MVA insurance companies in Canada, most notably Aviva Canada, one of the largest insurers. Aviva Canada will routinely ask for clinical process notes and records for each session, so they can determine what has transpired in the actual therapy. The psychologist is also asked to provide a legal statutory declaration of services simply designed to block, deny, or suspend claims under the guise of fraud prevention. This information is then used to determine whether the client should continue to see the psychologist and whether the psychologist is meeting the standards of his or her profession established by the appropriate regulatory body, which is outside of the scope of insurance companies to regulate. They have routinely filed complaints against psychologists who do not play along with their hegemonic political impositions and intimidation tactics. I have been subjected to this kind of abuse of process to the detriment of clients who are then cut off from their insurance benefits, despite the fact that the insurer had pre-approved the clinical services that were then delivered in good faith and the consumer had purchased a policy in good faith to cover such expenses. Record keeping and progress monitoring can be used as a weapon to deny legitimate claims and hurt claimants and psychotherapeutic practitioners who do not comply with routine requests to release session notes.

Although I can understand and appreciate why the OPM Task Force wants to put in a plug for scientific psychology, evidence-based practice, accountability to others, and making psychotherapy relevant to the publicly funded sector, that still does not justify superimposing one stakeholder perspective on all modes of practice. In any case, this imposition should not apply to psychologists or psychotherapists in independent practice. It should be left up to the autonomous judgement of the clinician and client what treatment should entail. Given that psychologists

are already regulated—and the majority of psychotherapists are regulated in Canada too—why would we need to prove our accountability or competence to yet another external body that tells us how to practice? Why would a regulated health professional want to be evaluated by other third parties with their own self-centred agendas, who will demand to know what transpires in the therapy—including the innermost details of clients' personal private lives?

4 | UNNECESSARY INVASION OF PRIVACY AND LOSS OF CONFIDENTIALITY

With any publicly funded or third-party payer required to be accountable by using OPM reports and data, there is no guarantee of privacy or confidentiality because the third party will demand to see the progress data, including clinical notes and records (Mills, 2012; 2014). Patients lose their right to these privileges, and the psychologist or therapist will have no autonomy to refuse to comply. There will be loss of control over how the data may be shared or breached, and unpredictable decisions about how the data is interpreted or used against the patient, therapist, and/or both are guaranteed to present risks to the therapeutic unit. Not only could this data be used to terminate treatment prematurely by a self-serving agent or agency who makes rulings over funding, it also could be used to hurt or abuse the client, such as in cases where insurers deny claims, accuse the patient of lying, malingering, faking symptoms, or conclude that the patient does not require treatment when he or she does actually want and require it, which might also become part of litigation or arbitration proceedings. Patients' personal lives and the most private details of their thoughts and histories could be up for public inspection. This is why many patients do not want such information included in the clinician's notes and records, let alone progress or outcome data that could be misinterpreted, manipulated, or challenged in order to deny claims or prevent settlements from being paid out.

Practitioners are also at risk of having their confidential thoughts about patients, kept in their client files, taken or subpoenaed. If these were read by the patient, it could damage the therapeutic relationship or even open up the risk that the client could file a professional practice complaint against the practitioner with their regulatory college because they did not like what was written about them. Although any client file can be subpoenaed, in Canada there is no distinction between the patient file and the clinician's file. There is no privacy legislation that protects a therapist who maintains his or her own separate notebooks on clients apart from the whole clinical file. With loss of privacy and no assurance of the normative conditions (including legal limits) of confidentiality, records can also be used by third-party payers to lay complaints against the psychologist or psychotherapist by manufacturing accusations of professional misconduct, lack of compliance for not turning over records, and/or allegations that are beyond the control of the practitioner and patient to anticipate. This is why patients who seek out independent practitioners have more assured expectations regarding confidentiality and less invasion of their privacy by third-party requests. It also gives clients the right to choose their practitioners—a right that often does not exist with third-party agencies because the clinician has to be registered with the funder to be compensated for treating the patient. Although OPM data is only one aspect of larger ethical and privacy issues surrounding clinical notes and records, monitoring of symptoms and diagnostic criteria may be used in ways that are unintended by practitioners, especially when decisions about treatment may be arbitrary or determined by an administrator or adjuster.

5 | SYMPTOM MANAGEMENT VS. OTHER PURPOSES OF SEEKING PSYCHOTHERAPEUTIC TREATMENT

There are many reasons why a person would seek out talk therapy that do not revolve around clinical pathology. The proposed OPM requirements are focused on tracking symptoms, pathological clusters, clinical patterns, and diagnoses of psychological disorders, not to mention their severity, intensities, sequalae, progression, diminution, and follow-up outcomes once treatment is completed or terminated. This pathology-medical model approach to

client care reduces the human being to a clinical object or thing rather than a person. This objectification of the subject violates many forms of therapy and theoretical models, including (but not limited to) humanistic, person-centred, phenomenological, existential, experiential, holistic, psychoanalytic, and psychodynamic orientations, among many others.

There are many patients who are in therapy and seek treatment without evincing any clinical signs or symptoms or are in treatment to improve the subjective quality of their lives or happiness without necessarily being unhappy. The purpose of therapy may be complex and unique for each client, inquisitive, exploratory, or preventative in nature, and mediated by other motivations and factors that have nothing to do with symptom management. In fact, therapy is not solely about the quantification of symptom improvement. People are motivated by an increased need for self-awareness and insight, are seeking existential examination, are interested in becoming more self-consciously aware of who they are and who they can become, and/or developing a more meaningful, virtuous, and self-fulfilling life as a spiritual journey. Gaining greater skills at introspection and self-analysis is achieved through an in-depth inspection of one's personality and life facilitated by co-constructed, reflective space, and this may have nothing to do with symptom manifestation.

Those who insist that a symptom or clinical pathology paradigm must apply in order to justify receiving treatment will not allow patients to be seen or permitted to enter into therapy—let alone stay—using this restrictive model. In other words: no symptoms, no funding. Because psychotherapists see so many patients who do not fall into this symptom–treatment–management model, such exclusionary criteria would eliminate many people from initiating self-improvement or getting help. The exclusive focus on symptom manifestation, management, and improvement by definition constricts the practice of professional psychology and bars many other purposes, reasons, and rationales the public has for seeking therapy. If the criteria or categories for treatment are curtailed or restricted access is imposed on the population as a whole, then this would block access to mental healthcare rather than facilitate it, let alone promote it.

Another constraint and limitation to this proposed symptom-management progress and monitoring approach is that it could affect those in training or who seek out psychotherapy in order to become better therapists. This not only applies to graduate programmes, but also postgraduate training environments, free-standing institutes or professional schools, and private educational training centres or institutions. A good example of this is candidates in psychoanalytic training (not necessarily formal psychoanalysis) who must undergo their own therapy in order to graduate.

6 | RELATIONAL AND ATTACHMENT FACTORS IN THERAPY

Not only would access be controlled, blocked, denied, suspended, or prematurely stopped by adopting a symptom-formation criteria model and an OPM accountability rationale, such a decision would ignore the very foundation of what constitutes a successful therapy, namely, the therapeutic relationship. What is essential for therapeutic action and efficacy is the quality of the relationship that forms between practitioner and client, the uniqueness of fit in the therapeutic dyad, and the interpersonal milieu that is developed in a two-person approach to conceptualisation and treatment. There is a cornucopia of evidence to conclude that the quality of attachment and relational character of treatment is the foundation of successful progress and outcomes (Levy & Johnson, 2019; Mills, 2005; Wallin, 2007). Telling a client how to think, feel, and behave is not effective and is of little benefit unless he or she has established a therapeutic alliance and attachment to the therapist. As Safran (2003) pointed out in his analysis of psychotherapy research, the main empirical conclusions regarding treatment efficacy across all forms of therapy entail: (a) the qualitative degree of an established working alliance involving (but not limited to) the capacity to form trust and attachment to the therapist; (b) mutual assent and collaboration over the goals and process of treatment; and (c) the level of comfort and satisfaction the patient has toward the therapist regardless of symptom improvement.

Tasca et al. (2019) specifically tell us that 'the goal of this report is to provide guidance to psychotherapy practitioners as well as policy makers, educators, and funders of psychological interventions regarding measuring outcome and patient progress *to promote evidence-based treatment*' (p. 166, emphasis added). Here, their political agenda is unambiguous: they wish to sell a market brand across the board to practitioners, policy analysts, educators, and funders to promote a circumscribed and partisan vision of psychological practice that is regimented and uniform. The problem here is a conflation between OPM and EBTs, which the CPA Task Force lumps into one basket. This is a category mistake and dilutes from the main issue of OPM, yet without disguising its motive, rationale, and ideology. It further confounds the question of EBTs with implementing OPM tracking procedures in order to conform with EBT identity politics. This conflation should be undone and EBTs and OPM analysed as distinct issues, though still coalescing around themes of how best to practice, which has become highly politicised in contemporary Western culture.

There is fierce debate over what constitutes effective treatment within the evidence-based turf wars, with much disagreement from both proponents and their critics (Dalal, 2018; Sakaluk, Williams, Kilshaw, & Rhyner, 2019; Scholom, 2017; Shedler, 2010, 2015; Wampold et al., 2017), so I will not engage with that debate in this context. But when only a few forms of treatment are given currency and others deemed not to be empirically validated or are criticised for not being classified as evidence-based by independent third parties, professional or otherwise, then the politics of mental health treatment become a commercial affair that eliminates the professional background, training, autonomous decisions, and judgement of the practitioner and their clients' right to choose the type of therapy they wish to receive. We can readily imagine how restrictive the types of treatments allowed in this type of business model of service delivery would be. When the OPM Task Force introduces the quagmire of 'the science of accountability' in order to justify which forms of progress monitoring are acceptable and which are not, they risk marginalising many practitioners whose very theoretical orientation, methodology, and technical principles are at odds with mainstream identity politics. Many very good forms of treatment (and practitioners) could be disallowed altogether and clients will not get what they require, especially since many signature EBTs are of short duration and target specific goals or problems with a circumscribed clinical focus. Although the practice of OPM does not necessarily mandate the specific use of EBTs, it is often the case that decisions regarding treatment preference and efficacy already presuppose a predetermined intervention that is recommended, such as cognitive behavioural therapy. These short-term treatment modalities do not focus on the therapy relationship or on developing an attachment to the therapist. In fact, this clinical sensibility could be widely discouraged on the basis of cost, even when these factors are essential for any successful treatment to materialise. Here the business model of mental health service delivery is not only at odds with what is actually required in order to be effective, it is antithetical to fostering positive outcomes.

Psychotherapy practice never fits neatly into a predetermined and circumscribed formula or manualised, step-by-step method of technique because every patient requires personalised care: theoretical orientations overlap, methodology is overdetermined, and the forms of being and discourse adopted in the treatment relationship are peculiar to that unique intersubjective dyad. If independent psychologists or psychotherapists are prescribed a routine procedure for disseminating psychometric testing every week or twice a month, this is surely disruptive to the kind, style, and quality of care patients are accustomed to receive by competent practitioners who argue this type of prescriptivism is counterproductive to therapeutic progress and fostering the treatment relationship.

We can also envision scenarios where practitioners are selected and assigned to patients solely based on how they self-identify and what forms of therapy they practise to the exclusion of others. When Tasca et al. (2019) support the chilling suggestion of 'matching patients to therapists' (p. 170) determined by external bodies, freedom of the consumer and practitioner is imperilled. If this were to be allowed, we could easily imagine future situations where professional practice is manipulated by hegemonic authority or the state. In situations where clients and therapists were not matched, decisions could then be made independently from the therapy encounter with existing therapeutic relationships being disrupted, suspended, or arrested by a third party who randomly or capriciously concludes that a patient is not getting better (hence little symptom improvement) and abruptly orders

him or her to switch therapists, thus subverting the very conditions that make a treatment efficacious. If patients are arbitrarily forced to see another professional after they have already formed a working alliance, developed trust, safety, and attachment to their therapist—and after they have already spilled their guts and feel vulnerable, fragile, and/or ashamed at having done so—then this will be disastrous for our profession, as it will preclude the very thing that is nurturing and helpful: the relationship between patient and therapist is primary. It is also not inconceivable that a third-party payer will refuse to continue to pay for treatment if the client does not undergo a therapy determined by the agency, as if clinical competency were to be decided by an insurance adjuster or case manager who is not in the mental health field and who is not operating within his or her scope of expertise and competency to make such decisions in the first place.

7 | THE WORLD OF PRIVATE PRACTICE

Academics and researchers who do not practise or conduct therapy for a living tend to imagine hubristically that they have more knowledge than a clinician and can instruct the latter how to practise based on research studies rather than direct clinical experience and expertise. It also does not help the tensions in professional identity between academics and clinicians, who both often feel superior in their own ways. Policy that prescribes a professional practice behaviour over independent clinical judgement will always meet with resistance, if not defiance, especially when the Big Other utters commandments and gives directives based on authority, ethical mandates, and jurisprudence that belie the real world of private practice.

In private practice, the clinician may work differently to achieve the goals promoted by the academic without having to detract from the treatment with formal testing measures imposed on the clinical process. While conceding that OPM may enhance treatment initiatives for some patients, this should be co-determined by the therapeutic dyad rather than made procedurally compulsory. For example, Tasca et al. (2019) argued that the 'purpose of outcome monitoring is to assess the effectiveness of treatment for symptom reduction, quality of life, and other areas of functioning deemed important by the patient and provider' (p. 167). But, rather than using psychometric tests to get at progress and outcome, this should be done naturally and organically through dialogue and conversation in the moment-to-moment process of therapeutic exchange and analysis. Given that the Task Force emphasises the use of test measures, the clinician may view this as a superimposition of protocol that is not only unnecessary for collecting ongoing progress data, but can also retard the process of therapy and introduce awkward demands and transference phenomena that heighten resistance and defence, potentially leading to opposition, impasse, or acting out. There are certain vulnerable, narcissistic, paranoid, and traumatised patients, for instance, who would become immediately defensive were I to introduce formal assessment measures in this way *in session*, if they did not simply get up and leave. Because therapy is not a formal assessment or post-research follow-up activity, this way of working clinically, in my opinion, is simply bad technique and offensive to the intimacy of the therapeutic encounter, where the emphasis is on the patient's life and inner experience, the relationship between the participants, and the deepening work that ensues in such an emotional ambiance. The therapist who then shifts gears and acts like a formal researcher, administrator, or technician collecting data will not only potentially stymie such a relationship, but could easily create barriers to progress if not sully the therapy to the point of causing a premature terminus where the patient bolts from treatment.

Another practical matter is fees. The client would not expect to have to pay extra for time spent on the administration, completion, scoring, reporting, and recording of testing measures to be placed in the patient's file, nor would a psychologist or psychotherapist in independent practice do such work for free. The bottom line is, it takes time and costs money to conduct OPM activities. When the OPM Task Force is more concerned about accountability to a third party than the integrity of the therapeutic relationship, knowingly or not, they have become a mouthpiece for the insurer or Big Brother watching and evaluating the confidential work that is supposed to take place without external scrutiny or review. Here they are simply toeing a party line. Under these

bootstrapped conditions, it is the patient *and* the therapist who are being monitored. If such a recommendation were to be enforced, it would be a recipe for denying treatment and making the healthcare crisis in Canada even worse.

The idea that OPM would provide meaningful data that gives 'feedback to therapists' in the form of 'status alerts' and 'vital-signs' on patients' functioning so treatment can be adjusted when necessary (Tasca et al., p. 167) can appear odd to practitioners—as though the proponents have no idea of what actual clinical work is like. Psychotherapy is not conducted in the emergency room. The danger here is all too evident: a CPA ethics policy change that mandates the prescriptive use of psychometric measures as a routine part of the therapy hour in 'every session or every second session' throughout 'the course of treatment' (Tasca et al., p. 167) would distort the reflective space, purpose, freedom, and credibility of professional psychology in Canada, replace the complex emotional ingredients and overdetermined conditions for therapeutic action with technocratic ideology under the guise of medicine, and displace the historical practice of psychotherapeutic interventions since their inception during the rise of modern psychology. One might as well talk to a computer, an app, or a robot. Behavioural prescriptivism on how the therapy relationship should be constructed is not a best standard of practice. It ignores the idiosyncratic desires and conflicts of the client and the unique unconscious dynamics mobilised within inter-subjective relations inherent to the therapeutic dyad.

8 | A BUREAU-TECHNOCRATIC APPROACH TO PROGRESS MONITORING

Despite the fact that all psychologists are trained to some degree to utilise psychometrically sound and valid testing measurements and routinely conduct formal assessments with a variety of testing protocols, psychotherapists are not and do not. That is an exception to the rule. And when other therapists are trained to use such measures, they cannot diagnose a psychological or psychiatric disorder under existing legislation. Psychologists are currently reimbursed by third-party payers for providing formal assessments in a variety of clinical settings in both public agencies and private practice, such as in the automobile insurance industry and in worker insurance and compensation programmes that are government-regulated, and they employ formal progress and outcome measures that are part of the clinical services they provide. This is a stipulation of being funded for this type of work. But those in independent practice who do not have to be accountable to external funding agencies should not have to adopt such formal dictates when assessing treatment progress and outcomes for the simple reason that this curtails a clinicians' freedom.

The OPM Task Force points out that the majority of psychotherapists do not use progress and outcome measures, that there is scepticism among clinicians about using them, that they are too time-consuming to complete, costly to purchase, and also costly in terms of staff time to administer, which also burdens patients. Common attitudes are that such measures are superficial, are primarily used for performance reviews, audits, or to evaluate therapists (cryptically to justify dismissal for not meeting company expectations), are clinically contraindicated (they violate privacy and the therapy frame) and impractical. And, of course, the therapist will ask, 'Why do we need to give measures when all we have to do is ask the patient?'

The Task Force argues that with education and training these resistances can be overcome in both the public and private sectors and that OPM protocols should be adopted by *all* psychotherapy practitioners regardless of background, education, training, experience, professional designation, and work environment. I think this proposal is too ambitious and ultimately implementing it is neither feasible nor realistic.

Let us first examine the question of practicality. If we adopt the Task Force's recommendation, then the amount of training in terms of hours spent being taught and learning formal approaches to the fundamentals of assessment, psychodiagnostics, tests and measurements, test construction, research methods, reliability and validity constructs, understanding population norms and test samples, the various types of tests to select for use from the virtual sea of measures that are available, not to mention the cost of purchasing the more psychometrically sound and

statistically validated ones that are under copyright and sold by large testing companies—these requirements alone would simply be prohibitive. And even if these skills were not typically required to utilise OPM and only a limited subset of measures would be mandated, it would still take time and be costly. Implementing such policy changes and procedures in public, governmental, and external agencies and businesses would be an enormous undertaking and expense that employers, executives, administrators, and systems operation management teams (e.g., IT) would not be likely to support.

In order to aspire to these requirements, it would conservatively take 20–30 minutes for every hour of therapy to administer, score, interpret, and record the results of any progress and outcome monitoring tools in the client's chart or to upload them to a computer system, thereby expending a great deal more time and more monetary resources on progress tracking than on delivering therapy to those who need it. Any professional who has ever worked in the public healthcare sector—for example, in a hospital—knows too well the bureau-technocratic impositions of tracking work time and client contact hours in the central records system. Additionally, those in private practice would have to split up their work hours to devote more time to each client with regards to these extra requirements, which might further interfere with scheduling, especially if patients are seen by the hour. According to conservative estimates, publicly funded psychotherapy would likely serve one third fewer people and spend more money overall on OPM research. Not only does this not demonstrate sound financial logic, it further undermines the need for psychotherapists to do what they are trained to do best: that is, to help people via talk therapy.

What the OPM Task Force is essentially asking the CPA to do is not only to change the scope of psychologists' practice and competencies, but to set a precedent that would apply to other regulated health professionals as well. Not only is this outside their jurisdiction, it also assumes that all mental health professionals should be trained in their graduate and post-graduate training environments, or be retrained after registration, to adopt these competencies that have, traditionally, fallen within the scope of practice of psychologists. In other words, the Task Force would like to annex other mental health disciplines that currently practice psychotherapy, such as registered psychotherapists, social workers, mental health therapists, counsellors (of all types), nurses, occupational therapists, psychiatrists, and so forth, to retrain as psychologists. Given that a very large part of the graduate curriculum, particularly in schools of professional psychology, is devoted to studying the assessment process, psychodiagnostics, clinical interviewing, administering, scoring, and interpreting objective, projective, intellectual, cognitive, academic, and neuropsychological testing, report writing, and students are under supervision in practicum and internship settings for years, this pitch, that all psychotherapy practitioners should have virtually similar competencies, is idealistic at best, if not simply a pipedream.

Any decisions to impose new standards of practice on existing healthcare professions should only be taken in collaboration with those professions, which would likely view such injunctions as examples of vested self-interest coming from the dominant hegemony of psychology. What this would require is a sea change in all training programmes in mental health across the broad spectrum of disciplines in Canada, which would predictably meet with resistance, dismissal, and lack of compliance, as not every mental health graduate programme is designed to make everyone a psychologist, nor would established degree programmes change their curriculums to satisfy another health discipline's wish list. Furthermore, such a change in the scope of practice competencies in non-psychology graduate and post-graduate training venues would affect the registration process in provinces where other healthcare fields will claim to have equivalent training to that of psychologists and want to be licensed to practise as such, thereby predictably leading to applications for licensure being rejected by regulating bodies in psychology where the applicants do not have a terminal degree in psychology. We could further anticipate how this would complicate the requirements for eligibility to apply, perhaps even being challenged in court if graduates of non-psychology programmes can prove equivalent competence in psychotherapy and the psychometry that psychologists traditionally hold as peculiar to their professional training. If an argument can be made that there are really no distinctions in duties and competencies between psychologists and psychotherapists, then this might conceivably undermine the value and necessity of professional psychology, particularly in external agencies where a business model of service delivery prefers to hire psychotherapists for far less because they are better value on the dollar.

9 | CONCLUDING REMARKS

Although many of the recommendations that the OPM Task Force put forward are applicable in a service delivery system where accountability is expected and required in order to procure third-party or government funding for clinical interventions, they do not necessarily apply to psychologists and psychotherapists in independent practice. Therefore, the two groups of practitioners are not equivalent in their training, professional identities, clinical activities, competencies, and work environments, nor can they be said to perform synonymous functions when independent practice varies widely in context, scale, contingencies, and latitude. The OPM Task Force is not justified, I argue, in making blanket statements that treat all practitioners and patients as if they were the same, nor should they have to conform to political agendas that do not take into consideration the best interests of all stakeholders involved. Professional autonomy, the freedom of patients to select the service providers and types of therapy they want, and concerns around privacy invasion are paramount issues that are in need of further debate. The insistence that for OPM protocols psychometric measures must be used in all practice settings by all mental healthcare professionals in Canada who conduct psychotherapy is too dogmatic, ideological, misguided, and unrealistic. For these reasons, I conclude that the Canadian Code of Ethics for Psychologists is clear enough in its recognition of the value of progress and outcome evaluation, and is not in need of revision to explicitly stipulate that all psychologists must adopt narrow authoritarian practices that would cripple clinician and client liberty—and ultimately tarnish the integrity of the profession.

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