The Practice of Psychology and Psychotherapy in Quebec

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Abstract

The importance of effective and timely psychotherapy treatment for Canadians in need has received increased attention in recent years. Additionally, there has been a call to better understand the current practices of the psychology workforce, to first understand where we stand as a field (e.g., Hunsley, Ronson, & Cohen, 2013) and further, to gain insight into how to best utilize psychology experts in the provision of mental health services (Ronson, Cohen, & Hunsley, 2011). As the need for increased accessibility to psychotherapy treatment has come to the forefront of concerns in mental health care service delivery, initiatives to understand how best to implement programs aimed at increasing access have begun to be explored (e.g., Cavaliere, 2014). The following dissertation has two aims in line with these recent trends: (a) to document the perspectives of psychology practitioners regarding increasing access to psychotherapy and the implementation of a future government-funded psychotherapy model in a local Canadian context, and (b) in order to inform these future initiatives to increase access to psychotherapy, documentation of current routine psychotherapy treatment is needed; therefore the second aim is to document current psychotherapy treatment in the private sector, as there is a dearth of knowledge concerning service delivery in this sector.

To achieve these aims, first a survey study of psychologists and psychotherapists working in the private sector in Quebec (N = 671) was conducted focusing on themes such as psychotherapy format, age groups being served, collaboration with other health professionals, referral sources, fees for services, clinical tools used, wait-times, and use of supervision. Results indicated that the most served age population is adults (age 31-64); individual therapy is most commonly offered; and anxiety and mood disorders were reported to be the most frequently treated mental health disorders. The average number

of treatment sessions was 23.35 (*SD* = 20.82; *Mdn* = 18). It was not common for practitioners to have a wait-list longer than one week; and the average fee charged for individual therapy was $95.10 (*SD* = 16.69). To gain a more detailed understanding of private practice, a second study was conducted to examine the differences in practice characteristics among those of different levels of education, years of experience and theoretical orientation. Important differences were found in terms of psychotherapy fees, diagnoses and presenting problems treated, as well as in the use of validated clinical tools. The implications of the results of both of these investigations are discussed in relation to professional psychology, training and policy initiatives.

To achieve the second aim, a survey study was conducted of licensed psychologists and psychotherapists in both public and private practice in Quebec concerning accessibility to psychotherapy treatment and the favourable components of a future government-funded model of psychotherapy. Participants (*N* = 1462) completed an online questionnaire focusing on components of government-funded models of psychotherapy that are currently in place internationally. Results indicated that 77% of the sample '*strongly agreed*' that accessibility to psychotherapy should be increased. Diagnosable mental health disorders, particularly mood disorders, anxiety disorders, and schizophrenia and other psychotic disorders, as well as psychological functioning related to health, injury and illness, and family difficulties were identified as the problems to be prioritized. There was stronger agreement for clinicians in a future government-funded model of psychotherapy to be paid on a session-to-session basis as opposed to receiving a yearly salary; to be able to set their own fee; and to have freedom to choose the appropriate psychotherapeutic approach (e.g., cognitive behavioural therapy, emotion

focused therapy, etc.). Furthermore, the participants strongly believed in the treating clinician having responsibility in terms of clinical decision-making, over that of the referring family physician. To again gain a nuanced understanding of the perspectives of these practitioners, a second study sought to examine the differences in perspectives regarding a government-funded model of psychotherapy between those of different levels of education, years of experience, and work setting (public versus private). Important differences were found concerning fees and hiring structure, the use of validated measures to track treatment progress, as well as the central role of the treating clinician. The implications of the practitioners' perspectives, as well as the differences found among practitioners, concerning a government-funded model of psychotherapy are discussed in relation to accessibility policy initiatives.

Finally, a summary of the current characteristics of psychotherapy practice is presented in conjunction with information concerning the future of government-funded psychotherapy. Overlapping themes are highlighted across the four studies, and their larger implications for our field in terms of professional psychology and training initiatives are discussed. To close, the limitations of the current investigations as well as possible future research investigations are outlined.

Résumé

Au cours des dernières années, l'importance d'un traitement efficace et opportun pour les Canadiens nécessitant une psychothérapie a suscité une attention croissante. De plus, il y a eu une demande de mieux comprendre les pratiques actuelles des effectifs en psychologie: tout d'abord de comprendre où nous nous situons sur le terrain (p. ex., Hunsley, Ronson, & Cohen, 2013) et de surcroît, d'acquérir les connaissances nécessaires afin d'utiliser au mieux les experts en psychologie dans la prestation des services en santé mentale (p. ex. Ronson, Cohen, et Hunsley, 2011).

Comme la nécessité d'accroître l'accès à une psychothérapie s'est hissée au premier plan des préoccupations dans la prestation des services de soins en santé mentale, des initiatives ayant pour but de comprendre la meilleure façon de mettre en œuvre des programmes visant à accroître l'accès à la thérapie ont commencé à être explorées (p. ex., Cavalière, 2014).
La présente thèse a deux objectifs en concordance avec ces récentes tendances: (a) documenter les perspectives des praticiens en psychologie concernant une amélioration de l'accès à la psychothérapie et la mise en œuvre d'un programme de psychothérapie financé par le gouvernement; et (b) documenter la situation actuelle en termes d'offre de services et de services rendus au privé.

Pour atteindre ces objectifs, une étude par sondages auprès de psychologues et psychothérapeutes du Québec ($N = 671$) a d'abord été réalisée. Elle visait à documenter des thèmes tels que les formats de psychothérapie offerts, les groupes d'âge desservis, la concertation avec d'autres professionnels de la santé, les sources de référence, les frais de services, les outils cliniques utilisés, les temps d'attente et l'utilisation de méthode clinique de suivi en continu. Les résultats indiquent que la population d'âge la plus desservie est les 31-64 ans; la thérapie

individuelle est la plus fréquente et les troubles de santé mentale les plus souvent traités sont l'anxiété et les troubles de l'humeur. Le nombre moyen de séances était de 23.35 (*ET* = 20.82 ; *Mdn* = 18). Il était rare que les praticiens aient une liste d'attente de plus d'une semaine. Enfin, la moyenne des honoraires pour la thérapie individuelle était de $95.10 (*ET* = 16,69).

Pour acquérir une compréhension plus détaillée de la pratique privée, une seconde étude a été menée afin d'examiner les différences selon le niveau de formation des répondants, les années d'expérience et l'orientation théorique. Des différences significatives ont été trouvées en termes d'honoraires pour la psychothérapie, de diagnostic et des principaux problèmes traités, ainsi que dans l'utilisation d'outils cliniques validés. Les incidences des résultats de ces deux enquêtes sont discutées en lien avec la psychologie professionnelle, l'enseignement ainsi qu'avec les initiatives politiques.

Afin d'atteindre le deuxième objectif, une étude a été menée auprès de psychologues et de psychothérapeutes exerçant au Québec, aussi bien dans le système public qu'au privé. Cette enquête évaluait la facilité d'accès au traitement psychothérapeutique et les différentes stratégies de financement d'un programme de psychothérapie. Les participants (*N* = 1462) ont complété un questionnaire en ligne portant sur les composantes du modèle gouvernemental de psychothérapie qui sont actuellement en place dans d'autres pays. Les résultats indiquent que 77% des répondants sont «fortement d'accord» pour que l'accès à la psychothérapie soit augmenté. Parmi les troubles mentaux diagnostiquables - comme les troubles de l'humeur, les troubles d'anxiété, la schizophrénie et autres troubles psychotiques - le fonctionnement psychique lié à la santé, les traumatismes, la maladie et les difficultés familiales ont été identifiés comme prioritaires. Il y avait un fort consensus sur le fait que les cliniciens devraient être payés pour chaque séance plutôt que de recevoir un salaire annuel; qu'ils soient en mesure de définir leurs propres

honoraires; et qu'ils aient la liberté de choisir l'approche psychothérapeutique appropriée. Par ailleurs, les participants estimaient que le clinicien traitant devrait avoir plus de responsabilité en termes de prise de décision clinique que le médecin de famille référent.

Pour obtenir à nouveau une compréhension nuancée des points de vue des praticiens, une seconde étude visait à examiner les différences de points de vue sur la psychothérapie financée par le gouvernement, suivant le niveau de formation, les années d'expérience, et le milieu de travail (public ou privé) des répondants. Des différences importantes ont été trouvées concernant les honoraires et les structures d'embauche, l'utilisation de mesures validées pour suivre les progrès du traitement, ainsi que le rôle central du clinicien traitant. Les conséquences de ces résultats sont discutés en rapport avec les initiatives politiques de facilité d'accès.

Finalement, un résumé des caractéristiques actuelles de la pratique de la psychothérapie est présenté conjointement avec les informations concernant l'avenir de la psychothérapie financée par le gouvernement. Au travers des quatre études, des thèmes communs sont mis en évidence et leurs répercussions plus étendues dans notre domaine sont abordées en termes d'initiatives en psychologie et en formation professionnelles. En conclusion, les limitations des enquêtes en cours sont exposées ainsi que d'éventuelles futures enquêtes de recherche.

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Dedication

This work is dedicated to my parents. Thank you for never questioning what I was capable of.

Preface and Contribution of Authors

The following dissertation contains four manuscripts, all of which I am the primary author. I was responsible for conducting the literature review, conceptualizing the study design, survey development, data collection and analyses, final manuscript development and write-up, and submission for publication for each manuscript. This dissertation constitutes an original body of work. An additional published study written in French for which I am the primary author can be found at the following reference: Bradley, S., Doucet., R., Kohler, E., & Drapeau, M. (2016). Accessibilité à la psychothérapie subventionnée par l'État : comparaisons entre les perspectives des psychologues et des psychothérapeutes. *Santé mentale au Québec, 40*(4), 175-200. doi: 10.7202/1036099ar.

My supervisor, Dr. Martin Drapeau provided invaluable and consistent mentoring and consultation throughout all stages of this dissertation, including initial conception of research ideas, survey development and piloting, collaboration with experts in the field, data analysis and interpretation, as well as feedback on written manuscripts. To recognize Dr. Drapeau's seminal role in this work he is listed as a co-author on all four manuscripts contained in the dissertation.

Dr. John Service, a member of the thesis advising committee, was a valuable contributor in the conception of the research design, and the development and piloting of the survey instrument. He provided thorough editorial feedback on the literature review and final written manuscripts and is listed as a co-author for manuscript 1 (Chapter 2) and manuscript 2 (Chapter 3) for his contributions to this work.

Dr. Pasquale Roberge, a member of the thesis advising committee, is also listed as a co-author for manuscript 1 (Chapter 2) and manuscript 2 (Chapter 3). Dr. Roberge provided feedback on the early conceptual ideas of the research study designs, the survey development

and piloting process, as well as much feedback and editorial suggestions in the final write up of the dissertation.

Dr. Helen-Maria Vasiliadis is listed as a co-author for manuscript 1 (Chapter 2) and manuscript 2 (Chapter 3). In the early stages of conceptualizing the scope of the research questions, Dr. Vasiliadis provided expert opinion on the themes to be covered in the research studies, and provided helpful guidance in developing the survey items. Dr. Vasiliadis has also provided important feedback in the interpretation of survey results and their implications in the Quebec context, as well as editorial suggestions in the final written manuscripts.

Thesis Objectives

This dissertation aims to explore the attitudes of practitioners concerning access to psychotherapy and the implementation of a possible future government-funded model of psychotherapy in the local context. Additionally, this dissertation aims to document current psychological practice in Quebec, specifically in the private sector, to aid in informing government-funded psychotherapy initiatives.

The following outlines the dissertation, on a chapter-by-chapter basis, providing explanations for how the individual papers contribute to the objectives.

The literature review highlights both the need for updated tracking of psychology practice characteristics in the Canadian setting, as well as the current focus on increasing access to psychotherapy. Chapter 1 begins with a general introduction to the history of psychological practice and current trends in the field of psychology in Canada. Following this we focus on highlighting the current literature and rationale for increasing access to psychotherapy in the Canadian and Quebec context and outline models of government-funded psychotherapy that are in place in the United Kingdom (UK) and Australia.

Next we turn to a detailed review of psychological practice, highlighting the past documentation of trends in practice predominantly through the American Psychological Association (APA), and the lack of such documentation in the Canadian context. A rationale for the need to document treatment trends is presented, particularly given recent shifts in psychology in Canada as outlined below. The literature concerning psychological practice characteristics, including professional activities, the use of different psychotherapy formats and treatment of different age populations, employment settings, changes in influential theoretical orientations, the treatment of specific diagnoses and mental health problems, the technical aspects of clinical

practice (e.g., treatment length, frequency of sessions), and finally specific characteristics of private practice are presented. A summary of the current gaps in knowledge in terms of psychological practice is then discussed. Finally, a brief general summary of the areas of further investigation is presented along with the specific objectives of the thesis.

Chapter 2 is a research article reporting the results of a survey of practitioners, specifically psychologists and psychotherapists licensed to practice psychotherapy in Quebec, who are currently in private psychotherapy practice. The survey included themes such as psychotherapy format, age-group populations treated, diagnoses and presenting problems, referral sources, collaboration with other professionals, number and frequency of sessions, as well as psychotherapy fees. Chapter 3 is a research article investigating the differences in practice characteristics of the practitioners in Chapter 2 based on years of experience, level of education, and theoretical orientation. Together these articles document not only the current trends in private psychotherapy practice, but also highlight the nuanced differences between practitioners based on various key characteristics. The implications of these results in relation to professional psychology, training, and policy development, as well as limitations, are discussed.

Chapter 4 is a research article reporting the results of a survey investigation targeting the attitudes of psychologists and psychotherapists concerning accessibility to mental health services and components of a future government-funded model of psychotherapy. This survey aimed to highlight the perceived favourable and unfavourable components and principles of government-funded psychotherapy models. Chapter 5 is a research article addressing the differences in attitudes of the participants in Chapter 4 based on years of experience, level of education as well as work setting (i.e., private sector versus public sector). Each research article provides unique

insights into the perspectives of practitioners and discusses the implications of the results in terms of public policy and service delivery, and professional practice.

Chapter 6 integrates the findings from the four research articles and focuses on the characteristics of psychotherapy practice of today and how these relate to and compare in terms of future government-funded psychotherapy initiatives. The overarching implications for policy, professional psychology, professional training and future research are discussed, along with limitations. Additionally, throughout the four research studies contained in this dissertation the term *practitioner* when referring to the study participants include both licensed psychologists and psychotherapists. It was decided to include both psychologists and psychotherapists in the studies as both of these protected professional titles are regulated by the *Ordre des Psychologues du Québec* (OPQ) for the reserved practice of psychotherapy (see https://www3.ordrepsy.qc.ca/en/obtenir-un-permis/index.sn). Therefore to document the state of psychotherapy practice, it was decided to include both groups of regulated professionals.

CHAPTER 1: Introduction

The landscape of current psychological practice is in stark contrast to that of its beginnings over 70 years ago. During the mid-twentieth century, psychotherapy was not a primary activity of clinical psychologists in North America; in the United States, psychologists were only able to practice psychotherapy under the supervision of psychiatrists, and there was a greater emphasis on diagnostic testing (Garfield, 1981). Today, psychotherapy services are an integral part of the profession of psychology, and to society as a whole, as evidenced in the large number of psychologists conducting psychotherapy in hospitals, outpatient clinics, rehabilitation centers, counselling centers, community mental health centers, and university mental health centers, among others (Norcross & Karpiak, 2012). Approximately 85% of psychologists across Canada have reported conducting psychotherapy, with the majority of their professional time spent conducting psychotherapy and assessments (Hunsley, Ronson, & Cohen, 2013). Data from the APA's Division of Clinical Psychology in 2010 show that 76% of members conduct psychotherapy, with approximately 40% of their time devoted to diagnostic, assessment, and psychotherapy activities (Norcross & Karpiak, 2012).

For decades researchers in psychology have emphasized the importance of investigating and documenting current trends in psychological practice (Garfield & Kurtz, 1976; Hunsley et al., 2013; Norcross & Karpiak, 2012; Norcross, Karpiak, & Santoro, 2005; Prochaska & Norcross, 1983; Smith, 1982) as the field has been described as "rapidly growing and changing" (Garfield & Kurtz, 1976, p. 1), diverse, disordered, complex and fragmented (Garfield, 1981; Goldfried, 1980; Prochaska & DiClemente, 1982; Strupp, 1981). With ever-expanding research into therapeutic modalities, activities, and technologies, the importance of understanding current psychotherapeutic practice has not waned. However, research exploring the clinical practices of

psychologists in Canada is surprisingly lacking (Hunsley & Lefebvre, 1990; Hunsley et al., 2013; Ronson, Cohen, & Hunsley, 2011; Warner, 1991). Until a recent study documenting the practice characteristics of Canadian psychological practitioners (Hunsley et al., 2013), there had been no documentation of the characteristics and activities of psychologists in over two decades. This gap in the Canadian literature is further highlighted by the lengthy history in the United States, dating back at least five decades, of survey research investigating various characteristics and practices of psychologists including theoretical orientations (e.g., Norcross et al., 2005; Norcross & Prochaska, 1982a; Norcross, Prochaska, & Gallagher, 1989a; Prochaska & Norcross, 1983), therapeutic practices (e.g., Crowe, Grogan, Jacobs, Lindsay, & Mack, 1985; Norcross et al., 1989a), testing practices (e.g., Lubin, Matarazzo, Larsen, & Seever, 1986), and professional satisfaction (e.g., Norcross, Prochaska, & Gallagher, 1989b). Recently, there has also been information gathered in other areas of the world, such as Australia and the United Kingdom (UK) (see Mathews, Stokes, Crea, & Grenyer, 2010; Stokes, Mathews, Grenyer, & Crea, 2010; Stokes, Mathews, Grenyer, & Stokes, 2010), concerning the characteristics of psychotherapists (see also Tamtam, 2006), psychologists' education, training, specialist qualifications, and continuing education (Grenyer, Mathews, Stokes, & Crea, 2010), as well as employment settings and professional activities (Mathews et al., 2010; Stokes, Mathews, Grenyer, & Crea, 2010). As stated by Mathews and colleagues (2010), "without accurate and comprehensive data, confusion and misrepresentations arise concerning the availability, quality and ability of the psychology workforce" (p. 155).

It is disappointing that the same efforts have not been put forward within the Canadian context across the years. This information would allow for a better understanding of the current nature and standing of the field and of the professionals themselves, and would facilitate the

documentation and evaluation of the waves of change in practices and characteristics. The Canadian Psychological Association (CPA) has recently put efforts towards obtaining information about the demographics and practice characteristics of registered psychologists, and the demographics of their clients, through the Psychology Practice Network (Ronson et al., 2011). The CPA states:

> An accurate understanding of the psychological health needs of Canadians and the services provided to them depends in part on the collection of information from Canada's health service providers. Psychologists are Canada's largest group of regulated and specialized mental health care providers. However, largely because their services are increasingly provided in the private sector, information about psychologists and their services are not publicly collected. (Ronson et al., 2011, p. 8)

In light of this, the CPA has hopes that further documentation of the characteristics and activities of psychologists will continue, both as a means of informing the Public Health Agency of Canada, as well as contributing to the discipline of psychology itself (Ronson et al., 2011). The results of the survey conducted in 2009 by Hunsley and colleagues (2013) through the CPA Practice Network is the first step on the path of continued documentation of the practice of psychology in Canada. Surveying licensed members of the American Psychological Association (APA) concerning diverse aspects of their practice has yielded an immense body of knowledge about what psychologists do, where they work, with whom they work, and what orientations they espouse, (Garfield & Kurtz, 1974, 1975; Kelly, 1961; Norcross, Karg, & Prochaska, 1997a, 1997b; Norcross & Karpiak, 2012; Norcross et al., 2005; Norcross & Prochaska, 1982a, 1982b; Norcross et al., 1989a, 1989b). The importance of these studies cannot be understated, as "much of what passes for "common knowledge" and "obvious trends" in clinical psychology was originally identified in these studies" (Norcross et al., 2005, p. 1468).

The timing for investigating psychological practice characteristics in the Canadian

context is apt. Hunsley and colleagues (2013) highlight a number of significant shifts that have occurred since the last documentation of the characteristics of psychologists over two decades ago. These include a 40% increase in the number of registered psychologists (Canadian Institute for Health Information, 2011), an increase in the number of CPA accredited training programs and internship sites, the development of the Mutual Recognition Agreement (MRA; see www.cpa.ca/docs/file/MRA.pdf) which allows licensed psychologists to easily transfer their licensure to other provincial jurisdictions, and changes in registration requirements in different provinces (e.g., shift from a master's degree registration to a doctoral degree in Quebec, see www.ordrepsy.qc.ca/en/obtenir-un-permis/permis-de-psychologue/requirements-and-admission-procedures.sn). Beyond these, there is recognition of the greater number of licensed psychologists providing services in the private sector in Canada (Hunsley et al., 2013; Ionita & Fitzpatrick, 2014; Ronson et al., 2011), as well as the increased attention concerning evidence-based practice and formal tracking of treatment progress and outcomes (Hatfield & Ogles, 2004; Ionita & Fitzpatrick, 2014; Overington & Ionita, 2012).

Increasing Access to Psychotherapy Treatment

In addition to the changes listed above within the profession, accessibility to mental health care services, specifically psychotherapy, has increasingly become a priority within the Canadian context (Cavaliere, 2014; Moulding, Grenier, Blashki, Ritchie, Pirkis, & Chomienne, 2009; Peachey et al., 2013). Approximately ten years ago, the report entitled "Out of the Shadows at Last" (Kirby & Keon, 2006) proposed a reorganization of the mental health system, promoting a shared-care approach between mental health professionals (e.g., family physicians, psychiatrists, psychologists) with primary health care services delivering the majority of mental health treatment to aid in increasing accessibility.

The burden of mental health problems among Canadians can no longer be ignored, as these problems lead to harmful economic and social consequences, such as higher rates of unemployment (Centre for Addictions and Mental Health, 2012; Dewa & McDaid, 2010), disability (Centre for Addictions and Mental Health, 2012) and suicide. It is estimated that 4000 Canadians die prematurely every year due to suicide. The suicide rate of Canadian youth ranks third in the industrialized world and is among the leading causes of death in youths aged fifteen to twenty four (Canadian Mental Health Association, 2016). According to the Canadian Mental Health Association (2016) only 20% of children in need receive mental health treatment, and approximately half of adults who feel they have had difficulties with depression or anxiety have consulted a professional.

The recent Mental Health Care System study published in 2015 reported that the most fundamental area of prioritization in mental health treatment in Canada is accessibility to mental health professionals (Mood Disorders Society of Canada, 2015). Cost of services was labelled as a major obstacle in obtaining treatment for mental health problems for the majority of those sampled (68%). While 57% indicated having private insurance to cover mental health treatment, the majority of these individuals believed that their insurance coverage was not adequate to meet their mental health treatment needs. This report also highlighted the overall perception of the surveyed public of the lack of concern, fair treatment, respect and prioritization of mental health problems (see Mood Disorders Society of Canada, 2015). This is a bleak picture of the current landscape in the Canadian context in how we address mental health problems and attempt to meet the treatment needs of those suffering.

A recent report for the CPA entitled "An Imperative for Change: Access to Psychological Services for Canada" (Peachey et al., 2013), describes the lack of accessibility in Canada as a

silent crisis, and proposes possible action that could be taken to achieve increased accessibility. Further evidence of the call for increased access can be seen in a recent special issue of *Canadian Psychology*, focused on the provision of psychological services in Canada and accessibility to these services (see Cohen & Peachey, 2014; Drapeau, 2014). Specifically within the Quebec context, there has been increased attention to the issue of accessibility with the formation of the Coalition for Access to Psychotherapy (CAP) and the Quebec Health and Welfare Commissioner's report, *For More Equity and Results in Mental Health,* stating the need to ameliorate the inequalities in mental health care accessibility in Quebec (Commissaire à la santé et au bien-être du Québec, 2012). Finally, the report by the Institut National d'Excellence en Santé et en Services Sociaux (INESSS; 2015) on equitable access to psychotherapy services outlines that there is a need in Quebec for competent professionals to offer evidence-based psychotherapy treatments. INESSS (2015) states that access to these services is limited and often only available to those with the financial means to pay out-of-pocket or those covered through private insurance, and that the services are often sought privately. International efforts to make mental health care, specifically psychotherapy, more accessible have been implemented in both the UK and Australian health care systems through government-funded services (Clark, 2011; Department of Health, 2008a; Department of Health 2008b; INESSS, 2015; Pirkis, Blashki, Murphy, Hickie, & Ciechomski, 2006), and serve as an example for increased access to services.

Models of Government-Funded Psychotherapy

Improving Access to Psychological Therapies (IAPT)

The UK has implemented a model of government-funded psychotherapy entitled the 'Improving Access to Psychological Therapies' (IAPT) program. The foundations of the IAPT program were rooted in two major developments, the first being the development of the National

Institute for Health and Care Excellence (NICE) guidelines (see the NICE website: http://www.nice.org.uk/Guidance/Topic; NICE, 2009; 2011) for effective treatment of depression and anxiety disorders (Clark, 2011). The second fundamental development was the recognition, from research accumulated from clinicians as well as economists, of the economic burden of mental health problems such as anxiety and depression (e.g., medical costs, disability costs, welfare benefits, lost tax revenue due to loss of work; Clark, 2011; Layard, Clark, Knapp, & Mayraz, 2007; Mind, 2010), and the argument that these costs could be lessened if treatment for such mental health problems would be made available through government funding. It was out of these founding principles that the IAPT program was born.

The program was designed to train a workforce to offer evidence-based therapies for the treatment of depression and anxiety disorders, using a stepped-care approach. Those with mild to moderate depression and specific anxiety disorders can receive *low intensity treatments*, such as guided self-help, psycho-educational groups, and computerized CBT (Department of Health, 2008c; INESSS, 2015). These interventions are conducted by a psychological well-being practitioner (PWP), a professional who is not a psychologist but who has been trained in the program to offer these interventions. Those with more severe or chronic conditions such as severe depression and specific anxiety disorders (e.g., PTSD) can receive *high intensity* treatments, including face-to-face psychotherapy, usually CBT, but also interpersonal therapy and couples therapy, with a clinical psychologist (Clark, 2011; Clark et al., 2009; Department of Health, 2008d; INESSS, 2015). This stepped care approach follows the NICE guidelines (Department of Health, 2008e). At the outset of the program, the National Health Service (NHS) in England, of which there are 154 Primary Care Trusts (PCTs) that are responsible for the health care of their local residents, chose 2 PCTs to act as pilot sites for the IAPT program (Clark,

2011; Clark et al., 2009). These PCTs were provided with funding to recruit and train workers in the use of CBT oriented therapies for anxiety disorders and depression (Clark, 2011; Clark et al., 2009). Now 95% of PCTs have adopted the IAPT service model, and services are provided through family physician offices and mental health teams in hospitals and outpatient settings. Individuals can be referred to the program through a family physician, an employment support agency, other health professionals, or through self-referral (Clark, 2011; INESSS, 2015). A key principle of the program, and one shown to be related to better outcomes, is the 'step-up' process in which patients who are not responding to the first line 'low-intensity' treatment are then moved to the 'high-intensity' face-to-face therapies.

A distinctive feature of the IAPT program is the provision of an outcome tracking system. Patients complete a standardized measure of anxiety or depression (Generalized Anxiety Disorder 7- GAD-7; Patient Health Questionnaire Depression Scale- PHQ-9) (Clark, 2011; Clark et al., 2009), and an employment questionnaire (Clark, 2011; Clark et al., 2009; Department of Health, 2008a) at each session. It is the hope of the IAPT program developers that "a measure of the severity of depression and anxiety at the last clinical contact would be available for almost everyone" (Clark et al., 2009, p. 911). In the first three years of the program's inception, more than 680,000 individuals had completed treatment and close to 4000 new practitioners were trained in delivering treatments in line with the NICE guidelines (Department of Health, 2008b). Effectiveness studies have shown that the services provided through IAPT have resulted in clinical significant improvements for approximately 45% of those treated for both anxiety disorders and depression (Guyani et al., 2011; INESSS, 2015; Richards & Suckling, 2009), and have shown success in terms of maintaining employment, lessening reliance on social assistance, and in reducing the use of health care services (see INESSS, 2015).

While there have been successes in the IAPT program in its first years of inception, it was estimated that only 60% of the population had access to effective services. With an extension in funding, plans were put in place to expand IAPT services beyond the adult population presenting with anxiety and depression to include children, adolescents, the elderly, those with severe mental illness and those with chronic health conditions (Department of Health, 2008e; INESSS, 2015; Thornicroft, 2011).

The Australian Context: Better Outcomes and Better Access Programs

Over ten years ago an initiative to improve mental health care service delivery began in the Australian health care system (Hickie & Groom, 2002; Vasiliadis & Dezetter, 2015). Many factors were influential in the reform of mental health service, including the recognition of the inability of the current system to meet the mental health care needs of consumers, and the heavy reliance on primary care general practitioners (GPs) to deliver services (Hickie & Groom, 2002; Mental Health Council of Australia, 2003, 2005). As with the development of the IAPT program, an early driving force within the Australian context was the recognition of not only the economic burden of mental health problems, but also the cost-effectiveness of evidence-based psychological treatments (Vos, Corry, Haby, Carter, & Andrews, 2005). Furthermore, there was a strong current of support across disciplines to incorporate psychologists into the primary care system and use primary care as the main vessel for mental health treatment (Pirkis, Blashki, Murphy, Hickie, & Ciechomski, 2006)

Hence, the Australian government funded the Better Outcomes in Mental Health Care (BOiMHC) program, with the aim of increasing treatment rates of common psychological problems such as anxiety and depression (Australian Government Department of Health, 2015a; Hickie & Groom, 2002; INESSS, 2015). There are several components to the program, the first

being the Access to Allied Psychological Services (ATAPS), which allows GPs to refer patients to allied mental health professionals who deliver evidence-based focused psychological strategies, such as CBT and interpersonal therapy (Australian Government Department of Health, 2015a; Fletcher et al., 2012; Pirkis, Burgess, Kohn, Morley, Blashki, & Naccarella, 2006a). By GP referral, individuals can receive up to 12-individual therapy session per calendar year (the GP has to evaluate after 6 sessions), with the possibility of 18 sessions per calendar year for special circumstances. In addition to 12 individual sessions, patients can also receive 12 group therapy sessions per calendar year. ATAPS provides services primarily to individuals with high prevalence disorders, such as depression and anxiety (Australian Government Department of Health, 2015a; Hickie & Groom, 2002; Pirkis et al., 2006a; Pirkis et al., 2006b)

Another component of the BOiMHC initiative is education and training for GPs to enhance their knowledge and skills in assessment and diagnosis of mental health problems, preparation of a mental health plan, and training in delivering focused psychological interventions. Additionally, GPs are provided with access to mental health treatment consultation from psychiatrists within 24 hours (Australian Government Department of Health, 2015a; Hickie & Groom, 2002; Pirkis et al., 2006a; Pirkis et al., 2006b).

The ATAPS program functions in conjunction with the Better Access initiative, introduced in 2006, which gives medical rebates for mental health services through the Medicare Benefits Schedule (10 individual sessions/10 group therapy sessions per calendar year) (Australian Government Department of Health, 2015b; Pirkis, Ftanou, Williamson, Machlin, Spittal, Bassilios, & Harris, 2011). To access the Better Access services, a GP, psychiatrist or paediatrician must refer the client, and the GP must complete a mental health assessment and prepare a Mental Health Treatment Plan before referring out (Australian Government

Department of Health, 2015b). The types of treatments offered through the Better Access program include psycho-education, CBT, relaxation therapy, skills training, and interpersonal therapy, for a range of mental health problems (e.g., psychotic disorders, eating disorders, depression, anxiety, drug use problems, bereavement disorders, conduct disorder, sleep problems, post-traumatic stress disorder, among others) (Australian Government Department of Health, 2015b; INESSS, 2015). An individual can receive mental health services from both the ATAPS and Better Access programs as long as they do not exceed the established number of sessions per calendar year, and they are not referred through both programs simultaneously. Over 2 million individuals received treatment (predominantly CBT) in the first three years of the Better Access initiative, and over 110,000 individuals were treated through the ATAPS program. Routinely those treated in these programs receive no more than 6 sessions, and effectiveness studies show moderate to high effect sizes for improvement in those receiving treatment for anxiety and depression (Fletcher, 2012; INESSS, 2015; Pirkis et al., 2011).

Given the shifts in the field of psychology discussed above, and particularly the larger recognition of the need for increased access to psychotherapy services to better serve those with mental health problems, the timing is apt to better understand and document the current practice activities and characteristics of psychological practitioners. Prior to developing initiatives to increase access to psychotherapy treatment, having an understanding of the current standing of practices of psychological practitioners, and particularly psychotherapy treatment, in the local context is needed to inform these initiatives. We now turn our focus to outlining the historical documentation and waves of changes in psychologist and psychotherapist practice activities and characteristics.

Review of the Literature Documenting Psychological Practice

Professional Activities

Consistent historical tracking of the members of both the APA Division of Clinical Psychology (see Norcross & Karpiak, 2012; Norcross et al., 2005) and the Division of Psychotherapy (see Norcross, Hedges, & Castle, 2002; Norcross & Rogan, 2013) provide information on what professional activities psychologists are engaged in. For both divisions, across the last three decades psychotherapy remains the predominant activity (Division of Clinial Psychology: 87% of psychologists practiced psychotherapy in 1986, and 76% in 2010; Division of Psychotherapy: 99% in 1981, and 92% in 2012) (Norcross & Karpiak, 2012; Norcross & Rogan, 2013). This is followed by diagnosis and assessment (Division of Clinial Psychology: 75% in 1986, 76% in 2010; Division of Psychotherapy: 73% in 1981, 55% in 2012). For a detailed discussion of trends in professional activities please refer to Norcross and Karpiak (2012) and Norcross and Rogan (2013). These studies highlight two major trends across the last three decades that are of interest: a) while it is documented that psychologists engage in diverse activities (e.g., psychotherapy, assessment and diagnosis, research, teaching) there is a shift towards specialization, with psychologists taking on larger roles in fewer areas of practice (e.g., research, psychotherapy); and b) with the increase in specialization, there are fewer professionals engaging in both clinical supervision and consultation. It should be noted that while *fewer* psychologist are offering psychotherapy according to these studies, the percentage of professional time devoted to psychotherapy for those who do has remained stable or increased; however, such has not been the case for supervision and consultation. There is both a decline in the number of those who do these activities, and a decline in the amount of professional time devoted to these.

Hunsley and colleagues' (2013) survey of Canadian psychological practitioners (predominantly psychologists, but also included psychological associates) ($N = 538$) provides updated data concerning their professional activities. Prior to this there had not been documentation of psychologist general practice characteristics since Hunsley and Lefebvre's (1990) small survey sample of Canadian clinical psychologists ($N = 89$) over twenty years ago. Similar to the APA samples discussed previously, Hunsley and colleagues' (2013) sample indicated psychotherapy as the predominant activity (at least 85% of the sample reported that they conducted psychotherapy, with 41% of their weekly work hours on average being devoted to intervention). The next most practiced activity was assessment (at least 74% of the sample reported that they conducted assessment, taking up approximately 29% of weekly work hours.[1] Following these, 65% of the sample indicated conducting clinical/counselling consultation, with approximately 13% of their work time devoted to this. What is difficult about interpreting this is that it may include providing formal supervision, as supervision was not a stand along option within this survey. Teaching and research each only accounted for approximately 6% of professional work time (Hunsley et al., 2013). The amount of time devoted to both teaching and research is very similar to those of the APA Division of Psychotherapy, however those in the APA Division of Clinical Psychology indicated that research accounted for 15% of their professional work time (Norcross & Karpiak, 2012; Norcross & Rogan, 2013). Similar results were reported by Mathews and colleagues (2010) concerning the activities of 9330 Australian psychologists; approximately 43% of the respondents' professional time was devoted to

[1] In Hunsley et al. (2013) the percentages of respondents conducting specific psychotherapy modalities (e.g., individual, group) and specific assessments (e.g., mood and behavioral assessments; intellectual assessments) were given; however total percentages for all types of psychotherapy and assessments were not provided. Therefore the highest percentage per type of psychotherapy format (e.g., individual therapy) and assessment (mood and behaviour assessment) were outlined here.

counselling and intervention, 15% to assessment and approximately 5% was devoted to teaching and research each.

Overall, there have not been dramatic shifts in the activities of psychologists in Canada since Hunsley and Lefebvre's (1990) study over twenty years ago, with the exception of more professional work time spent in assessment and diagnosis in the updated study (28.5% in 2010 as compared to 16% of work time in original study). From the data currently available in the Canadian context we do not see the trend of specialization as clearly as has been documented through the APA.

Psychotherapy Format and Age Populations

Individual therapy has historically been, and remains, the predominant psychotherapy format offered (Hunsley & Lefebvre, 1990; Hunsley et al., 2013; Norcross & Karpiak, 2012; Norcross & Rogan, 2013). Approximately 85% of Hunsley and colleague's (2013) sample of Canadian psychological practitioners indicated conducting indivdiual therapy, which is quite similar to the results obtained over twenty years ago, in which at least 86% indicated conducting individual therapy (Hunsley & Lefebvre, 1990). Two studies focusing on psychological practice in Canadian hospitals also documented that the most common routine professional activity was individual therapy (reported by 89% of sampled hospitals in 1987, and 91% in 2004; see Arnett, Martin, Steiner, & Goodman, 1987; Humbke, Brown, Welder, Fillion, Dobson, & Arnett, 2004). Finally, similar results are indicated in Norcross and Karpiak's (2012) study of the APA Division of Clinical Psychology (98% of those who offered psychotherapy conducted individual therapy, occupying on average 79% of their psychotherapy time) and Norcross and Rogan's (2013) study of the Division of Psychotherapy (99% conducted individual psychotherapy, occupying 80% of their psychotherapy time).

Couple/marital therapy is the next most dominant psychotherapy format (27% of Hunsley and colleague's (2012) Canadian sample; approximately 50% of Norcross & Karpiak's (2012) sample; and 75% of Norcross & Rogan's (2013) sample), followed by family therapy (approximately 30% across the different samples) and finally group therapy (approximately 20% across the different samples; see Hunsley & Lefebvre, 1990; Hunsley et al., 2013; Norcross & Karpiak, 2012; Norcross & Rogan, 2013). From the information available within the Canadian context, there is a general trend of fewer professionals offering couple/maritial therapy and family therapy (see Arnett, Martin, Steiner, & Goodman, 1987; Humbke, Brown, Welder, Fillion, Dobson, & Arnett, 2004; Hunsley & Lefebvre, 1990; Hunsley et al., 2013).

In terms of offering services to different age groups, more than 75% of sampled Canadian psychological practitioners offered services to young adults (18- 25) and adults (26 – 59), approximately two thirds offered services to adolescents, and approximately half offered services to either children (under 12) and older adults (60 and older) (Hunsley et al., 2013). The majority (62.5%) of Ionita and Fitzpatrick's (2014) sample of 1668 Canadian psychologists also indicated adults as their primary clientele, followed by older adults (12%) and children (10.5%).

Employment Setting

In the United States we can see a trend of psychologists decreasingly being employed in medical settings, and increasingly being employed in the private sector (Norcross & Karpiak, 2012; Norcross & Rogan, 2013). Over the last three decades, we see an increase in surveyed members of the APA offering psychological services in the private sector (Division of Clinial Psychology: 31% in 1981, 41% in 2010; Division of Psychotherapy: 51% in 1981, 62% in 2012). Following private practice, the next most common work settings have been a university, (Division of Clinial Psychology: 22% in 1981, 26% in 2010; Division of Psychotherapy: 17% in

1981, 15% in 2012), followed by various medical settings (e.g., general hospital, psychiatric hospital, outpatient clinic).

The steady presence of psychologists in the private sector is also evident in the Australian context, as 31% of a sample of 8,086 Australian psychologists reported private practice as their primary job, and 53% as their second job (Mathews et al., 2010). These percentages are higher than those reported by the Australian Institute of Health and Welfare in 2006 (AIHW; 2006). Additionally, 40% of a sample of 581 Australian psychologists indicated independent practice as their primary position (Byrne & Davenport, 2005), and 22% of a sample of 1,167 members of the Australian Psychological Association working in the public sector reported that they planned to resign or reduce their hours to work in independent practice (Forsyth, 2009).

Historically there has been sparse documentation within the Canadian context of psychologist employment settings. From the data that are available, it appears that psychologists continue to have a consistent presence in both the public and private domains. Over twenty years ago, three quarters of Hunsley and Lefebvre's (1990) small sample indicated working in more than one setting, with the most common being private practice (30%, primary work setting; 38%, secondary work setting). Other primary settings included hospitals (22%), and academic settings (10%). Data collected by the Association of State and Provincial Psychology Boards in 2008-2009, reported that 20% of the 189 Canadian psychologists surveyed were primarily working in private practice, and 13% in hospital settings; however, these data were collected on psychologists from all specialties, not exclusively those in psychotherapy practice (Greenberg, Caro, & Smith, 2010).

More recent Canadian data come from Hunsley and colleagues' (2013) sample of psychological practitioners. Results of their survey indicated that 28% of the participants

worked exclusively in independent private practice, 23% exclusively in the public sector, and 38% in the public sector but also privately as a secondary position. This appears to indicate an increase of psychologists working privately, either as a primary or secondary position. Another indicator of the large amount of services offered in the private sector comes from Ionita and Fitzpatrick's (2014) survey of 1668 Canadian psychologists, in which 63% of the sample indicated receiving payment for psychotherapy services directly from the client. In looking to those who work predominantly with children and adolescents, 68% of a sample of Canadian psychologists ($N = 137$) indicated that they provided the majority of their services in the public sector, and approximately 30% provided the majority of their services through independent private practice (Hunsley, Ronson, Cohen, & Lee, 2014). The higher occurrence of publicly offered services in this sample was likely due to the fact that many services for adolescents and children are offered within a school setting.

Historical Documentation of Theoretical Orientation

Over 40 years ago researchers in the United States had documented the heavily endorsed eclectic orientation in psychological practice (see Garfield & Kurtz, 1976; Kelly, 1961), as well as the influence of the psychoanalytic orientation (see Kelly, 1961; Wildman & Wildman, 1967). The 1980's brought a shift in the field with the surge of influence of the cognitive and behavioural orientations (Prochaska & Norcross, 1983; Smith, 1982; Watkins, Lopez, Campbell, & Himmell, 1986). Indeed, as noted in Norcross and colleagues' (2005) summarization of the APA Division of Clinical Psychology from 1960-2003, the late 80's and the 90's continued to mark the increase in the cognitive orientation, the steady endorsement of the eclectic modality, and the slow but continuing decline in influence of the psychodynamic orientation. Most recently, Norcross and Karpiak's (2012) documentation of the APA Division of Clinical

Psychology indicated the continued rise of the cognitive behavioural orientation, and a slight decrease in the eclectic/integrative orientation. However, this may not be representative of all practitioners, as Norcross and Rogan's (2013) study documenting the Division of Psychotherapy indicated that the majority of respondents endorsed a psychodynamic/psychoanalytic orientation, approximately 25% an integrative orientation, and 20% a cognitive or behavioural model.

There has been disjointed documentation within the Canadian context. Similar to those practicing in the United States, over twenty years ago, the most common theoretical orientation of practicing psychologists in Canada was eclecticism, followed by the cognitive-behavioural orientation (Hunsley & Lefebvre, 1990; Warner, 1991). Continuing in this trend, recent Canadian studies have shown the ever-rising influence of the cognitive behavioural orientation, as well as the endorsement of multiple orientations. Hunsley and colleagues' (2013) sample indicated an overwhelming endorsement of the cognitive behavioural orientation with 80% endorsing this either solely or in combination with other orientations. This was followed by the humanistic/experiential orientation (30%) and psychodynamic (26%). Ionita and Fitzpatrick's (2014) large survey study of 1668 Canadian psychologists' use of progress monitoring measures also documented the use of different theoretical orientations; the majority of this sample (42%) endorsed between three and five orientations, with cognitive behavioural therapy being rated as the most influential, followed by humanistic, and psychodynamic. Finally, specifically within the Quebec context, there has been an increased endorsement of cognitive-behavioural as a primary orientation (from 18.4% in 1993 to 38% in 2013), and a decline in endorsing other orientations (e.g., humanistic, psychodynamic; Jaimes, La Rose-Herbert, & Moreau, 2015). However, the rise in endorsing the cognitive-behavioural orientation has had a slower pace in Quebec when compared to the rest of Canada, as only 55.8% endorse it as a primary or

secondary orientation (see Jaimes, La Rose-Herbert, & Moreau, 2015). The authors speculated that the specific culture within Quebec might contribute to this. As French is the first language of the majority of psychologists, the influence of literature and training that is not English, and the fact that French-speaking countries continue to be influenced by the psychodynamic/psychoanalytic model, may be key factors in this phenomenon.

Treatment of Mental Health Problems and Diagnoses

Statistics Canada (2012) outlines the most prevalent mental health problems in the Canadian population, with over 2.8 million people meeting the criteria for major depression, bipolar disorder, generalized anxiety disorder, or substance abuse in a 12-month period. Hunsley and colleagues (2012) compared the types of mental health problems most commonly treated, as reported by psychology practitioners in Canada, in a public versus private setting, as well as those with a master's versus doctoral degree. Across all groups, the most common mental health problems were anxiety disorders (reported by 97% in private and 76% public), mood disorders (reported by 89% in private and 73% in public), intrapersonal problems (reported by 95% in private and 72% in public), and interpersonal problems (reported by 93% in private and 59% in public). For a discussion of the differences between the rates of diagnoses treated in the public and private sector, please see the section below pertaining to private practice.

Technical Aspects of Psychotherapy in Canada

A study conducted through the CPA Psychology Practice Network (Ronson et al., 2011) asked practicing psychologists from across Canada ($N = 140$) to answer questions concerning frequency of sessions, duration of therapy, presenting problems, and diagnoses from two different clients currently within their practice. The data demonstrated that clients were most commonly referred by a physician, psychiatrist, or were self-referred. The average number of

sessions at the time of the study was 14 for the first wave of identified clients, and 24 for the second. Over half of the professionals reported that on average less than 8 sessions would be remaining in the treatment, and approximately 90% indicated less than 20 sessions remained. In terms of setting, 40% were being seen in private practice and 30% in the public health care setting. Across both waves of identified clients, approximately 50% reported CBT as the modality used in session (with 20% humanistic), and between 20-30% identified assessments of mood, behavior, and personality. Ten to thirteen percent (10-13%) of the sample reported that they conducted each of the following: interpersonal therapy, psychodynamic therapy, and intellectual functioning assessments. Clients on average had three presenting problems, most commonly intrapersonal problems, followed by interpersonal problems, mood disorders and finally anxiety; with anxiety disorders and mood disorders being the most common diagnoses. Participants reported that the health status of the clients had greatly improved for 20% of clients, improved for 50%, and 25% had seen no change. This data provides rich information about the practice of psychology in Canada; however the authors state that it is difficult to generalize these findings to the larger Canadian context, as with only 140 participants discussing two clients each this may not be representative of the range of client characteristics and problems being seen in clinical practice (Ronson et al., 2011).

Characteristics of those in Private Practice

As mentioned previously, there has been an increase in psychologists practicing privately (Byrne & Davenport, 2005; Norcross & Karpiak, 2012), and research concerning those working in the private sector has indicated that those in private practice report lower levels of burnout and greater job satisfaction (Boice & Myers, 1989; Vrendenburgh, Carlozzi, & Stein, 1999). However, little effort has been put forth in investigating those practice variables and

characteristics that are specific to the realm of private practice, particularly in comparison to those working in the public sector (Norcross & Prochaska, 1983; Schneider, 1981). Results of an older study comparing a sample of 210 doctoral level psychotherapists in private practice with those working in the public sector ($N = 72$) reported that those in private practice tend to be older, more experienced, have higher career satisfaction, devote more time to marital/couple therapy, work less hours per week, and conduct little research (Norcross & Prochaska, 1983). For this particular sample, no differences were found between those working privately and those in the public sector in terms of gender, receiving personal therapy or theoretical orientation. Although this provides an initial exploration of the differences in those working in these two settings, the small sample size and the fact that the study was conducted thirty years ago make the findings difficult to generalize to the psychotherapy settings of today. Other studies of activities and characteristics of private psychotherapy practice have limited samples and are also dated (see Koss, 1979; Norcross, Nash, & Prochaska, 1985; Tryon, 1983).

In turning to more recent data, Stokes, Mathews, Grenyer and Crea (2010) conducted a comprehensive investigation ($N = 8,086$) of the differences in psychologists working in the public sector, employed in the private sector, or practicing independently in Australia. Similar to the previous results, those in independent private practice were older, spent more time in psychotherapy and mental health interventions and less time consulting organizations and groups, compared to those employed by a private company or public institution. Additionally, those in independent private practice spent the least time on research, and worked primarily with adults and couples (Stokes, Mathews, Grenyer, & Crea, 2010). Furthermore, those in independent practice identified the government funded *Better Access to Mental Health Care* initiative as the primary funding arrangement, followed by out-of-pocket payment; an

encouraging finding of the initiative to subsidize mental health treatment and increase accessibility. However, there is increasing concern resulting from these findings, as well as others (Forsyth, 2009; Gleeson & Brewer, 2008), for retaining senior professionals in the public sector, as many migrate to independent practice. Better work conditions and increased remuneration may need to be considered to remedy this concern.

Private Practice in Canada

The most updated Canadian data comparing psychologists in public and private practice comes from Hunsley and colleagues' (2013) investigation of the general practice characteristics of Canadian psychological practitioners. In this sample, significantly more individuals with a clinical or counselling degree were employed in the private sectors, and those with a doctoral degree made up the majority of those in exclusive public practice (67%). Similar to previous research, those in exclusive private practice conducted significantly more individual therapy, couple therapy, vocational assessments, and consultations with the corporate and legal sectors. Those in the public sector spent significantly less time in intervention, and more time teaching, conducting research, providing group therapy, conducting assessments (e.g., mood and behaviour assessments, neuropsychological assessments), providing organization and program consultations, and consulting with health and educational institutions. Those in exclusive private practice saw significantly more clients on average per week (16-17), compared to those in the public sector (on average 12 per week). Finally, the presenting problems most often seen by those in the public sector included psychological problems of childhood, cognitive functioning problems of childhood, psychosis, and learning problems, whereas mood disorders, anxiety disorders, intrapersonal and interpersonal issues, vocational concerns and health and life stressors were most often presented in the private sector.

Current Gaps in Documenting Psychological Practice in Canada

While recent years have seen greater recognition of the need for documenting psychological practice in the Canadian context, there still exist gaps in our understanding of those offering and those seeking psychological services. Specifically, as more and more service users seek psychotherapy treatment in the private sector, it is becoming increasingly important to gain a thorough understanding of this sector. This includes not only the types of treatments offered, but also the clinical tools used in routine practice, the fees associated with these services, the length of treatment, the referral pathways as well as the collaboration of psychology practitioners with other health care professionals.

With the current highlighting of the need for increased access to psychotherapy and the focus on developing initiatives to increase public funding of psychotherapy services (INESSS, 2015; Peachey et al., 2013), understanding the perspective of psychologists, the largest group of specially trained mental health professionals in the provision of psychological treatments, is needed.

Summary and Research Objectives

Recent efforts have been put forth to better understand psychological practice in Canada (e.g., Hunsley et al., 2013; Ionita & Fitzpatrick, 2014; Ronson et al., 2011), as historically psychology in Canada has greatly fallen behind in terms of tracking trends in practice. Given the recent increase in practitioners offering services in the private sector as outlined previously (e.g., INESSS, 2015; Ronson et al., 2011), there is a need for a greater understanding of psychological practice in this sector. Furthermore, with the focus on increasing access to psychotherapy treatments, and the efforts being put forth to understand appropriate care models for the local health care context, the perspectives of psychology practitioners needs to be investigated so that

their role in a possible government-funded psychotherapy model can match their needs and expertise. It is integral to have information documenting the practices of psychology practitioners so that government-funded initiatives are in line with current practices; without this information guiding the development of new psychotherapy initiatives, there may be low adherence to new government-funded models.

The following studies aim to document the perspectives of psychologists and psychotherapists concerning access to psychotherapy and the possible development of a government-funded psychotherapy model. Furthermore, in order to inform these future psychotherapy accessibility initiatives, the following studies also aim to document the current characteristics of psychotherapy treatment in the Quebec context, particularly in the private sector, as there is a dearth of knowledge concerning service delivery in this sector. We begin with the studies focused on current private psychotherapy practice, followed by the studies exploring the perspectives of psychologists and psychotherapists concerning a government-funded psychotherapy model.

CHAPTER 2: Psychotherapy in the Private Sector in Quebec: A Survey of Licensed Psychologists and Psychotherapists

Bradley, S., Service, J., Roberge, P., Vasiliadis, H.M., & Drapeau, M., (2016a). *Psychotherapy in the private sector in Quebec: A survey of licensed psychologists and psychotherapists*. Manuscript submitted for publication.

Abstract

Recent efforts have been put forth in the Canadian context to document current trends in psychotherapy practice (e.g., Hunsley, Ronson, & Cohen, 2013; Hunsley, Ronson, Cohen, & Lee, 2014); however, information concerning private psychotherapy practice is significantly lacking (Ronson, Cohen, & Hunsley, 2011). With an increased focus on the importance of access to mental health care (Bradley & Drapeau, 2014; Cavaliere, 2014), knowledge of those being served in the private psychotherapy sector is needed to have a complete picture of psychotherapy service needs and delivery. The aim of the present study was to document the current practice characteristics (e.g., psychotherapy format offered, age groups being served, collaboration with other professionals, referral sources, fees for services, clinical tools used, wait-times) of licensed psychologists and psychotherapists in the private sector of Quebec. Participants were 671 psychologists and psychotherapists currently offering private psychotherapy services. Results indicated that the most served age population is adults (age 31-64); individual therapy was the most common psychotherapy format; and the average number of clients seen per week in the private setting was 13.49 (*SD* = 8.46). Anxiety and mood disorders were reported to be the most frequently treated mental disorders. The average number of treatment sessions was 23.35 (*SD* = 20.82; *Mdn* = 18). The average fee charged for individual therapy was $95.10 (*SD* = 16.69); 27% of the sample indicated that they offer a sliding scale, and 20% indicated that they have offered psychotherapy at no cost. Survey results are discussed in relation to current trends in the Quebec and larger Canadian context, as well as the implications of these results for practitioners, trainees, and also in relation to improving mental health care services.

***Keywords*: psychotherapy practice; private practice; psychologist; psychotherapist; survey; psychotherapy fees**

Psychotherapy in the Private Sector in Quebec: A Survey of Licensed Psychologists and Psychotherapists

The mental health care needs of Canadians, and the failure to meet these needs, has become a hot topic within our health care system, among researchers, mental health care organizations, the media, governments and the public (e.g., Cavaliere, 2014; Peachey, Hicks, & Adams, 2013). The need for appropriate mental health treatment has never been greater; as of 2011, one in five Canadians suffer from a mental health problem (Mental Health Commission of Canada, 2012). Mental health problems are also one of the primary causes of disability in Canada and worldwide (Centre for Addictions and Mental Health, 2012; World Health Organization, 2009). The recent Mental Health Care System survey, conducted through The Mood Disorders Society of Canada (2015) reported that 38% of surveyed Canadians had to wait more than a year to receive an initial mental health diagnosis. The 2014 Survey on Living With Chronic Diseases in Canada (Public Health Agency of Canada, 2014) states that approximately 12% of Canadians have a mood or anxiety disorder, with 93% being prescribed medication and only 20% receiving a psychological intervention.

The efficacy and cost-effectiveness of psychotherapy in the treatment of diverse mental health problems has been well documented (American Psychological Association [APA], 2013; Australian Psychological Society, 2010; Hunsley, 2002; Hunsley, Elliot, & Therrien, 2014; Lambert & Ogles, 2004). Psychologists are the largest group of regulated specialized mental health professionals in Canada (Peachey et al., 2013). These professionals receive between five and eight years of graduate training (at the doctoral level) (Canadian Psychological Association, 2015) in the use of evidence-based psychotherapy treatments for mental health problems. Access to these highly trained professionals however, has been shown to be inadequate. Family

physicians' offices are often overloaded with patients presenting with mental health problems (Grenier, Chomienne, Gaboury, Ritchie, & Hogg, 2008; Moulding, Grenier, Blashki, Ritchie, Pirkis, & Chomienne, 2009). Reports of systemic and economic barriers to adequate referral pathways to appropriate mental health professionals offering psychotherapy treatments leave many in need of specialized treatments without appropriate care (Peachey et al., 2013). This lack of access to adequate mental health treatment has reached a breaking point in Canada (Peachey et al., 2013), with costs for services being labelled as the greatest barrier to treatment (Mood Disorders Society of Canada, 2015). Simply put, those with the most specialized training in psychotherapy treatment are not readily accessible to many of those in need.

With the increased focus on mental health care needs, the CPA has called for documentation of the roles, practice characteristics and service demands of Canadian psychologists (Ronson et al., 2011). Having this information available to the provincial and territorial health service planners, health care professionals, and to the public will serve to improve planning and funding of mental health services. It is only through comprehensive documentation that a clear and accurate portrait of the workforce of psychologists and other mental health providers can be drawn (Stokes, Mathews, Grenyer, & Crea, 2010).

The field of psychology in Canada has lagged behind in terms of documenting the characteristics and practices of its mental health professionals. Until Hunsley and colleagues' (2013) recent survey on the practice of psychology in Canada, these general characteristics had not been investigated in over two decades (Hunsley & Lefebvre, 1990; Warner, 1991). In comparison, the American Psychological Association (APA) has been surveying its members in terms of practice activities and characteristics for over four decades (Garfield & Kurtz, 1976; Norcross & Karpiak, 2012; Norcross, Karpiak, & Santoro, 2005; Prochaska & Norcross, 1983;

Smith, 1982). The data from these studies served as the core knowledge in understanding the practice of psychology in North America (Norcross et al., 2005).

In Canada, the dominant activity of licensed psychologists is psychotherapy, particularly individual therapy with the adult population (Hunsley et al., 2013; Ionita & Fitzpatrick, 2014), followed by assessment activities. Hunsley and colleagues' (2013) recent study ($N = 538$) showed that the most prevalent presenting problems the majority of psychologists treat include anxiety disorders, mood disorders, intrapersonal difficulties and interpersonal difficulties. The cognitive-behavioural orientation, followed by an integrative/eclectic orientation, were reported as the most frequently endorsed orientations among Canadian practitioners (Hunsley et al., 2013; Jaimes, La Rose-Herbert, & Moreau, 2015), with the exception of Quebec where the dominance of the cognitive-behavioural orientation is not as strong, as fewer practitioners endorse this (Jaimes et al., 2015) compared to other Canadian samples (Hunsley et al., 2013; Ionita & Fitzpatrick, 2014).

A factor to be considered in the field of psychology is the increase of psychologists working in the private sector (Hunsley et al., 2013; Peachey et al., 2013). This trend is even more apparent in other countries, such as the United States (Norcross & Karpiak, 2012) and Australia (Byrne & Davenport, 2005). In Quebec alone, 4842 members of the *Ordre des Psychologues du Québec* (OPQ) work either part time or full time in the private sector (Ordre des Psychologues du Québec, 2015), a sizable increase in the last five years (Ordre des Psychologues du Québec, 2010). In Ionita and Fitzpatrick's (2014) large survey of the practice of psychology in Canada ($N = 1,668$), approximately 63% of this sample received payment for services directly from the client. Documenting the field of psychology now includes a greater need to investigate practice characteristics of those in private practice, as never before has there

been as many psychologists offering services in this sector.

In turning to characteristics of those in private practice, results of an older study comparing a sample of 210 doctoral level psychologists in private practice with those working in the public sector ($N = 72$) reported that those in private practice tend to be older, more experienced, work less hours, have higher career satisfaction, and devote more time to marital/couple therapy (Norcross & Prochaska, 1983). More recent data from a large sample ($N = 8,086$) in Australia comparing those employed in the public sector, employed in the private sector, or practicing independently, similarly reported that independently employed psychologists were older, worked primarily with adults and couples, spent less time conducting group therapy or organizational consultation, spent less time conducting research and more time in direct intervention with clients (Stokes Mathews, Grenyer, & Crea, 2010).

In Canada, Hunsley and colleagues (2013) noted that those exclusively in private practice compared to exclusively public practice are more likely to hold a clinical or counselling degree, as opposed to a school psychology or neuropsychology degree; spend more time in providing direct intervention; provide services to more clients per week; are less likely to provide assessment and group therapy; and finally, are more likely to treat mood and anxiety disorders, interpersonal and intrapersonal difficulties, work-related difficulties, and health related difficulties.

To our knowledge there has not been a comprehensive documentation of the specific details of private psychotherapy practice within the Canadian context. With the ever-increasing number of professionals taking their psychotherapy practice into this domain, the importance of documenting this professional setting cannot be understated. Furthermore, as it has been documented that those in private practice report higher levels of personal accomplishment

(Rupert & Kent, 2007), and lower levels of burnout and higher job satisfaction (Ackerley, Burnell, Holder, & Kurdek, 1988; Boice & Myers, 1989; Dupree & Day, 1996; Vrendenburgh et al., 1999), there is the potential for this trend of moving to private practice to continue.

Study Objective

The objective of the present study was to obtain a detailed documentation of the specific practice characteristics of those in private practice. As recognized by the CPA (Ronson et al., 2011), to better understand the mental health service needs of Canadians information from service providers such as psychologists is needed, as little information has historically been documented. Additionally, as services are often being offered privately, there is also the recognition of the need for detailed information of the psychotherapy services offered specifically in this domain. Within the local context of Quebec, the Institut National d'Excellence en Santé et en Services Sociaux (INESSS; 2015) published a report on the inequality of access to psychotherapy services, and indicated that only a third of the professionals in Quebec licensed to offer psychotherapy services work in a public setting, with the majority working privately. This means that to receive adequate psychotherapy treatment many individuals often must turn to the private sector. Given the call for increased documentation of psychologists' services at the national level, as well as the recognition of the amount of psychotherapy services offered privately at the provinicial level in Quebec, the timing for documenting psychotherapy services in this domain is apt. For the purpose of the current study it was decided to recruit psychologists and psychotherapists in Quebec currently practicing psychotherapy on a full or part-time basis in the private sector.

Method

Survey

An online survey was developed for the current study focusing on various themes related to private psychotherapy practice such as psychotherapy format, age-group populations treated, diagnoses and presenting problems, referral sources, collaboration with other professionals, number and frequency of sessions, as well as psychotherapy fees, among others (see Tables 2-10). In developing the survey items, instructions outlined in the Tailored Design Method (Dillman, Smyth, & Christian, 2009) for survey development and recruitment were followed. Furthermore, previous survey studies of psychologists were consulted (e.g., Hunsley et al., 2013; Norcross & Karpiak, 2012), as well as relevant literature pertaining to psychotherapy practice (e.g., Clark, 2011; Cook, Biyanova, Elhai, Schnurr, & Coyne, 2010; Norcross et al., 2005).

Ethical approval for the study was obtained through the McGill Research Ethics Board. Prior to recruitment, the survey instrument was professionally translated into French, and each version, French and English, was piloted. Sixteen clinicians (psychologists, psychotherapists, and advanced psychology doctoral students) were recruited for piloting. The piloting process included opportunities for written online feedback of the pilot survey, as well as feedback discussions with the principal investigator. Modifications were made to the final survey based on pilot feedback, and the clarity and accuracy of the translation were confirmed through a final pilot of both the English and French surveys with a bilingual psychologist.

Participants

Psychotherapy is a reserved activity in Quebec that can be practiced by psychologists, physicians, and those holding a psychotherapy permit (labelled psychotherapists) (see https://www3.ordrepsy.qc.ca/en/obtenir-un-permis/permis-de-psychotherapie/psychotherapist-

permit.sn for details concerning the title *psychotherapist*). Participants for the present study included psychologists and psychotherapists licensed with the OPQ who self-identified as working full or part-time in a private psychotherapy setting. An email invitation was sent in June 2014 to 4059 clinicians fitting these criteria (3518 psychologists, 541 psychotherapists) requesting participation in the online questionnaire. An incentive to complete the study was contained in the email invitation: a chance to win one of three Apple Ipad Minis. In total, 739 participants responded to the study (18% return rate); however, 68 individuals did not complete the questionnaire and were excluded from the final sample ($N = 671$). The majority of participants, 79%, were licensed as psychologists ($n = 526$), and 21% ($n = 140$) were psychotherapists. Twenty-five percent (25%) of the sample identified as male, 75% female. Approximately 90% of the sample completed the survey in French, and 10% in English; 50.3% of the participants practice in an urban setting, and 49.7% practice in a semi-rural or rural setting (refer to Table 1 for the remaining demographic and professional information). The sample was generally representative of the population of licensed psychologists and psychotherapists in Quebec (see Ordre des Psychologues du Québec, 2015).

Data Analysis

The dataset was screened for errors, and outliers were removed prior to data analysis (Cousineau & Chartier, 2010; Field, 2013). The majority of the survey items contained less than 5% missing data, which is considered within the acceptable range (Tabachnick & Fidell, 2007). For those items with more than 5% missing data, these missing data were imputed through expectation maximization methods (Graham, 2009; Tabachnick & Fidell, 2007). The frequencies were calculated for all ordinal and categorical variables, as well as the descriptive data for all continuous variables. This information can be found in Tables 2-10.

Results and Discussion

Private Practice Characteristics

The clinicians in this sample reported a large range of hours devoted to their private practice. The majority of the sample (57.6%) reported working 20 hours or less per week in a private practice setting. In terms of the number of clients seen for psychotherapy services, almost two thirds (62%) of the sample reported providing services to 15 or less clients per week, with almost half seeing 10 or less clients per week (see Table 2 for details). This provides further evidence, as in Hunsley's and colleagues (2013) survey study of Canadian practitioners, that many psychologists are in part time private practice. While respondents were not asked to indicate their other work settings, we might assume that only a minority would not be working in another setting. Stokes, Mathews, Grenyer, & Crea (2010) found similar results concerning the Australian psychology workforce, with the majority of the sample reporting private practice as their primary or secondary job position.

Psychotherapy Format and Client Populations

As indicated in Table 2, approximately 80% of the sample reported that in their private practice, the majority of their psychotherapy time was spent in individual therapy; less than 10% of the sample indicated spending less than 60% of their time in individual therapy. This was followed by 42% of the sample reporting that they conducted couple/marital therapy, however approximately 30% of these respondents reported conducting couple therapy for less than 20% of their psychotherapy time. Across many previous studies of general psychotherapy practice, individual therapy has consistently been reported as the most used psychotherapy format, followed by couple therapy (Humbke, Brown, Welder, Fillion, Dobson, & Arnett, 2004; Hunsley et al., 2013; Norcross & Karpiak, 2012; Norcross & Rogan, 2013). While only 27% of Hunsley

and colleagues' (2013) sample of practitioners in both the public and private sectors reported conducting couple/marital therapy, a significantly higher proportion of those in private practice (48%) engaged in couple/marital therapy compared to public (11%), which is similar to the rate found in this sample. Approximately 96% of the sample indicated that 'none' of their psychotherapy time was devoted to group therapy, and approximately 73% indicated 'none' of their time being devoted to family therapy. The present results for those engaged in group therapy (approximately 4%) is quite low compared to the 20% typically reported across studies (see Hunsley & Lefebvre, 1990; Hunsley et al., 2013; Norcross & Karpiak, 2012; Norcross & Rogan, 2013). However, this may be explained by the fact that the present study is based exclusively in the private setting. These results again more closely mirror Hunsley and colleagues' (2013) subsample of private clinicians; a significantly less proportion of which (12%) reported conducting group therapy compared to those in a public setting (26%). Family and group psychotherapy formats appear to be more common place in the public setting than the private setting.

When asked about providing psychotherapy services to different age populations, the group that received the highest rated time in therapy was adults (age 31 to 65), with approximately 58% of the sample indicating that they spend more than 60% of their psychotherapy time with this age population. Following this was young adults (age 18 to 30), with approximately 60% of the sample indicating that they spend 20% to 60% of their service time with this population (see Table 2). Other Canadian studies have also documented that the most commonly served population is adults, in both public and private settings (Hunsley et al., 2013; Ionita & Fitzpatrick, 2014), even though the prevalence rates of mental health problems are similar in both the youth and elderly population (Canadian Coalition for Seniors' Mental Health, 2006; Canadian Mental

Health Association, 2010, 2016; World Health Organization, 2016). This is an important finding for service planners and funders, as it highlights how children, youth and elders are underserved populations in terms of mental health treatment in the private sector.

As shown in Table 2, more than half of the sample indicated that the majority of their caseloads had private insurance. This is similar to data reported from the general Canadian population; with recent data showing that approximately 57% of Canadians have private insurance for mental health treatment (Mood Disorders Society of Canada, 2015). Finally, being on leave from work was not very common, with almost half of the sample indicating less than 20 percent of their clients were on leave from work. This may be indicative of the level of severity within the population being served by the current sample of practitioners; potentially these clients do not present with severe symptoms, as often mental health concerns can interfere with one's ability to work and be a reason for disability leave (Centre for Addictions and Mental Health, 2012). As not many of the clients served by the respondents of our survey are on leave from work, this may also be indicative of the fact that many individuals unable to work could be facing financial barriers and would be unable to pay for services privately, therefore they do not seek them out.

Diagnoses and Presenting Problems

Table 3 outlines the presenting problems and diagnoses that are treated most frequently. Anxiety disorders were reported as most frequently treated, as 86% of the sample reported treating these on an 'often' to 'very often' basis, followed by mood disorders (69% treat these on an 'often' to 'very often' basis). This is not surprising as these are among the most prevalent mental health concerns in Canada, with 4.7% of the population meeting the criteria of a major depressive episode and 2.4% meeting the criteria for generalized anxiety disorder alone, in a 12

month period (Statistics Canada, 2012). These disorders have also been targeted as the high priority disorders to be the focus of treatment in government-funded psychotherapy programs in the UK and Australia (Australian Government Department of Health, 2015a, 2015b; Clark, 2011). Furthermore, significantly more private practice clinicians reported treating mood and anxiety disorders compared to those in the public sector in Hunsley and colleagues' (2013) Canadian sample (97% of private compared to 76% of public for anxiety disorders; 89% of private compared to 73% of public for mood disorders). Schizophrenia and other psychotic disorders were the least frequently treated disorder, as approximately 75% of the sample indicated '*never*' treating these, in line with Hunsley and colleagues' (2013) sample in which only 16% of private clinicians treated psychosis, which was significantly lower than for psychologists in the public sector (29%). In terms of presenting problems, interpersonal problems were rated most frequently, with 73.1% of the sample indicating treating this '*often*' or '*very often'*, followed by adjustment to life stressors, with 71.3% treating this '*often*' or '*very often*', mirroring what was reported in Hunsley and colleagues' (2013) subsample of clinicians in private practice.

Clinical Characteristics and Perceived Response to Psychotherapy

Table 4 shows all frequencies for survey items related to clinical characteristics of the clientele served, such as comorbidity of mental health as well as physical health problems, psychopharmacological treatment and suicidal ideation. Close to a third of the sample indicated that 'most' of their clients were also receiving psychopharmacological treatment; this is not surprising given the prevalence of family physician treatment of mental health problems, as well as the routine use of medication to treat prevalent disorders such as mood and anxiety disorders (Mood Disorders Society of Canada, 2015). Comorbidity of both mental and physical health

problems were reported as not generally characteristic of the respondents' caseload. Approximately half of the sample indicated that 'none' or 'few' of their clients have a comorbid health condition, and in terms of a comorbid mental health condition, 52% indicated 'some' and 28% indicated 'few'.

Table 4 indicates the frequencies for survey items pertaining to perceived response to psychotherapy (i.e., percentage of clients who report improvement, etc.). Overwhelmingly, the consensus was that psychotherapy leads to positive gains, as more than 90% indicated that '*most*' or "*all"* of their clients report or show improvement as a result of psychotherapy. Furthermore, only 20% of the sample indicated that '*few*' of their clients report or show deterioration as a result of psychotherapy, and approximately 80% indicated that '*none*' of their clients report or show deterioration. This must be considered in terms of the documented lack of accuracy of clinicians in estimating client progress and deterioration (Hannan et al., 2005; Hunsley, Aubry, Vestervelt, & Vito, 1999).

Fees, Number and Frequency of Sessions

All descriptive data for fees associated with psychotherapy can be found in Table 5. The average amount charged per hour for individual therapy was $95.10 (*SD* = 16.69), with a range of $45.00 to $160.00. While the average is in line with what the OPQ reports ($80 - $120 per psychotherapy hour (www3.ordrepsy.qc.ca/en/public/la-psychotherapie/how-much-should-a-psychotherapy-cost.sn) this is much lower than what is recommended in other provinces, even in those with a master's level licensing requirement (see Canadian Psychological Association, 2015; note that approximately 3 in 4 psychologists in Quebec practice with a master's degree, as the doctorate became mandatory only in 2006) such as $180 in Alberta (Psychologists' Association of Alberta, 2014), $170 in Nova Scotia (Association of Psychologists of Nova Scotia,

2012), $160 in Saskatchewan (Psychology Association of Saskatchewan, 2011) and $150 in New Brunswick (College of Psychologists of New Brunswick, 2015). A possible explanation for this may be the fact that Quebec has by far the largest number of registered psychologists compared to other Canadian provinces (with a ratio of 95 psychologists per 100,000 inhabitants, while the Canadian average is 58 per 100,000 inhabitants; Statistics Canada, 2009), making the rates for services more competitive.

The highest fees for the present sample were associated with couple/marital therapy and family therapy, both with an average cost of $107 per hour. Approximately 20% of the participants indicated that they have offered psychotherapy services at no cost, and 27% indicated offering psychotherapy services on a sliding scale.

Table 6 lists the frequencies related to the number and frequency of psychotherapy sessions. Approximately 71% of the sample reported that most clients are seen on a weekly basis, with more than three quarters (77%) of the sample reporting that they '*never*' see clients twice weekly. The average number of sessions reported was 23, with a median of 18. The average minimum number of sessions was 6.5. These results are similar to other Canadian studies. In Ronson and colleagues' (2011) investigation of clinical practice, 140 licensed practitioners reported characteristics of two identified clients. The average session number for the first set of identified clients was 14, and the second set was 24, with over half reporting that less than 8 sessions were likely remaining. In a similar investigation of youth psychological services, Hunsley, Ronson, Cohen, and Lee (2014) asked 137 practitioners providing services to children and youth to provide information on one of their cases. The average number of assessment sessions was 3 (*Mdn* = 2), the average number of therapy sessions to date was 10.8 (*Mdn* = 5), and the average anticipated number of sessions remaining was 10 (*Mdn* = 5).

The average number of session reported in these previous studies, as well as the results of the present study, are much higher than that which is covered for mild to moderate mental health concerns in the government-funded psychotherapy programs in the UK (Department of Health, 2008a; INESSS, 2015) and Australia (Australian Government Department of Health, 2015a, 2015b; INESSS, 2015) where 6 – 10 sessions is set as the norm, and 18 – 20 sessions only provided for severe mental health problems. In the UK's 'Improving Access to Psychological Therapies' (IAPT) program the average number of sessions is approximately five sessions (Richards & Suckling, 2009), and in the Australian government-funded psychotherapy program entitled *Access to Allied Psychological Services* (ATAPS), the majority of individuals are seen for 6 sessions (INESSS, 2015; Vasiliadis & Pirkis, 2013). In terms of treatment that is covered by the government compared to out of pocket payment in the private sector, perhaps there is more of a focus on brief interventions and symptom reduction. The private setting may allow for more treatment time to be spent on relapse prevention or follow-up treatment sessions. Investigating the rates of treatment drop out in both the public and private settings would also be of importance in explaining the differences in treatment length. In the first three years of the IAPT program, of the 600,000 individuals to begin treatment, only 350,000 completed treatment (Department of Health, 2008b). In the present sample, participants reported that it was not common for clients to drop out or no longer show up for sessions (approximately 65% reported that none or few of their clients drop out). The data concerning routine session numbers from the current investigation, previous Canadian studies, as well as data from government-funded models of psychotherapy all need to be considered in the future planning of a government-funded model of psychotherapy in the local context.

Wait-times, Preparation Time and Supervision

In terms of a wait-list for services, 61.6% indicated that the wait-list for their services was approximately one week or less (with 39% indicating no wait-list). This is a stark contrast from that of the public system, where wait lists can range from a number of weeks to a number of months (see www.ordrepsy.qc.ca/en/public/la-psychotherapie/how-much-should-a-psychotherapy-cost.sn). This short wait-time may be related to the high density of psychologists offering services in Quebec. For administrative and/or preparation time, approximately half of the sample indicated either 15 or 20 minutes for every psychotherapy hour (see Table 6). Additionally, participants were asked to report the frequency of informal case discussion and the number of hours of formal clinical supervision received in one year. Results indicated that the average number of hours of supervision per year was 12.49 (see Table 6 for all descriptive details), and approximately half of the sample indicated engaging in informal case discussions with colleagues either once or twice a month. It would be of interest to investigate differences in terms of supervision and case discussion based on years of psychotherapy experience and work setting, such as those who are part of a group practice or have an independence practice. Furthermore, as supervision and peer consultation is a core feature in psychotherapy practice, it would also be of interest to investigate the perceived impact of the opportunities for this, or lack thereof, on one's practice.

Referral Sources and Collaboration

More than half the sample (60.1%) reported that *'most'* of their clients self-refer, followed by family physician referrals, and referrals from an employee assistance program (EAP) (see Table 7). This indicates the autonomous role clients have in seeking services, as well as the significant role of family physicians and EAPs in getting service users into treatment. It is not

surprising that family physicians are a core source of referral, as they are most often the central access point in the health system, and many report positive attitudes towards the role that psychologists play in effective treatment of mental health problems (Grenier et al., 2008). However, family physicians have also indicated that the cost of psychological services is the predominant barrier in referring individuals for psychotherapy treatment (Grenier et al., 2008). Therefore these numbers could be higher if the economic burden was lessened.

In terms of collaboration with other professionals, 51% of the sample reported that '*some*' or '*most*' of their clients require consultation with a psychiatrist, whereas only 37% indicated that '*some*' or '*most*' have access to a psychiatrist. In contrast, 37% of the sample indicated that '*most*' or '*all*' of their clients would require consultation with a family physician, and 52% reported that '*most*' or '*all*' of their clients have access to a family physician (see Table 8). Therefore the need for access to family medicine is being met more so than that of psychiatry. Sixty-one percent (61%) of the sample reported that it either was '*difficult*' or '*very difficult*' to consult a psychiatrist for a case. In terms of consultation with family physicians, although better than access to psychiatry, 44% of the sample still indicated that it was either '*difficult*' or '*very difficult*'. Similarly, respondents indicated it was either '*very difficult*' or '*difficult*' to directly refer to a psychiatrist (76%) or to a family physician (68%). The greatest ease of collaboration reported by this sample was with other psychologists.

Use of Clinical Tools in Psychotherapy Treatment

Table 9 reports the frequencies for survey items pertaining to the use of diverse clinical tools and measures in psychotherapy (e.g., personality inventories, established clinical guidelines). Generally speaking, respondents did not report frequently using clinical tools. Self-developed assessment inventories were the most frequently used tools; however the rate was still

modest, with 19% using these on an "*often*" to "*always*" basis. What this may be highlighting is the autonomous nature of psychotherapy practice; while there are validated scales to assess or measure symptoms there is also the tendency to use a self-developed assessment inventory. This is reflective of Baker, McFall, and Shoham's (2009) report on the role of science, or lack there of, in clinical psychology. Baker and colleagues (2009) outline the ambivalence in clinical psychology in terms of the role of science in informing psychological assessment and interventions. While we have strong evidence in support of using assessment and treatment tools and interventions, often these are not delivered or implemented in routine practice, as clinical intuition – not scientific evidence – is often given the most importance in terms of clinical decision making (Drapeau & Hunsley, 2014; Ionita & Fitzpatrick, 2014).

Others have commented on the difficulty of translating tools such as progress monitoring measures specifically to those in independent practice, as isolation may contribute to less awareness and use (Hatfield & Ogles, 2004; Ionita & Fitzpatrick, 2014). In a training context, practical issues (lack of resources) surrounding the use of validated progress monitoring measures was identified as the primary barrier to their use (Overington, Fitzpatrick, Drapeau, & Hunsley, 2016). It is yet to be seen if it is the lack of awareness of validated measures, or other practical constraints that may explain their limited use in the private sector.

More than 90% of the sample reported 'never' or 'rarely' using projective tests, which is not surprising, as the decline in the use of these has been documented in others samples (see Norcross & Karpiak, 2012; Norcross, Prochask, & Gallagher, 1989b). Approximately 65% of the sample reported 'never' using personality inventories, and 65% reported never using established clinical guidelines. While the medical profession has a lengthy history in the development and implementation of clinical guidelines (Cullen, O'Leary, Langton, Stanley,

Kelly, & Bury, 2005; Davis & Taylor-Vaisey, 1997), evidence of implementation of these by psychologists is minimal and attitudes towards their use are often mixed (Mullen & Bacon, 2004). However the use of the National Institute for Health and Care Excellence (NICE) guidelines are a fundamental feature of the UK's IAPT program (Clark, 2011). Psychology has generally fallen behind in developing clinical guidelines compared to the medical profession; furthermore, many guidelines available in the context of Quebec and elsewhere are of low quality (see Stamoulos, Reyes, Trepanier, & Drapeau, 2014). The language barrier must also be considered in the Quebec context, as many clinicians may either not be aware of or not be inclined to use guidelines only available in English, such as the NICE guidelines.

Recently, there has been a focus on the importance of outcome tracking (Ionita & Fitzpatrick, 2014; Overington & Ionita, 2012), or monitoring client response to psychotherapy treatment. As stated earlier, it is challenging for clinicians to accurately estimate client improvement or deterioration simply through clinical judgement (Hannan et al., 2005; Hatfield, McCullough, Franz, & Krieiger, 2010; Hunsley, Aubry, Vestervelt, & Vito, 1999); however, the use of validated measures to track treatment progress continues to be low, and this trend was found in the current study. Half of the clinicians in this sample reported '*never*' using validated scales to track treatment progress, and 17% of the sample reported using these "*sometimes*" and 10% "*often*". Recent research suggests that rates of implementation of these progress monitoring measures is generally low (see Ionita & Fitzpatrick, 2014). A recent large survey study (N = 1668) of progress monitoring in Canadian psychological practice indicated that while one third of the sample were aware of progress monitoring measures, only 12% were routinely using these (Ionita & Fitzpatrick, 2014). The current results are in line with this finding. However, the present investigation may have captured the larger proportion of professionals implementing

these on an intermittent basis (17% indicated "*sometimes*" using these). Ionita and Fitzpatrick (2014) found that those primarily serving adults (as opposed to children, groups, couples, organizations), which is congruent with the majority of the present sample, were significantly more likely to be aware of and implement progress monitoring measures. This may be related to the fact that more of these measures are tailored to the adult population. Ionita and Fitzpatrick (2014) also found that those with a master's level education had less awareness of these measures compared to those with a doctoral degree. This must be considered in the current sample, as well as the larger population of psychologists and psychotherapists in Quebec, as approximately 70% of these licensed clinicians are educated at the master's level.

These data must be considered in light of the current sample also reporting high improvement rates among their clients (90% of the sample report that *'most'* or *'all'* of their clients report or show improvement). However, with such low rates of using validated measures to track treatment outcome, and the documented inaccuracy of clinical judgement (Hannan et al., 2005; Hunsley, Aubry, Vestervelt, & Vito, 1999), it is difficult to determine the true accuracy of outcomes and points to a potential lack of self-critical assessment of treatment effectiveness.

New Trends in Psychotherapy Interventions

Finally, Table 10 contains the frequencies for survey items pertaining to attitudes toward new trends in psychotherapy intervention, such as computerized psychotherapy, long-distance/tele-therapy, and bibliotherapy (coached self-help books) for milder forms of depression and anxiety disorders. Norcross, Pfund and Prochaska (2013) conducted a Delphi poll with experts in psychotherapy on the future trends in psychotherapy. The items listed previously, such as computerized interventions, client self-directed change (e.g., bibliotherapy), as well as didactic-directive therapist interventions for relapse prevention such as homework, problem

solving techniques, and cognitive restructuring were identified as the components that will increase in the future psychotherapy treatments (Norcross et al., 2013). Furthermore, many of these components are used in the government-funded model of psychotherapy treatment in the UK entitled 'Improving Access to Psychological Therapies' (IAPT) for mild to moderate depression and anxiety (Department of Health, 2008a). Results from the current study show that more than two thirds of the sample were in favour of the use of self-help books, almost half agreeing with the use of long-distance/tele-therapy, and finally approximately 20% in agreement with the use of computerized psychotherapy. As 45% of the sample indicated psychodynamic/psychoanalytic or humanistic/existential as their primary orientation, which all place high value on the therapeutic relationship, this may explain the lack of support for computerized therapy.

Another component of the UK's stepped-care program is the use of practitioners with less training and expertise, known as psychological wellbeing practitioners (PWPs) who are well trained and supervised by psychologists, to provide low intensity treatments, such as those listed above (Clark, 2011). In asking the present sample their agreement on delegating certain interventions (e.g., exposure for phobias) to an assistant under their supervision, 72% of the sample disagreed with this (with approximately 30% strongly disagreeing). It is challenging to know if this disagreement is grounded in clinical judgement and expertise concerning who one sees fit to deliver services, such as the level of perceived expertise needed to implement these interventions, or if it is more of a practical economic/professional issue of having an assistant hired that one would have to supervise and be responsible for. It is also possible that such resistance to delegating clinical acts, even under supervision, is tied to specific theoretical models (e.g., psychodynamic, humanistic), or perhaps a protectiveness over the practice of

psychotherapy and attitudes about the level of training needed to conduct interventions, or simply that clinicians are not sufficiently trained in and exposed to what may be referred to as a form of collaborative care. From an economic perspective it would however be more cost-effective for an interventionist with less training to deliver low intensity treatments (e.g., guided self-help, exposure for phobias) than a doctoral level trained clinician. This is also a better use of resources, possibly resulting in an increase in the number of patients receiving services. It would be advantageous for future research to investigate the reasons for the current opposition to delegating low intensity treatments.

Summary and Implications

As a means of adding to the current documentation of the characteristics of psychological practice in Canada, the objective of this investigation was to provide a snapshot of the detailed characteristics of psychotherapy practice in the private sector in Quebec. Generally, those in the private sector of Quebec work part time, routinely serve adults in individual therapy, who commonly have private insurance to assist in funding these services. These professionals reported very short wait times and treated a range of mental health problems, routinely for up to twenty sessions. This investigation showed family therapy and group therapy are not routine practices in private psychotherapy practice.

The practice of measuring outcomes with validated scales, or using established clinical guidelines was minimal among the participants, however mirroring the expected rates documented in other studies. Finally, the participants reported the difficulties they encounter in collaborating with other professionals, particularly psychiatrists, and to a lesser degree, family physicians.

Implications for Trainees and New Professionals

For those interested in psychological practice, the current investigation provides a glimpse of typical private psychotherapy practice in a Canadian setting. As adults were the main population served by those in this investigation, those interested in treating mental health problems often seen in youth and child populations, such as ADHD and disruptive behavioural disorders as well as pervasive developmental delays, may have greater opportunities in the public hospital systems as well as the school systems, as these are often the settings in which these populations are served (Hunsley, Ronson, Cohen, & Lee, 2014). Alternatively, while the prevalence rates of mental health problems are similar to that of the adult population (Canadian Coalition for Seniors' Mental Health, 2006; Canadian Mental Health Association, 2016) this study has shown that the youth population as well as the elderly population and those with comorbid health problems are under represented in the private sector. There are mental health needs not being met in this sector, and therefore less competition among providers to meet the needs of these underserved populations. This lower competition could be an inducement that helps to increase the number of providers in the private sector.

The information pertaining to rates charged per psychotherapy hour provides a benchmark for trainees or for those interested in entering private practice, particularly in Quebec, in setting their hourly fee. Additionally, documenting the referral pathways of those entering private psychotherapy treatment allows trainees and new professionals to understand the importance of advertising their services, or becoming well known in a community, as so many individuals self refer. Furthermore, this study underscores the importance of developing relationships with family physicians as well as EAPs, as these are high sources of referrals.

Implications for Collaborative Care

Recently there has been a focus on the need for increased collaboration between mental health professionals and medical professionals, with much attention paid to the primary care setting (Gagné, 2005). Additionally, research has investigated ways of increasing opportunities for collaboration between psychologists and medical professionals such as psychiatrists and family physicians (Grenier et al., 2008; Lee, Schneider, Davidson, & Rogerson, 2012). What can be seen from the current investigation is the need for increased collaboration and patient access to psychiatrists and family physicians for psychologists practicing in the private sector. A study of family physicians in Quebec indicated that approximately half of those surveyed had no contact with mental health professionals and resources, and only referred approximately 17% of those with common mental health problems to a mental health professional (Fleury, Farand, Aube, & Imboua, 2012). Generally, the family physicians in Fleury and colleagues' (2012) study reported that the mental health system was difficult to access, wait-times for mental health services were long, and it was challenging to communicate with mental health professionals. Furthermore, the family physicians indicated being in favour of increased contact with psychologists and psychotherapists through reports and telephone consultation (Fleury et al., 2012). What can be seen is that the difficulties in access and communication with medical professionals reported by our sample are also reported by medical professionals in Quebec. Professionals in psychology, psychiatry and family medicine all report being open and willing for increased interdisciplinary collaboration and report seeing the value in this for effective treatment (Fleury et al., 2012; Lee et al., 2012); however, professionals from all sides comment on how challenging this is.

Factors related to fostering coordination with mental health services include working in

hospital settings and having informal relationships with mental health professionals (Fleury et al., 2012). Additionally, Craven and Bland (2006) report that pre-existing relationships and in-person contact between professionals can also lead to increased collaboration. Private practitioners working independently of others face even greater challenges in establishing collaborative opportunities, as they are not engrained in a mental health team or hospital setting and may not have as many opportunities for in-person contact. As it stands there is not an established route or mechanism for consultation or referral from the private sector to psychiatrists and family physicians. This is something that needs to change, as so many individuals are served privately, but the collaboration with medical professionals remains so challenging. It appears that the means in which collaboration is most likely to happen is through informal and in-person opportunities for case consultation. A more formalized route for relationship building between professionals needs to be developed.

Lee and colleagues (2012) in their investigation of collaboration between psychologists and psychiatrists reported that those professionals who are no longer in training have greater opportunities for collaboration and this most predominantly happens through consultation on a case-by-case basis. Fostering relationships at the training level has been recommended by Lee and colleagues (2012), such as interdisciplinary co-supervision or specific workshops tailored to interdisciplinary care. A focus on initiatives for improving the relationships between private practitioners and medical professionals, from both the psychology and medical associations and organizations, could only help to enhance collaborative relationships and in turn improve comprehensive care for those in need.

Implications for Accessibility Initiatives and Public Policy

Increasing access to mental health care is a core issue in Canada presently. Specifically

in Quebec, the report *For More Equity and Results in Mental Health* by the Quebec Health and Welfare Commissioner highlights the need to address the gaps in accessibility to psychological services (Commissaire à la santé et au bien-être du Québec, 2012), with suggestions for the public health insurance program to fund these services. Furthermore, in the Quebec setting there has been the development of the Coalition for Access to Psychotherapy (CAP) (Cavaliere, 2014). In line with these developments, a study of Quebec psychologists and psychotherapists was conducted to investigate the attitudes of these practitioners concerning the structure of a government-funded model of psychotherapy, based on the models established in the UK and Australia (see Chapter 4; Bradley & Drapeau, 2014). A core component of these government-funded models is outcome tracking (Burgess, Pirkis, & Coombs, 2015; Clark, 2011). While many in this study are not using measures to track treatment outcome, more than 50% of a similar sample either '*agreed*' or '*strongly agreed*' that validated measure to track treatment outcome should be used in a publically funded psychotherapy model (see Chapter 4; Bradley & Drapeau, 2014). Therefore there may be more openness to these measures than is represented in those using them in the present investigation.

Similarly, while the use of established clinical guidelines is also low in the current sample, in Bradley and Drapeau's (2014) study (to be discussed in Chapter 4) approximately two thirds of the sample '*agreed*' or '*strongly agreed'* with the notion of using a psychotherapy approach considered to be evidence-based by a neutral agency after a review of the scientific evidence, again indicating potential openness to the use of tools such as established clinical guidelines. As represented in this sample, and shown in other studies (Hatfield & Ogles, 2004; Ionita & Fitzpatrick, 2014), those in private practice use clinical tools (such as progress monitoring measures) to a lesser extent. There is the potential for improved services by using

clinical guidelines and outcome tracking in the private sector. Therefore initiatives to enhance knowledge and use particularly of those in private practice are needed.

Finally, in looking to develop a government-funded psychotherapy program in Quebec, the information about the number of treatment sessions from this investigation must be taken into consideration. Based on the information provided about those being served by this sample, such as the majority being able to work, and many not having a comorbid mental or physical health problem, it could be said that this does not represent the more severe population of those receiving treatment for mental health problems. However, typically the individuals served by the present sample often receive up to twenty sessions. This is surprising, as mentioned previously, twenty sessions is often the norm in the government-funded psychotherapy programs offered in the UK and Australia for only those with more chronic or severe mental health problems. It appears that longer treatments are the routine care in the private setting. Additionally, although the present sample reported that many of their clients have private insurance to partially or completely cover the cost of services, the recent Mental Health Care System Study reported that slightly more than half of the surveyed Canadians feel that their current private insurance coverage does not meet their mental health care treatment needs (Mood Disorders Society of Canada, 2015), let alone those with no insurance coverage. If we want to best meet the needs of Canadians, we need to look to the data in routine practice as a guidepost for structuring services.

That being said however, the objectives of psychotherapy in the public and private sector must also be considered. The focus in the UK program is on symptom reduction and return to work, and once this has been achieved services may stop, whereas there is the possibility that the objectives of the therapy in the private setting may be different. Perhaps individuals who seek services privately are seeking something more or different than symptom reduction, therefore

explaining the average longer course of therapy. Further investigation would be needed to explore this idea.

Limitations and Future Directions

There are several limitations to consider when interpreting the study results. A response rate of less than 20% is modest. The sample size for the psychologists is considered generalizable in terms of the target population (response rate of approximately 15%), and although the response rate was higher for psychotherapists (26%), a somewhat larger sample size would have been ideal in terms of generalizing to the population of psychotherapists (Direction Research, 2011). In terms of demographic characteristics (e.g., gender, theoretical orientation and level of education, with the doctoral degree being the requirement for licensure as of 2006 in Quebec) the sample is generally representative of the target population (Jaimes, La Rose-Herbert, & Moreau, 2015; Ordre des Psychologues du Québec, 2015). One methodological strength of the recruitment process was that all licensed psychologists and psychotherapists with a functioning email address provided to the OPQ were given equal opportunity to participate in the study; however, it is not possible to document any differences between those who responded to the survey invitation and those who did not. Finally, a major limitation in the study design is that it is based on self-report, which leaves the possibility for error in reporting on one's practice. When possible these results were discussed in the relation to objective data such as those from Statistics Canada as well as from other studies using more objective methodologies (Hunsley et al., 2014; Ronson et al., 2011).

As the sample itself is diverse, it would be of interest for future investigations to explore the differences that exist among the subgroups within the present sample, such as those with a master's degree versus a doctoral degree, those licensed as a psychologist versus a

psychotherapist, or those of differing years of experience. Often differences can be found among subgroups when investigating psychological practice (see Hunsley et al., 2013, Ionita & Fitzpatrick, 2014; Bradley, Doucet, Kohler, & Drapeau, 2015c). Particularly in the case of the present study, in which the majority of the participants have a master's degree, investigating differences among those with a master's versus doctoral degree would allow for generalizations to be made to other provinces with psychologists predominantly licensed at the doctoral level. While this would aid in generalizing results, it is important to document the characteristics of private practice in all Canadian provinces, as the regulation of psychotherapy is at the provincial level. This would allow for a snapshot of private psychotherapy practice in our country as a whole, as well as to gain an understanding of uniquely provincial or regional characteristics.

Finally, the present study explores only a portion of the realm of psychotherapy practice in Quebec. Gathering the same data from those in the public sector would allow for direct comparison of the differences in terms of clientele, length of treatment, and opportunities for referral and collaboration with other professionals, among other characteristics.

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Table 1. *Demographic Information*

Age	**25-34**	**35-44**	**45-54**	**55-64**	**65+**		
	13%	26%	22%	27%	12%		
Years of Practice	**Less than 5**	**5-10**	**11-15**	**16-20**	**21-25**	**26-30**	**30+**
	12%	20%	17.5%	13.5%	14%	10%	13%
Academic Degree	**Bachelor's Degree***	**Master's Degree***	**Doctoral Degree**	**Psy. D**	**Other**		
	5%	63%	20%	9.5%	2.5%		
Number of Professionals	**Solo Practice**	**2-4**	**5-7**	**8+**			
	47.7%	25.1%	12.8%	14.4%			
Theoretical Orientation	**Cognitive-Behavioural**	**Psychoanalytic/ Psychodynamic**	**Humanistic/ Existential**	**Integrative/ Eclectic**	**Systems/ Family Systems**	**Other**	
Primary Orientation	35.4%	22.8%	22.6%	9.7%	6.5%	3.1%	
Secondary Orientation	23.7%	11.7%	18.5%	14.3%	17.6%	3.7%	

Note. * Some respondents may be practicing with a bachelor's or master's degree as they would have been licensed prior to the new doctoral requirements and/or are originally from out of Quebec and have been accepted for licensure based on equivalences.

Table 2. *Survey Items Pertaining to Psychotherapy Format and Client Populations*

	0 - 5	**6 -10**	**11-15**	**16 -20**	**21 -25**	**26 - 30**	**31 - 35**	**36+**
How many hours of your work week is devoted to your private practice?	13.3%	18.9%	12.1%	13.3%	12.3%	11.8%	9.4%	8.9%
In your private practice setting, on average how many clients per week do you provide psychotherapy services to?	21.4%	23.1%	17.6%	19.5%	10%	6.7%	1.7%	

	None	**Less than 20%**	**20% - 39%**	**40% - 59%**	**60%- 79%**	**80% +**
In your private practice, what proportion of your time is typically devoted to each of the following psychotherapy formats:						
Couple Therapy	57.5%	29.3%	9.3%	2.2%	1.3%	.3%
Group Therapy	95.8%	3.6%	0.4%	0.1%	0%	0%
Family Therapy	73.2%	20.5%	4.2%	1%	0.9%	0.1%
Individual Therapy	0.3%	0.9%	1.6%	5.7%	10.6%	80.8%
In your private psychotherapy practice, what proportion of your time is typically devoted to each age group:						
Children (12 and under)	71.6%	13%	7.5%	4%	1.9%	1.9%
Adolescents (13 to 17)	49.1%	36.1%	9.6%	3.7%	.9%	.6%
Young Adults (18 to 30)	11.7%	22.1%	43.5%	17.6%	3.6%	1.5%
Adults (31 to 65)	6.6%	4.2%	10.9%	30.5%	30.5%	17.3%
Older Adults (66+)	47.7%	47.8%	4%	0.1%	0%	0.3%
In your private psychotherapy practice, approximately how many of your clients are:						
Male	1.2%	53.5%	34.9%	4.7%	5.6%	0%

Female	0%	0%	5.5%	45.4%	34%	15%	
Identify as 'Other'	88.5%	10.1%	.3%	.3%	.3%	.3%	
	None	**Less than 20%**	**20% - 39%**	**40%-59%**	**60%-79%**	**80% +**	**Do not know**
In your private psychotherapy practice, approximately how many of your clients:							
Have private insurance?	1.2%	8.2%	12.3%	18.9%	21.1%	33.9%	4.3%
Are on leave from work due to a mental health concern?	12.5%	35.9%	30.7%	11.5%	6.4%	2.6%	0.3%
Are a visible minority? *	31.1%	52.8%	9.7%	4%	0.1%	0.1%	2.1%

Note. * Variables with imputed missing data.

Table 3. *Survey Items Concerning Presenting Problems and Diagnoses*

	Never	Rarely	Sometimes	Often	Very Often
In your private psychotherapy practice, please indicate the frequency with which your clients present each of the following problems as their primary reason for seeking services:					
Adjustment to life stressors	1.5%	6.3%	20.9%	48.5%	22.8%
Couple/Marital difficulties	6.1%	6.0%	36.4%	39.6%	11.8%
Disorders found in the DSM, ICD, etc.	0%	9.5%	29%	46.1%	15.4%
Family difficulties*	0%	10.3%	45.6%	37.3%	6.9%
Gender or sexuality-related difficulties*	21.2%	54.1%	20.3%	4.5%	0%
Grief/Bereavement	4.1%	24.2%	49.4%	19.7%	2.6%
Interpersonal difficulties	0%	3.1%	23.8%	52.2%	20.9%
Personal Problems (e.g., existential problems)	3.5%	13%	39.1%	33.1%	11.2%
Psychological problems related to health, injury or illness	6.5%	27.1%	42.5%	19.4%	4.5%
Sexual abuse and trauma	11.3%	35.5%	36.1%	13.1%	4%
Work/Vocational difficulties	8.3%	11.2%	36.2%	36.2%	8.1%
In your private psychotherapy practice, please indicate the frequency with which your clients require treatment primarily for the following diagnoses:					
Anxiety Disorders	0%	0%	14.1%	49%	36.9%
ADHD and Disruptive Behavioural Disorders	22.4%	30%	28.1%	14%	5.5%

Eating Disorders*	21%	50.8%	24.9%	3.3%	0%
Mood Disorders	0.2%	6.8%	24.1%	44.5%	24.4%
Personality Disorders	9.3%	26.9%	40%	19.8%	4.2%
Pervasive Developmental Disorders*	71.4%	22.4%	6.3%	0%	0%
Schizophrenia and other Psychotic Disorders*	75.6%	24.4%	0%	0%	0%
Sexual Disorders*	29.7%	47.5%	19.5%	3.3%	0%
Sleep Disorders	12.2%	16.9%	39.6%	26%	5.2%
Somatoform Disorders*	24.4%	38.5%	29.5%	7.6%	0%
Substance Abuse*	26.1%	40.2%	27.4%	6.3%	0%

Note. * Variables with imputed missing data.

Table 4. *Client Clinical Characteristics and Response to Psychotherapy Treatment*

	None	Few	Some	Most	All
In your private practice, typically how many of your clients:					
Also receive psycho-pharmacological treatment?	0%	8.4%	64%	27.6%	0%
Meet the criteria for 2 or more mental disorders?	6.4%	28.3%	52.1%	13.2%	0%
Have a comorbid medical condition (e.g., diabetes, chronic pain)?	9.2%	40.9%	46.5%	3.5%	0%
Have suicidal ideations?	5.9%	46.9%	44.6%	2.6%	0%
Report or show improvement as a result of psychotherapy?	0%	0%	8.2%	86.4%	5.5%
Report or show no change as a result of psychotherapy?	16.5%	64.9%	18.5%	0%	0%
Report or show deterioration as a result of psychotherapy?	79.1%	20.9%	0%	0%	0%
Fail to continue treatment (e.g., cancel or just stop coming to sessions)?	5.7%	60.5%	33.8%	0%	0%

Table 5. *Survey Items Concerning Psychotherapy Costs*

	n	***M***	***Mdn***	***SD***	***Minimum***	***Maximum***
In your private psychotherapy practice, on average, what do you charge for one hour of psychotherapy?						
Individual Therapy	649	$95.10	$87.50	16.69	$45.00	$160.00
Couple/Marital Therapy	263	$106.79	$90.00	29.40	$45.00	$260.00
Family Therapy	143	$106.54	$100.00	30.50	$60.00	$260.00
Group Therapy	23	$76.20	$40.00	67.95	$17.50	$265.00
	n	**%**				
Do you ever offer psychotherapy services at no cost?						
Yes	136	20.3%				
No	533	79.7%				
Do you offer a sliding scale?						
Yes	178	27.1%				
No	480	72.9%				
	n	***M***	***Mdn***	***SD***	***Minimum***	***Maximum***
When offering a sliding scale:						
What is the lowest cost ($) per session?	175	$55.36	$60.00	22.78	$0	$120
What percentage (%) of your clientele pays for services at a reduced price?	172	20.92%	15%	18.96	1%	100%

Table 6. *Number and Frequency of Psychotherapy Sessions, Wait-list, Supervision and Preparation for Psychotherapy*

	n	***M***	***Mdn***	***SD***	***Minimum***	***Maximum***
Typically, in regards to the clients that complete their treatment, what is the:						
Minimum number of sessions*	671	6.5	5.5	5.2	1	50
Average number of sessions*	671	23.35	18	20.82	1	210
Maximum number of sessions*	671	72.7	59.94	61.43	4	450

	None	**Few**	**Some**	**Most**	**All**
In your private practice, how many of your clients are typically seen at the following frequencies:					
2 or more sessions per week*	77.5%	22.5	0%	0%	0%
1 session per week	0%	5.8%	19.1%	70.9%	4.1%
2 sessions per month	0%	3.7%	10.1%	51.5%	34.7%
1 session per month*	15.9%	49 %	33.8%	1.2%	0%

	No Wait-list	**Less than 1 week**	**Approximately 1 week**	**Approximately 2 weeks**	**Approximately 3 weeks**	**Four Weeks or More**
How many weeks do potential clients wait on a waiting list for your private psychotherapy services?	39%	7.9%	14.7%	11.8%	10.8%	15.7%

	0 – 5 Minutes	**10**	**15**	**20**	**25**	**30**	**35**	**40**	**45+ Minutes**
On average, how much administrative/ preparation time (e.g., case notes, preparation) is devoted to each hour of client contact?	2.8%	17.1%	28.5%	23.9%	6.6%	13.5%	1.5%	2%	4.2%

	Once per day	Twice per week	Once per week	Twice per month	Once per month	Other frequency
Please indicate the frequency with which you engage in informal case discussion with colleagues.	0%	12.9%	18.9%	20.3%	28%	15.6%
	n	***M***	***Mdn***	***SD***	***Minimum***	***Maximum***
Please indicate the number of hours per year you receive of formal clinical supervision.*	671	12.37	10.00	14.34	0	150

Note. * Variables with imputed missing data.

Table 7. *Referral Sources*

	None	Few	Some	Most	All	Do Not Know
Typically, how many of your clients:						
Are referred by a psychiatrist?	34.4%	44.8%	20.8%	0%	0%	0%
Are referred by a family physician?	5.8%	15.7%	60.3%	18.2%	0%	0%
Are referred by a community mental health organization (e.g., Ami-Quebec)?	56.1%	31.1%	12.8%	0%	0%	0%
Are referred by an Employee Assistance Program?	21.1%	22.8%	39.2%	16.4%	0.5%	0%
Are referred by a governmental agency (i.e., SAAQ, IVAC)?	37.7%	26.8%	31.5%	3.9%	0%	.2%
Self-refer?	0%	5.5%	30%	60.1%	4.4%	0%

Table 8. *Collaboration with other professionals*

	None	Few	Some	Most	All	Do Not Know
Typically, how many of your clients:						
Would require consultation with a psychiatrist?	4.1%	44.8%	48.3%	2.9%	0%	0%
Currently have access to a psychiatrist?	7.7%	54.7%	34.2%	3.5%	0%	0%
Would require consultation with a family physician?	0%	11%	51.6%	33.1%	4.2%	0%
Currently have access to a family physician?	0%	9.4%	38.3%	48.1%	4.2%	0%
	Very Difficult	**Difficult**	**Easy**	**Very Easy**	**N/A**	
How easy is it for you to consult with each of the following professionals concerning individuals within your private practice?						
Family Physician	9%	34.5%	39.9%	6.2%	10.4%	
Psychiatrist	30.5%	31.4%	20.1%	2.9%	15.2%	
Psychologist	0.9%	4.8%	56.4%	15.9%	22%	
Psychotherapist	0.6%	2.4%	36.1%	9.5%	51.4%	
Social Worker	0.8%	5.0%	46.1%	10.2%	38%	
	Very Difficult	**Difficult**	**Easy**	**Very Easy**	**N/A**	
How easy is it for you to have access to the following professionals, in order to directly refer clients to them?						
Family Physician	36%	31.8%	14.3%	3%	14.9%	

Psychiatrist	49.2%	27%	9.2%	2.4%	12.2%
Psychologist	2.1%	9.1%	62.8%	14.4%	11.5%
Psychotherapist	1.4%	3%	38.4%	9%	48.2%
Social Worker	3.3%	12.8%	35.2%	7%	41.7%
How often do you refer a client to a medical professional to rule out medical causes when a client presents with:	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
Anxiety	5.8%	21.1%	37.6%	26.2%	9.4%
Depression	4.4%	15.6%	32.4%	30.2%	17.4%

Table 9. *Use of Clinical Tools in Psychotherapy Treatment*

	Never	**Rarely**	**Sometimes**	**Often**	**Always**
Please indicate the frequency with which you use each of the following in your private psychotherapy practice:					
Manualized treatments	43%	22.9%	22.1%	11.9%	0%
Validated scales to track/document client progress (e.g., BDI, OQ-45, PCOMS)	50.5%	18.3%	17%	10.6%	3.6%
Established Clinical Guidelines (e.g., NICE, Qualaxia)*	76.6%	15.9%	7.5%	0%	0%
Formal Diagnostic Inventories (e.g., SCID)	56.2%	21.5%	15.9%	6.4%	0%
Self-developed assessment inventories	49.4%	11.9%	18.8%	13.1%	6.8%
Personality Inventories (e.g., MMPI, NEO)	65.4%	18.6%	11.7%	4.3%	0%
Projective Tests (e.g., Rorschach, TAT)*	81.4%	11.6%	7%	0%	0%

Note: * Variables with imputed missing data.

Table 10. *New Trends in Psychotherapy Interventions*

	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**	**I Do Not Know**
For milder forms of depression and anxiety disorders, to what extent do you agree that the following treatment options could be helpful?					
Bibliotherapy (coached self-help books)	6.5%	16.2%	49.2%	15.5%	12.6%
Computerized therapy	15.1%	26.8%	19.9%	2.4%	35.8%
Long distance/tele-therapy	9.8%	19.2%	38.3%	8%	24.8%
	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**	
To what extent do you believe that certain interventions (e.g., exposure for phobias) that are part of your psychotherapy treatment, could be delegated to an assistant under your supervision, who is not a psychologist/ psychotherapist.	29.4%	42.7%	25.7%	2.1%	

Transition from Chapter 2 to Chapter 3

The first manuscript found in Chapter 2 focused on the characteristics of psychotherapy practice in the private sector in Quebec. This study provided a snapshot of general practice characteristics that can serve to inform both service users as well as training programs, professional associations, and current and future psychotherapy practitioners.

To add to the documentation of private psychotherapy practice presented in Chapter 2, an investigation of the differences found among the sample of practitioners in the first study based on level of education, years of experience, and theoretical orientation is presented in Chapter 3. As the workforce of those licensed to practice psychotherapy is diverse in terms of education level, theoretical lens and years of experience it is important to understand how these characteristics may potentially influence one's psychotherapy practice. The implications of these differences are discussed in relation to training and professional psychology, public policy, as well as for new professionals and trainees.

CHAPTER 3: A Survey of Psychologists and Psychotherapists in Private Psychotherapy Practice: Differences in Practice Characteristics across Years of Experience, Theoretical Orientation and Level of Education

Bradley, S., Service, J., Roberge, P., Vasiliadis, H.M., & Drapeau, M., (2016b). *A survey of psychologists and psychotherapists in private psychotherapy practice: Differences in practice characteristics across years of experience, theoretical orientation and level of education.* Manuscript submitted for publication.

Abstract

To add to the recent efforts of documenting psychological practice in Canada (e.g., Hunsley, Ronson, Cohen, & Lee, 2014; Ionita & Fitzpatrick, 2014), the aim of this investigation was to explore the differences in private psychotherapy practice characteristics (e.g., populations served, length of treatment, hourly rate, referral sources, inter-professional collaboration) among clinicians of different levels of education, years of experience and theoretical orientation. An online survey was used to gather information from psychologists and psychotherapists ($N = 671$) licensed to practice in Quebec and currently offering private psychotherapy services. Results indicated that those licensed at the doctoral level compared to those at the master's level reported more frequently treating clients meeting the criteria for a diagnosable mental health condition, treating those with comorbid mental health problems, charging more for psychotherapy services and more frequently providing services to children and adolescents. Those espousing a cognitive-behavioural orientation reported charging significantly more per individual psychotherapy hour, reported significantly fewer treatment sessions, and reported a higher frequency of using manualized treatments, formal diagnostic inventories and validated measures to track treatment progress compared to those of a psychodynamic and humanistic orientation. Compared to those of a humanistic and cognitive-behavioural orientation, those of a psychodynamic orientation reported significantly more hours of formal clinical supervision per year. Those with the most years of experience provided treatment to significantly more clients per week, provided services more frequently to adults and the elderly as well as those with comorbid health problems compared to those with fewer years of experience. Those with the least years of experience reported significantly fewer treatment sessions and reported more frequently providing services to children and adolescents as compared to those with the most years of experience. Further results and the implications of these are discussed in the context of the current climate of psychotherapy service delivery.

***Keywords*: psychotherapy; private practice; psychologist; survey; theoretical orientation; years of experience; education**

Psychologists and Psychotherapists in Private Psychotherapy Practice: Differences in Practice Characteristics across Years of Experience, Theoretical Orientation and Level of Education

A current trend in the field of psychology in Canada is to put forth efforts to better document the practice of psychology, and the characteristics, activities and expertise of those offering psychological services, as many have discussed the dearth of knowledge and understanding of the historical changes in psychological practice in Canada (Hunsley, Ronson, & Cohen, 2013; Ionita & Fitzpatrick, 2014; Ronson, Cohen, & Hunsley, 2011). Some of these recent efforts have included documenting the professional characteristics and activities of psychological practitioners (see Hunsley et al., 2013), exploring the practice of psychology in hospital settings (Humbke, Brown, Welder, Fillion, Dobson, & Arnett, 2004), capturing the knowledge and use of progress monitoring measures to track psychotherapy treatment progress (Ionita & Fitzpatrick, 2014), documenting psychological service for Canadian youth (Hunsley, Ronson, Cohen, & Lee, 2014), exploring the collaboration between psychologists and family physicians (Grenier, Chomienne, Gaboury, Ritchie, & Hogg, 2008), and finally gathering data from the majority of Canadians whom have received a graduate degree in psychology, with the hope of better understanding the need, supply and demand of those in the psychology field (see www.cpa.ca/PGS).

The practice of psychology is multifaceted and diverse, with the role of a psychologist taking many different forms. Accredited programs across Canada train in the areas of assessment, intervention and consultation at the individual, couple, group, family and organization level, as well as offering training in research and supervision. Furthermore, psychologists develop competencies in working with specific populations (e.g., adults, children, elderly) or diagnostic groups (e.g., mood disorders, psychosis). Adding to the complexity of

psychological practice is the fact that professional licensure is at the provincial level. While there is a unifying force across jurisdictions, the Mutual Recognition Agreement (MRA) (see www.cpa.ca/docs/file/MRA.pdf) which ensures that those licensed in any provincial jurisdiction meet core competencies in order to practice psychology in another province, each provincial jurisdiction independently determines and regulates the criteria for registration as a psychologist. Differences across jurisdictions can include the level of education, as well as required hours of supervised practice (www.cpa.ca/accreditation/PTlicensingrequirements/). Historical changes in licensing requirements, such as moving from a master's to doctoral level, developing a new regulated title such as 'psychotherapist' as in the case of Quebec, or Bill 171 in Ontario restricting the use of the titles 'psychotherapist' and 'registered mental health therapist' (www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=519), can also result in shifts in the characteristics of the practitioners in a single jurisdiction's workforce.

Not only is it important to track the characteristics and activities of those in psychological practice, given the diversity of the professionals, we must also investigate the differences among these professionals based on different levels of education and training, work setting, demographic variables, and professional characteristics such as espoused theoretical orientation. Through investigations such as these we are provided with a more nuanced understanding of the profession, which serves to inform national and provincial associations and regulatory bodies of the needs of their members, and inform training programs at both the master's and doctoral level of recent trends in the field so as to better tailor the training offered to graduate students. In addition to this, documenting the unique characteristics of psychological practitioners within different subgroups provides potential trainees with a realistic snapshot of the diverse professional profiles of psychology practitioners. Finally, this information can also serve to

inform the public, as well as public and private service providers and funders, of the diverse characteristics of the psychology workforce. This in turn helps individuals more knowingly access services, and providers to more effectively plan services.

Many previous investigations have sought to document such group differences. In comparing Canadian psychological practitioners with a master's degree and doctoral degree Hunsley and colleagues (2013) found that those with a doctoral degree spent more professional time in assessment, teaching and research, whereas those with a master's degree spent more time in intervention, and provided services to more clients on a weekly basis. Furthermore, those with a doctoral degree were more likely to consult with organizations and programs. Ionita and Fitzpatrick (2014) reported that those with a doctoral degree compared to a master's degree were significantly more aware of progress monitoring measures used to track treatment progress. Additionally, higher levels of education among psychology practitioners have been associated with more favourable attitudes toward evidence-based practices (Aarons, 2004), and increased use of treatment manuals. Wallace and von Ranson (2011) reported greater use of manuals among practitioners with a Ph.D. or Psy.D.

In investigating differences across theoretical orientations, it has been found that those endorsing cognitive and/or cognitive-behavioural orientations are more likely to endorse tele-health, or internet-based interventions, compared to those ascribing to a psychodynamic/analytic or existential orientation (Mora, Nevid, & Chaplin, 2008; Perle et al., 2013). Addis and Krasnow's (2000) study investigating psychologist's attitudes toward the use of treatment manuals showed that those endorsing a cognitive-behavioural orientation have more favourable attitudes than psychodynamically-oriented psychologists. Additionally, Becker, Smith and Jensen-Doss (2013) also reported that endorsing a CBT orientation was related to increased

likelihood of frequent manual use, as well as increased openness in the use of evidence-based practices. Stewart and Chambless (2007) investigated the influence of psychotherapy research on private practitioners' decision making in treatment, and reported that those with a cognitive-behavioural orientation had significantly more positive attitudes towards research influencing practice than both eclectic and psychodynamic practitioners. Alternatively, psychodynamic practitioners were found to be more likely to receive personal therapy, and rated this as significantly more important than those endorsing cognitive-behavioural and humanistic orientations (Bike, Norcross, & Schatz, 2009; Norcross, Strausser-Kirtland, & Missar, 1988).

The influence of psychological practitioners' years of experience, or years of licensure, has also been a topic of investigation across multiple studies. In an investigation of Quebec psychologists' sense of competency, more years of licensure was related to higher perceived levels of competence (Bradley, Drapeau, & DeStefano, 2012). Additionally, more years of experience have also been shown to be related to a sense of personal accomplishment in clinical psychologists (Schimpf, 2009). In investigating awareness of progress monitoring measures, Ionita and Fitzpatrick (2014) found that those with more years since graduation were significantly less aware of these measures. In terms of attitudes toward evidence-based practices, those with fewer years of experience had moderately more favourable attitudes compared to those with more years of experience (Addis & Krasnow, 2000). A close proxy of years of experience is practitioner age, and it has been found that older practitioners were less likely to use treatment manuals (Becker et al., 2013; Wallace & von Ranson, 2011), and had less favourable attitudes toward the use of evidence-based practices (Aarons, 2004; Becker et al., 2013). Practitioner age has also been associated with significantly lower levels of burnout and emotional exhaustion (Ackerley, Burnell, Holder, & Kurdek, 1988; Huberty & Huebner, 1989;

Rupert & Kent, 2007). Understanding these differences in attitudes and practices of psychology clinicians is important to gain insights into our diverse workforce.

Study Objective

For the scope of the present study, it was decided to explore differences related to characteristics among psychologists and psychotherapists of different levels of education, years of experience, as well as different theoretical orientations, as these characteristics have been shown to be related to differences in psychological practice. As there is a dearth of research in documenting the characteristic of psychotherapy practice in the private setting in Canada, the aim of the present study was to focus on private practitioners.

Method

Survey

An electronic survey used for the present investigation was developed based on previous literature concerning the practice characteristics of psychologists (e.g., Hunsley et al., 2013; Norcross & Karpiak, 2012) with the aim of capturing relevant themes in routine private psychotherapy practice. The survey addressed the populations treated (age, etc.), diagnoses and presenting problems, psychotherapy format, referral sources, psychotherapy fees, number and frequency of sessions, and collaboration with other professionals, among other themes (also see Bradley, Service, Roberge, Vasiliadis, & Drapeau, 2016a). Prior to data collection the survey was translated from English to French, and was piloted with sixteen clinicians. For a detailed description of the survey development, piloting process, and recruitment process please refer to Bradley and colleagues (2016a) in Chapter 2.

Participants

An email invitation was sent in June 2014 to 4059 (3518 psychologists, 541

psychotherapists) requesting participation in the study. The final sample included 671 participants (68 were excluded for not completing the questionnaire). Please see Table 1 for all demographic data, and please refer to Bradley and colleagues (2016a) for a detailed description of the participants.

Data Analysis

Prior to data analysis, the dataset was screened for errors, and outliers were removed (Cousineau & Chartier, 2010; Tabachnick & Fidell, 2007). The majority of the survey items were within the acceptable range of missing data (less than 5%); otherwise missing data were imputed through expectation maximization methods (Graham, 2009; Tabachnick & Fidell, 2007). Specific survey items of interest were compared across years of experience (10 or fewer years of practice, 11-20 years, and finally 20 or more years), between those with a master's degree and those with a doctoral degree (both PhD and PsyD), and finally across theoretical orientation (the three most espoused orientations were used in the present study: cognitive behavioural therapy, humanistic/existential, and psychoanalytic/psychodynamic). Mann-Whitney *U* tests and Kruskal-Wallis tests were used in analyzing ordinal variables, and continuous variables when the assumption of normality was violated. In the cases of multiple comparisons, a Bonferroni correction was applied to control for Type 1 errors (Tabachnick & Fidell, 2007).

Results and Discussion

Given the number of variables of interest, only those items resulting in significant differences across the groups of interest are reported in Tables 2 through 4.

Education

Those at the doctoral level reported treating children and adolescents significantly more

frequently than those at the master's level, and conversely those at the master's level reported treating adults and older adults more frequently. This may relate to the fact that doctoral programs can offer specific training in child and/or school psychology that is not available at the master's level, therefore allowing doctoral-level psychologists to specialize in the treatment of children and youth.

As not all individuals seeking psychotherapy treatment meet the criteria of a diagnosable mental health disorder, we asked participants about treating individuals both with diverse mental health disorders, as well as common presenting problems. As can be seen in Table 2, in terms of common presenting problems (e.g., grief, marital problems, vocational difficulties), clinicians at the master's level reported treating a number of these problems at a significantly higher frequency than those at the doctoral level. This may be an indication of a more diverse caseload for those at the master's level, as well as a trend toward treating individuals with more situational problems as opposed to diagnosable mental disorders. Perhaps those trained at the doctoral level tend to specialize and market their clinical services with certain clinical populations (e.g., mood disorders, eating disorders), and therefore carry a less diverse caseload.

Clinicians licensed to practice at the doctoral level reported treating individuals presenting with a diagnosable mental health problem significantly more frequently, as well as individuals with comorbid mental health disorders. This may be capturing either differences in the severity of conditions treated by those at the doctoral level, or potentially more training and competence in terms of formal diagnoses at the doctoral level. Perhaps the same clinical presentation could be categorized as a situational problem, but those with more training in formal diagnosis would tend to see this through a diagnostic lens. While the results indicated higher reported treatment of diagnosable mental health problems among those at the doctoral level, the findings did not

indicate specific disorders were seen more frequently by these clinicians. When asked about treating specific disorders, the only significant difference found was a significantly higher reported frequency of treating substance abuse for those at the master's level.

Those at the doctoral level reported charging a significantly higher fee per psychotherapy hour than those at the master's level for both individual and couple therapy. With the majority of practitioners being licensed at the master's level in Quebec, and the density of psychologists and psychotherapists available in Quebec as compared to other provinces (Quebec has the greatest number of licensed psychologists per province; see Ordre des Psychologues du Québec, 2015), this may create a climate of competitive rates for services, particularly among the large group of master's level practitioners, making it challenging to raise psychotherapy service rates. Additionally, clinicians at the doctoral level have completed significantly more years of training than those at the master's level leading to greater expertise, therefore warranting a higher fee.

In relation to differences in fees is the finding that the only difference in referral rates between those at the doctoral level and master's level was the significantly higher rates of referrals from EAPs for those at the master's level. EAPs often aim to send referrals to providers willing to accept a particularly low reimbursement rate. The present results confirm that significantly more referrals are sent to those with a master's degree, presumably as these practitioners are willing to offer services at a lower rate than those with a doctoral degree.

When asked about the use of tools in treatment such as manualized treatments, formal diagnostic inventories, and validated measure for tracking treatment progress, those at the doctoral level reported using these tools at a significantly higher frequency in their treatment than those at the master's level. These findings mirror other findings concerning the differences in awareness of progress monitoring measures (Ionita & Fitzpatrick, 2014), attitudes toward

evidence-based practice (Aarons, 2004), and use of manualized treatments (Wallace & von Ranson, 2011). The present results seem to highlight a potentially fundamental difference in the training of those at the doctoral and master's level that then translates to practice. As accredited doctoral programs in Canada place great importance on both the scientist and practitioner roles of their graduates, and as a doctoral dissertation is a required research component, those at the doctoral level have greater opportunities for exposure to and knowledge of research methods and scientifically informed treatments. The field is increasingly focusing on the translation of research into clinical practice (Kazdin, 2008; Tasca, Grenon, Fortin-Langelier, & Chyurlia, 2014), and the call for evidence-based practice (EBP) is taking a central focus in psychotherapy treatment. The CPA's definition of EBP includes the use of progress tracking in psychotherapy treatment (Dozois et al., 2014), and therefore psychologists and psychotherapists need to be moving in the direction of formally tracking treatment progress in order to have an evidence-based practice (or a practice-based evidence approach). As can be seen in the previous results of Bradley and colleagues (2016a) reported in Chapter 3, generally speaking private practitioners do not rely heavily on manualized treatments or the use of validated assessment and progress monitoring tools; however, the present results highlight that this is more pronounced in those with a master's degree. Additionally, as outlined in Chapter 5, an investigation of the differences in attitudes towards the use of mandated evidence-based treatments in a government-funded model of psychotherapy show that those licensed at the master's level have significantly less favourable attitudes toward this (Bradley & Drapeau, 2014).

Theoretical Orientation

Significant differences were found among those espousing different theoretical orientations and the frequency of treating individuals with specific presenting problems or disorders (see

Table 3). Cognitive-behavioural therapy practitioners reported treating mood and anxiety disorders more frequently than humanistic and psychodynamic practitioners, as well as treating mood disorders more frequently than psychodynamic practitioners. This is not surprising as often CBT focuses on mood and anxiety disorders, and is considered an evidenced-based practice for many of these disorders (Canadian Psychological Association, 2012; National Institute for Health and Care Excellence [NICE], 2009; NICE, 2011). Those espousing a psychodynamic orientation reported treating personality disorders more frequently than CBT practitioners, and reported treating sleep disorders less frequently than both CBT and humanistic practitioners. Additionally, CBT practitioners reported treating clients also receiving psychopharmacological treatments more than psychodynamic practitioners, and treating clients with comorbid mental health concerns more frequently than humanistic practitioners. Given that CBT practitioners reported treating anxiety and mood disorders significantly more frequently than psychodynamic practitioners, and that psychopharmacology is the most routine treatment for these disorders in Canada (Public Health Agency of Canada, 2014), it is not surprising that CBT practitioners reported higher rates of parallel psychopharmacology treatment among their clients.

Generally speaking, as indicated in Table 3, aside from adjustment to life stressors and work/vocational related difficulties, CBT practitioners reported treating many presenting problems, such as grief, gender or sexuality related difficulties, interpersonal problems, and sexual abuse, significantly less frequently than humanistic practitioner and psychodynamic practitioners. This could point to the focus on formal diagnosis for treatment planning among CBT therapists, as many CBT manualized treatments target specific diagnoses (e.g., Leahy, Holland, & McGinn, 2012).

In terms of rates per psychotherapy hour, for individual therapy, CBT practitioners reported charging significantly more than both psychodynamic and humanistic practitioners (see Table 3). However, for couple/marital therapy both CBT and psychodynamic practitioners reported charging significantly more than humanistic practitioners.

A trend certainly stands out in terms of the results regarding the use of clinical tools in practice. As seen in Table 3, when asked about the use of such tools as manualized treatments, validated scales to track treatment progress, the use of established clinical guidelines, formal diagnostic inventories and self-developed diagnostic inventories, CBT practitioners reported using these significantly more frequently than psychodynamic practitioners, and for some of the tools, significantly more than humanistic practitioners as well. This mirrors the findings of previous investigations of the influence of theoretical orientation, specifically endorsing CBT, and one's openness to evidence-based practice, the use of progress monitoring measures, and manualized treatments (Aarons, 2004; Becker et al., 2013; Ionita & Fitzpatrick, 2013; Wallace & von Ranson, 2011).

In relation to this, those espousing a CBT framework reported significantly lower minimum, average and maximum number of sessions than psychodynamic and humanistic practitioners. This is an important finding, as increasingly shorter treatment courses are becoming desirable to third-party payers. The trend of shorter treatments has also impacted psychodynamic psychotherapy in recent years, with research and training now going into brief or short-term dynamic treatments (e.g., Liliengren, Johansson, Lindqvist, Mechler, & Andersson 2015; Town, Abbass, & Bernier, 2013). While not reflected in the present data, future research tracking treatment length may reflect the impact of this. Insurance companies and government-funded models of mental health treatment are increasingly focusing on a limited number of

sessions for psychotherapy treatment (Australian Government Department of Health, 2015b; Clark, 2011). Furthermore, a noted barrier in family physicians referring patients for psychological services is often the cost (Grenier et al., 2008), making shorter-term treatments that are less costly more desirable for the referrer and service consumer. This may be related to our finding that CBT practitioners reported more frequent referrals from family physicians than psychodynamic practitioners. However, family physicians most frequently see patients with anxiety and mood problems (Public Health Agency of Canada, 2014), and as stated earlier, CBT focuses on the treatment of these prevalent disorders.

Finally, in terms of formal supervision, psychodynamic practitioners reported significantly more hours of supervision compared to CBT and humanistic practitioners. In another study investigating patterns of supervision, psychodynamic practitioners were found to engaged in this more frequently (Grant & Schofield, 2007). With psychodynamic practitioners being more open to the idea of personal therapy (Bike, Norcross, & Schatz, 2009; Norcross, Strausser-Kirtland, & Missar, 1988), another study found that being open to therapy was predictive of engaging in on-going supervision (Grant & Schofield, 2007). The psychodynamic orientation may be potentially embedding in its practitioners the importance of ongoing learning and training to a greater degree than other orientations. This phenomenon and its impact on treatment outcome warrant future investigations. In the case of informal case discussion, humanistic practitioners reported a significantly higher frequency compared to psychodynamic.

Years of Experience

Our investigation of differences across years of psychotherapy practice experience show that those in their first ten years of practice (labelled as group 1) reported providing services to significantly fewer clients per week than those with ten to twenty years of practice (group 2), and

those with more than twenty (group 3) years of practice (see Table 4). This suggests that offering private services may not be the primary work setting for those early in their career, and with experience practitioners migrate further into the private sphere, a phenomenon that has been commented on in the Australian context (Forsyth, 2009; Gleeson & Brewer, 2008). Those starting out in their careers are most likely focused on securing a position and gaining experience, and with the building of their professional network, they begin to then migrate into the private sector. Specifically in the context of Quebec, the conditions in the public sector, particularly in terms of financial compensation, are poor, therefore making the public system undesirable to many clinicians (see www.apqc.ca/includes/documents / AnalysedecisionCRT_201506_Cloutier.pdf; Bradley, Doucet, Kohler, & Drapeau, 2016c).

Interestingly, when investigating the differences in age populations served by the three groups of practitioners, those with the least years of experience (group 1) reported treating adolescents and young adults significantly more than those with twenty or more years of experience (group 3), and those with more than twenty years of experience reported treating adults significantly more frequently than group 1 and group 2, and reported treating the elderly significantly more frequently than those with fewer than ten years of experience (group 1). As self-referral is the number one source of referral within this sample (see Bradley et al., 2016a), it appears there may be a trend of self-selecting a therapist similar to one's age group (a close proxy to years of experience), with practitioners in the early phases of their career serving younger people, and those in the latter years of their career serving older adults and the elderly. In relation to this, those with twenty plus years of experience also reported treating clients with co-morbid health conditions more frequently than those in their first ten years of practice. This makes sense given that there is a higher rate of treating the elderly and chronic medical

conditions increase with age (Smith, 2012).

A general trend appears where those in their later years of practice, primarily those with twenty and more years of experience, reported treating many different presenting problems and disorders significantly more frequently than those in their first ten years of practice (e.g., grief, work-related difficulties, somatoform disorders, sexual disorders) (see Table 4). This points to questions such as a more diverse case load in later years of practice or increased comfort level treating multiple problems, or perhaps a tendency for those in their early years of practice to choose a niche population to work with (e.g., mood disorders, anxiety disorders). Recently both nationally and internationally there has been a focus on treating highly prevalent disorders, such as anxiety and mood disorders, perhaps leading those early in their practice to focus on these high prevalence disorders (Clark, 2011; Department of Health, 2008a).

The only differences found in terms of rates charged per psychotherapy hour were in charging for individual psychotherapy services. Those with twenty or more years of practice charged significantly more than those in the first ten years of their practice.

Interestingly, those in their first ten years of practice reported significantly fewer average number of treatment sessions than those with twenty or more years of practice, and also reported significantly fewer maximum number of sessions than both those with ten to twenty years of practice (group 2), and those twenty or more years of practice (group 3). A potential influential factor in this trend is the increased use of time-limited, manualized, and evidence-based treatments, such as those offered within the CBT framework, as CBT has been documented to be the most influential orientation at this time (see Bradley et al., 2016a; Hunsley et al., 2013; Norcross & Karpiak, 2012). Therefore those in their earlier years of practice have a higher likelihood of receiving training in time-limited therapies. In relation to this are the results

concerning the use of validated measures to track treatment outcome. These types of measures, and the principle of formally tracking treatment outcome, while still modestly used in the field (see Ionita & Fitzpatrick, 2014), have received increased attention in the recent past and may relate to the present results indicating that those in their first ten years of practice reported using outcome tracking measures more frequently than those with twenty or more years of experience. This is similar to previous research findings relating more years of experience with less awareness of these measures (Ionita & Fitzpatrick, 2014), and generally less openness to evidence-based practices (Addis & Krasnow, 2000).

In terms of access to other health professionals, the practitioners in their first ten years of practice reported that their clients have significantly less access to psychiatrists and family physicians than those with more years of experience. As stated above, the group with the least years of experience reported treating younger clients, and therefore this may be a reflection of the difficulty in gaining access to family physicians (Forget, 2014) and psychiatrists in Quebec for the younger generation of patients. Additionally, this may be a reflection of the increased collaborative network that may develop between psychologists/psychotherapists and other health professionals as ones gains practice experience, therefore, allowing increased access through referral by ones psychologist/psychotherapist to other health professionals. Related to the idea of an increased collaborative health care network for those with more years of experience are the results that indicate that those in their first ten years of practice reported significantly fewer referrrals from EAPs and family physicians than the other two groups. Potentially in the private sector, it takes time to build one's practice and develop professional connections with referers and other health professionals.

Not surprisingly, those in their first ten years of practice reported significantly more hours

of formal clinical supervision than those with twenty or more years of experience. However, those with twenty or more years of experience reported significantly more informal case discussion than those with fewer than ten years of experience.

Summary and Implications

The results of the current investigation highlight important and unique information about differences in private psychotherapy practice based on practitioner characteristics. The age populations being served in the private setting differed across practitioner education and years of experience, with doctoral level practitioners serving younger populations more frequently, and those with fewer years of experience serving younger populations and those with more years of experience serving older populations. These findings may be overlapping, as the doctoral level of training is more prevalent among those with fewer years of experience (68% of those with 21 or more years of practice are licensed at the master's level, whereas 46% of those in their first 10 years of practice are licensed at the master's level).

Along with age population differences, the frequency of treating different clinical populations, or those seeking treatment for different diagnoses or presenting problems, also differed across our characteristics of interest. Those at the doctoral level reported treating clients who meet the criteria for a diagnosable mental health disorder more frequently, and those with the most years of experience reported treating many diverse disorders and presenting problems more frequently than those with fewer years of experience. Furthermore, those espousing a CBT orientation reported treating anxiety disorders more frequently, humanistic practitioners reported treating marital/couple problems more frequently, and psychodynamic practitioners reported treating those with a personality disorder more frequently than CBT practitioners.

The rates charged per psychotherapy hour differed across all of the practitioner

characteristics, with doctoral level practitioners, those espousing a CBT orientation, and those with the most years of experience all charging higher rates for individual therapy. Furthermore, in terms of the average number of treatment sessions, those espousing a CBT orientation, and those with the least years of experience reported fewer treatment sessions.

There were differences in the use of validated clinical tools used to assess and diagnose, as well as track treatment progress. Doctoral level practitioners, those espousing a CBT orientation, and those within the first 10 years of practice compared to twenty or more years of practice, reported using these tools more frequently.

Finally, the reported frequency of referrals from EAPs and family physicians differed across practitioner characteristics. Those at the master's level, espousing a humanistic orientation compared to psychodynamic orientation, and with the most years of experience compared to those with the least, reported more frequent referrals from EAPs. Those espousing a CBT orientation compared to psychodynamic, and those with the most years of experience compared to the least, reported more frequent referrals from family physicians.

Implications for Trainees and New Professionals

This investigation provides those considering training in psychology, currently in training, or beginning their practicing career to have a concrete understanding of diverse aspects of private psychological practice. For example, those deciding which level of education to pursue are provided with information concerning the types of populations, both demographic and clinical, more frequently served by those with a master's degree versus a doctoral degree, or the difference in fees typically charged. Furthermore, choosing one's theoretical orientation is a complex and multifaceted process for many trainee therapists. While the present results certainly do not limit one to work with the populations more frequently seen by those endorsing a specific

orientation, this does provide information that may aid in the process of choosing one's own clinical orientation or understanding the practical components of espousing different orientations. If one wishes to work with certain populations, it may be important to consider the frequency in which practitioners of different orientations or levels of training treat these populations.

The information pertaining to the clientele served by those early in their psychotherapy practice career, such as a younger client base, provides a realistic snapshot of potentially what to expect, or whom to target, in terms of building one's private practice client base. Again, new professionals are not limited by information such as this; simply being aware means incorporating such information as best seen fit. Importantly, the results indicating that those early in their practice receive fewer referrals from EAPs and family physicians compared to those with more years of experience allows those early in their practice to be aware of the possible challenges that may exist in building one's client base and collaborative network, and that with increased experience there is the potential for a referral base to grow.

Implications for Professional Psychology and Training

Evidence-based Practice

Many of the results of the current investigation are important for psychology associations, licensing boards, and training institutions. This study provides information concerning the adoption of evidence-based clinical tools in private practice, such as manualized treatments, validated assessment tools and progress-monitoring measures. As shown in Bradley and colleagues (2016a), generally the use of these validated clinical tools is quite modest in this sample, and other investigations have shown that specifically those in private practice are less likely to be aware of and use tools such as progress monitoring measures (Hatfield & Ogles,

2004; Ionita & Fitzpatrick, 2014). Therefore generally providing training opportunities and incentives to increase awareness and use of validated clinical tools for those in private practice is important. However, the present results have identified those populations of practitioners who use these validated measures the least, therefore allowing for more opportunity for specific targeting of training opportunities and initiatives to enhance the use of evidence-based clinical tools among these practitioners. If psychology, and specifically psychotherapy, are truly wanting to move in the direction of empirically informed treatment, it may be important to specifically target master's level training programs to provide opportunities for training and use of these validated measures. Furthermore, psychology and psychotherapy licensing boards and associations could potentially provide opportunities and incentives for training in the use of these measures particularly for those with more years of experience. Alternatively, should continuing education requirements include and perhaps require training in the use of validated measures to track treatment outcome? Outcome tracking and the use of evidence-based practices is a core component in government-funded psychotherapy programs internationally (Clark, 2011; Pirkis et al., 2011), and is engrained in the CPA's definition of evidence-based practices (Dozois et al., 2014). If evidenced based practice is a fundamental principle for psychology in Canada, efforts must be put forth to enhance the adoption of this among our private practitioners.

Collaboration

Opportunities for collaboration with other health professionals is generally limited for the current sample (see Bradley et al., 2016a), and the present results indicated that collaboration for those in the earliest years of practice is the most limited. With the increased attention paid to the benefits of collaborative care (see Gagne, 2005; Grenier, Chomienne, Gaboury, Ritchie, & Hogg, 2008) early career psychologists and psychotherapists particularly have to be provided with

opportunities for collaboration and increased contact with other health professionals. Our training institutions and psychology associations should focus efforts on initiatives to increase contact with other health professionals for these early career psychologists and psychotherapists to foster relationships. As Craven and Bland (2006) have shown, in-person contact among professionals is beneficial for developing collaborative care.

Implications for Public Policy

Increasing access to mental health care has become an important initiative in Quebec (Cavaliere, 2014; Commissaire à la santé et au bien-être du Québec, 2012), and nationally (Peachey et al., 2013). Government-funded mental health programs to increase access to services that have been adopted in the UK and Australia offer evidence-based psychotherapy treatments, for a set number of sessions, and use outcome tracking tools to measure treatment success (see Department of Health, 2008b; Pirkis et al., 2011). For similar initiatives to be implemented at the provincial or national level in Canada, these need to be informed by data from practitioners in the local context. For a discussion of practitioner attitudes concerning a government-funded psychotherapy program in Quebec see Bradley and Drapeau (2014) in Chapter 4.

The current data provide program and policy developers and funders with important information about structuring government-funded services. If it is decided that manualized treatments and outcome tracking are to be a core component of government-funded mental health services it is important to be aware of those groups of professionals that may need more education and exposure to these, such as those licensed at the master's level, those not espousing a CBT orientation, and those with many years of practice experience. Furthermore, if a set number of sessions are to be mandated, a number of things must be considered. Those espousing

a CBT framework reported fewer average treatment sessions, which may be alluring to funders of these programs. However, a phenomenon that must be considered is the fact that practitioners of different orientations also reported treating different mental health concerns. Therefore there is the potential for different presenting problems, or severity of problems, to require different treatment lengths.

The idea of practitioners treating different presenting problems with varying levels of severity, and the impact of this on treatment course and outcome is not new (Atkinson & Christenson, 2011). Those investigating the influence of levels of training on outcome have discussed the difficulty in measuring this given that some practitioners treat patients with more severe or chronic conditions (Berman & Norton, 1985). Therefore, given that the present data indicated different presenting problems for groups of practitioners (master's vs. doctoral, CBT vs. psychodynamic), and different treatment lengths, this must be taken into account.

Retention of Senior Practitioners in the Public Setting.

Those with more years of experience in this study reported greater numbers of clients seen per week, potentially indicating a migration to increased private psychotherapy work as one gains experience in their career. Anecdotally, this certainly seems to be the case for experienced practitioners, and never before have so many licensed psychologists and psychotherapists been working in the private sector (see INESSS, 2015; Ordre des Psychologues du Québec, 2015). If such is the case, this may indicate a challenge in retaining senior psychologists and psychotherapists in the public sector. The poor compensation of psychologists in the public system is well known in Quebec, and others have discussed the problem of losing experienced practitioners to the private setting in other contexts, such as Australia (see Forsyth, 2009; Gleeson & Brewer, 2008). Provincial health care funders need to be aware of this phenomenon,

and to consider means of retaining these experienced practitioners in the public system, not only to serve the populations in need, but also to train psychology practicum and internship students. Additionally, those developing and funding new programs for government-funded mental health care services must also be aware of proper conditions and compensation. If those in the private sector are to be included in a government-funded psychotherapy program, which they have indicated that they are in favour of (see Bradley & Drapeau, 2014, in Chapter 4), the current fees for services expected for those of different years of experience and different levels of education cannot be ignored if there is to be buy in from practitioners to offer these services.

Limitations and Future Directions

The present study has a number of limitations. While self-report surveys are often used in the field of psychology (e.g., Hunsley et al., 2013; Ionita & Fitzpatrick, 2014; Norcross & Karpiak, 2012) this type of methodology can be challenging, as it is not an objective form of reporting. There is always a potential for errors or personal biases in reporting on one's practice. While this type of documentation of trends in the field of psychology has been historically important, and will remain so in order to track future developments, efforts to obtain objective data concerning psychotherapy treatment should be used in conjunction with self-report surveys.

Additionally, the present response rate of approximately 20% is modest, and a larger sample size, particularly of psychotherapists, was desired to increase the generalizability of the results. The response rate of psychologists, while modest, is considered sufficient for generalizability (see Bradley et al., 2016a; Direction Research, 2011). The sample appears representative of psychologists in terms of theoretical orientation, gender and education (see Bradley et al., 2016a; Jaimes, La Rose-Herbert, & Moreau, 2015; Ordre des Psychologues du Québec, 2015).

This investigation documented psychological practitioners at differing levels of education, orientation, and years of experience, therefore allowing for potential generalizability to practitioners of similar characteristics. However, the sample is limited to the province of Quebec. While the sample is generally representative of Quebec practitioners, such may not be the case for other provinces. It would be of value to investigate similar characteristics in private practice in other provinces. This would allow for an increased understanding of the national culture of psychotherapy services in Canada, and also to gain a detailed understanding of differences in each regional jurisdiction to assist in informing education, training and service planning.

Finally, as psychologists and psychotherapists have different training and educational backgrounds, it is of interest to investigate differences in practice characteristics between these two groups of professionals to gain further detailed understanding of the psychotherapy workforce.

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Table 1. *Demographic Information*

License	**Psychologist**	**Psychotherapist**				
	79%	21%				
Sex	**Female**	**Male**				
	75%	25%				
Work Setting	**Urban**	**Semi-Rural/ Rural**				
	50.3%	49.7%				
Language	**French**	**English**				
	90%	10%				
Age	**25-34**	**35-44**	**45-54**	**55-64**	**65+**	
	13%	26%	22%	27%	12%	
Years of Practice	**Less than 5**	**5-10**	**11-15**	**16-20**	**21-25**	**26-30**	**30+**
	12%	20%	17.5%	13.5%	14%	10%	13%
Academic Degree*	**Bachelor's Degree**	**Master's Degree**	**Doctoral Degree**	**Psy. D**	**Other**	
	5%	63%	20%	9.5%	2.5%	
Number of Professionals	**Solo Practice**	**2-4**	**5-7**	**8+**		
	47.7%	25.1%%	12.8%	14.4%		
Theoretical Orientation	**Cognitive-Behavioural**	**Psychoanalytic/ Psychodynamic**	**Humanistic/ Existential**	**Integrative/ Eclectic**	**Systems/ Family Systems**	**Other**
Primary Orientation	35.4%	22.8%	22.6%	9.7%	6.5%	3.1%
Secondary Orientation	23.7%	11.7%	18.5%	14.3%	17.6%	3.7%

Note. * Some respondents may be practicing with a bachelor's or master's degree as they would have been licensed prior to the new doctoral requirements and/or are originally from out of Quebec and have been accepted for licensure based on equivalences.

Table 2. Significant Results (p < .01) when Comparing Level of Education

	Master's			Phd/Psy.D					
Survey Items	***Median***	***Mean Rank***	***SD***	***Median***	***Mean Rank***	***SD***	***U***	***z***	***r***
In your private practice, what proportion of your time is typically devoted to couple therapy?	2.00	**326**	.88	2.00	266	.58	32, 716	- 4.46	.18
In your private psychotherapy practice, what proportion of your time is typically devoted to each age group:									
Children (12 and younger)	1.00	294	.76	1.00	**336**	.53	46, 215	3.44	.14
Adolescents (13 to 17)	2.00	291	.78	2.00	**341**	.78	47, 235	3.53	.14
Adults (31 to 65)	5.00	**330**	.99	5.00	258	1.03	31, 157	- 4.81	.19
Older Adults (66+)	2.00	**328**	.56	2.00	261	.58	31, 662	- 4.98	.20
In your private psychotherapy practice, please indicate the frequency with which your clients present each of the following problems/diagnoses as their primary reason for seeking services:									
Couple/Marital difficulties	4.00	**312**	.74	4.00	271	.68	33, 020	- 2.87	.12
Disorders found in the DSM, ICD, etc.	3.00	279	.79	4.00	**328**	.87	43, 602	3.47	.14
Gender or sexuality-related difficulties	2.00	**319**	.78	2.00	282	.75	35, 904	- 2.66	.11
Grief/Bereavement	3.00	**318**	.81	3.00	267	.71	32, 657	- 3.64	.15
Personal Problems (e.g., existential problems)	3.00	**312**	.86	3.00	272	.88	33, 737	- 2.81	.11
Psychological problems related to health, injury or illness	3.00	**313**	.88	3.00	270	.72	33, 125	- 2.98	.12
Sexual abuse and trauma	3.00	**313**	.96	2.50	274	.66	33, 994	- 2.69	.11
Work/Vocational difficulties	3.00	**320**	.92	3.00	260	.67	31, 247	- 4.09	.17

Substance Abuse	2.00	**322**	.69	2.00	277	.74	34, 988	- 3.03	.12
In your private practice, typically how many of your clients meet the criteria for 2 or more mental disorders?	3.00	290	.78	3.00	**330**	.61	45, 048	2.83	.11
In your private psychotherapy practice, on average, what do you charge for one hour of:									
Individual psychotherapy	90	285	17.58	100	**326**	20.00	43, 183	2.74	.11
Couple therapy	100	110	24.54	120	**154**	28.12	6, 725	4.07	.16
How often do you refer a client to a medical professional to rule out medical causes when a client presents with:									
Anxiety	3.00	**320**	1.02	3.00	272	.97	33, 641	- 3.26	.13
Depression	3.00	**320**	1.03	3.00	270	1.05	33, 440	- 3.36	.14
Please indicate the frequency with which you use each of the following in your private psychotherapy practice:									
Manualized Treatments	1.00	281	1.05	2.00	**331**	1.11	44, 422	3.51	.14
Validated scales to track/document client progress (e.g., BDI, OQ-45, PCOMS)	1.00	283	1.10	2.00	**347**	1.32	48, 251	4.49	.18
Formal Diagnostic Inventories (e.g., SCID)	1.00	285	.82	1.00	**321**	1.03	42, 251	2.58	.10
Personality Inventories (e.g., MMPI, NEO)	1.00	288	.75	1.00	**326**	.76	43, 436	2.95	.12
Projective Tests (e.g., Rorschach, TAT)	1.00	298	.51	1.00	**328**	.46	44, 765	2.80	.11
Typically, how many of your clients are referred by an Employee Assistance Program (EAP)?	3.00	**332**	.93	3.00	247	.99	28, 971	- 5.80	.23

Note. * Numbers in bold represent the group with the higher mean rank

Table 3. Significant Results (p < .01) when Comparing Theoretical Orientation

	CBT		Psychodynamic		Humanistic			
Survey Items	***Median***	***Mean Rank***	***Median***	***Mean Rank***	***Median***	***Mean Rank***	χ^2	**Post-hoc Analysis**
In your private psychotherapy practice, what proportion of your time is typically devoted to each age group:								
Adolescents (13 to 17)	2.00	287	1.00	245	2.00	237	15.58	CBT > Humanistic
Adults (31 to 65)	5.00	250	5.00	247	5.00	297	11.54	Humanistic > CBT Humanistic > Psychodynamic
In your private psychotherapy practice, please indicate the frequency with which your clients present each of the following problems as their primary reason for seeking services:								
Adjustment to life stressors	4.00	278	4.00	203	4.00	265	28.11	CBT > Psychodynamic Humanistic > Psychodynamic
Couple/Marital difficulties	4.00	240	4.00	241	4.00	293	14.86	Humanistic > Psychodynamic Humanistic > CBT
Family Difficulties	3.00	256	4.00	295	3.00	243	11.33	Psychodynamic > Humanistic
Gender or sexuality-related difficulties	2.00	236	2.00	268	2.00	300	19.55	Humanistic > CBT
Grief/Bereavement	3.00	233	3.00	258	3.00	290	15.22	Humanistic > CBT
Interpersonal Difficulties	4.00	230	4.00	286	4.00	260	15.70	Psychodynamic > CBT
Personal Problems (e.g., existential problems)	3.00	218	4.00	273	4.00	302	33.60	Humanistic > CBT Psychodynamic > CBT
Psychological problems related to health, injury or illness	3.00	264	3.00	221	3.00	270	11.27	Humanistic > Psychodynamic

Sexual abuse and trauma	3.00	228	3.00	282	3.00	280	18.61	Humanistic > CBT Psychodynamic > CBT
Work/Vocational difficulties	3.00	262	3.00	209	4.00	293	26.12	Humanistic > Psychodynamic CBT > Psychodynamic
In your private psychotherapy practice, please indicate the frequency with which your clients require treatment primarily for the following diagnoses:								
Anxiety Disorders	4.00	289	4.00	205	4.00	229	38.75	CBT > Humanistic CBT > Psychodynamic
Mood Disorders	4.00	278	4.00	211	4.00	256	20.73	CBT > Psychodynamic
Personality Disorders	3.00	232	3.00	291	3.00	256	15.65	Psychodynamic > CBT
Sexual Disorders	2.00	241	2.00	261	2.00	300	15.53	Humanistic > CBT
Sleep Disorders	3.00	267	3.00	217	3.50	276	14.80	Humanistic > Psychodynamic CBT > Psychodynamic
In your private practice, typically how many of your clients:								
Also receive psycho-pharmacological treatment?	3.00	279	3.00	225	3.00	249	16.59	CBT > Psychodynamic
Meet the criteria for 2 or more mental disorders?	3.00	279	3.00	259	3.00	235	9.40	CBT > Humanistic
In your private psychotherapy practice, on average, what do you charge for one hour of:								
Individual therapy	90.00	300	90.00	226	90.00	219	36.01	CBT > Psychodynamic CBT > Humanistic
Couple therapy	105	104	110	104	90.00	71	14.97	CBT > Humanistic Psychodynamic > Humanistic

Typically, in regards to your clients that complete their psychotherapy treatment, what is the:								
Minimum number of sessions	5.00	222	6.00	316	5.00	273	35.72	Psychodynamic > CBT Humanistic > CBT
Average number of sessions	12	191	27.51	348	15.00	290	103	Psychodynamic > Humanistic Psychodynamic > CBT Humanistic > CBT
Maximum number of sessions	40.00	200	90.08	322	66.26	302	70.90	Psychodynamic > CBT Humanistic > CBT
Typically, how many of your clients are:								
Referred by an Employee Assistance Program	3.00	261	3.00	233	3.00	293	12.58	Humanistic > Psychodynamic
Referred by a family physician	3.00	281	3.00	232	3.00	251	13.20	CBT > Psychodynamic
How often do you refer a client to a medical professional to rule out medical causes of anxiety?	3.00	266	3.00	224	3.00	286	14.66	Humanistic > Psychodynamic
Please indicate the frequency with which you use each of the following in your private psychotherapy practice:								
Manualized Treatments	2.00	318	1.00	195	1.00	219	82.45	CBT > Psychodynamic CBT > Humanistic
Validated scales to track/document client progress (e.g., BDI, OQ-45, PCOMS)	2.00	326	1.00	199	1.00	220	91.50	CBT > Psychodynamic CBT > Humanistic
Established Clinical Guidelines (e.g., NICE, Qualaxia)	1.00	285	1.00	236	1.00	255	18.78	CBT > Psychodynamic
Formal Diagnostic Inventories (e.g., SCID)	2.00	280	1.00	232	1.00	230	17.54	CBT > Psychodynamic CBT > Humanistic

Self-developed assessment inventories	2.00	274	1.00	225	1.00	256	11.44	CBT > Psychodynamic
Please indicate the frequency with which you engage in informal case discussion with colleagues.	6.00	253	5.00	239	6.00	292	10.37	Humanistic > Psychodynamic
Please indicate the number of hours per year you receive of formal clinical supervision.	6.50	230	13.75	314	10.00	262	28.13	Psychodynamic > Humanistic Psychodynamic > CBT

Table 4. Significant Results ($p < .01$) when Comparing Years of Experience

Survey Items	Group 1: 10 Years or Less		Group 2: 11 – 20 Years		Group 3: 20+ Years			
	Median	***Mean Rank***	***Median***	***Mean Rank***	***Median***	***Mean Rank***	χ^2	**Post-hoc Analysis**
In your private practice, on average how many clients per week do you provide psychotherapy services to?	9.00	265	15.00	357	15.00	37	33.91	Group 2 > Group 1 Group 3 > Group 1
In your private practice, what proportion of your time is typically devoted to couple therapy?	1.00	284	1.00	323	2.00	378	35.12	Group 3 > Group 1 Group 3 > Group 2
In your private psychotherapy practice, what proportion of your time is typically devoted to each age group:								
Adolescents (13 to 17)	2.00	349	2.00	348	1.00	300	12.06	Group 1 > Group 3
Young Adults (18 to 30)	3.00	362	3.00	336	3.00	300	13.48	Group 1 > Group 3
Adults (31 to 65)	4.00	284	4.00	322	5.00	379	30.31	Group 3 > Group 1 Group 3 > Group 2
Older Adults (66+)	1.00	287	2.00	335	2.00	365	24.47	Group 3 > Group 1
In your private psychotherapy practice, please indicate the frequency with which your clients present each of the following problems as their primary reason for seeking services:								
Gender or sexuality-related difficulties	291	2.00	338	2.00	361	2.00	18.74	Group 3 > Group 1
Grief/Bereavement	279	3.00	326	3.00	361	3.00	24.77	Group 3 > Group 1
Psychological problems related to health, injury or illness	273	3.00	335	3.00	352	3.00	24.28	Group 2 > Group 1 Group 3 > Group 1
Sexual abuse and trauma	282	2.00	335	2.00	351	3.00	17.51	Group 2 > Group 1

								Group 3 > Group 1
Work/Vocational difficulties	286	3.00	319	3.00	361	4.00	19.95	Group 3 > Group 1
In your private psychotherapy practice, please indicate the frequency with which your clients require treatment primarily for the following diagnoses:								
Mood Disorders	321	4.00	347	4.00	293	4.00	10.54	Group 2 > Group 3
Pervasive Developmental Disorders	292	1.00	323	1.00	373	1.00	33.98	Group 3 > Group 1 Group 3 > Group 2
Schizophrenia and other Psychotic Disorders	313	1.00	322	1.00	357	1.00	11.96	Group 3 > Group 1
Sexual Disorders	299	2.00	318	2.00	372	2.00	21.25	Group 3 > Group 1 Group 3 > Group 2
Somatoform Disorders	283	2.00	313	2.00	390	2.00	42.59	Group 3 > Group 1 Group 3 > Group 2
In your private practice, typically how many of your clients:								
Have a comorbid medical condition (e.g., diabetes, chronic pain)?	297	2.00	343	3.00	346	3.00	10.77	Group 3 > Group 1
In your private psychotherapy practice, on average, what do you charge for one hour of individual psychotherapy?	286	90.00	313	90.00	361	100.00	19.56	Group 3 > Group 1
Typically, in regards to your clients that complete their psychotherapy treatment, what is the:								
Average number of sessions	293	15.00	337	15.00	362	15.50	14.84	Group 3 > Group 1
Maximum number of sessions	249	35.00	345	50.00	392	50.00	65.34	Group 2 > Group 1 Group 3 > Group 1
Typically, how many of your clients:								

Are referred by a family physician	296	3.00	329	3.00	347	3.00	10.81	Group 3 > Group 1
Are referred by an Employee Assistance Program	299	2.00	329	3.00	357	3.00	11.59	Group 3 > Group 1
Typically, how many of your clients:								
Currently have access to a psychiatrist	289	2.00	343	2.00	338	2.00	13.16	Group 2 > Group 1 Group 3 > Group 1
Currently have access to a family physician	294	3.00	321	4.00	348	4.00	10.93	Group 1 < Group 3
How often do you refer a client to a medical professional to rule out medical causes when a client presents with:								
Anxiety	296	3.00	352	3.00	335	3.00	10.25	Group 2 > Group 1
Depression	291	3.00	357	4.00	336	4.00	14.08	Group 2 > Group 1
Please indicate the frequency with which you use each of the following in your private psychotherapy practice:								
Validated scales to track/document client progress (e.g., BDI, OQ-45, PCOMS)	369	2.00	325	1.00	298	1.00	18.68	Group 1 > Group 3
Please indicate the frequency with which you engage in informal case discussion with colleagues.	301	5.00	322	5.00	356	6.00	10.07	Group 3 > Group 1
Please indicate the number of hours per year you receive of formal clinical supervision.	347	12.00	297	10.00	270	6.99	20.97	Group 1 > Group 3

Transition from Chapters 2 and 3 to Chapter 4

Manuscript one found in Chapter 2, and manuscript two found in Chapter 3, focused on the documentation of the current characteristics of private psychotherapy practice in Quebec, as well as an analysis of differences among practitioners based on level of education, years of experience and theoretical orientation. These studies provide new detailed information about routine private practice, and can serve to inform mental health care initiatives in the future.

We now turn our investigation to increasing access to psychotherapy treatment, and specifically the development of a government-funded model of psychotherapy in the Quebec context. Chapter 4 contains manuscript 3, which is a survey study investigating the attitudes of psychologists and psychotherapists toward diverse components of government-funded models of psychotherapy treatment currently in place in other countries. This study serves to document the components perceived as favourable or unfavourable from the perspective of practicing psychologists and psychotherapists in Quebec. The implications of these findings concerning favourable and unfavourable components are discussed in relation to the development of a government-funded model of psychotherapy in Quebec.

Chapter 4: Increasing Access to Mental Health Care through Government-Funded Psychotherapy: The Perspectives of Clinicians

Abstract

The lack of accessibility to mental health care in Canada has been described as a silent crisis, with the Canadian Psychological Association (CPA) proposing possible actions that could be taken to achieve increased accessibility (Peachey, Hicks, & Adams, 2013). Efforts to make psychotherapy more accessible have been implemented in both the United Kingdom (UK) and Australian health care systems through government-funded services (Clark, Layard, Smithies, Richards, Suckling, & Wright, 2009; Hickie & Groom, 2002). The aim of the present study was to document the attitudes of psychologists and psychotherapists licensed to practice in Quebec toward accessibility to psychotherapy, and government-funded psychotherapy programs. Participants (N = 1462) completed an online questionnaire; results indicated that 77% of the sample '*strongly agreed*' that accessibility to psychotherapy should be increased. Participants indicated that priority for government-funded psychotherapy should be given to those with diagnosable mental health disorders, particularly mood disorders, anxiety disorders, and schizophrenia and other psychotic disorders, as well as psychological functioning related to health, injury and illness, and family difficulties. Participants indicated that treatment priority should be based on severity of illness. There was stronger agreement that clinicians working within a government-funded psychotherapy program should be paid on a session-to-session basis as opposed to receiving a yearly salary; to be able to set their own fee; and to have freedom to choose the appropriate psychotherapeutic approach (e.g., cognitive-behavioural therapy; emotion focused therapy) and appropriate treatment materials (e.g., psycho-educational handouts) to be used in treatment. Other results concerning the structure of a government-funded psychotherapy program are discussed, as well as the implications for increasing accessibility.

Key words: psychotherapy; accessibility; mental health care; increasing access; psychologist; survey

Increasing Access to Mental Health Care through Government-Funded Psychotherapy: The Perspectives of Clinicians

The waves of needed change in Canadian healthcare services have been felt for over a decade, beginning with two seminal reports, the "Kirby Report" (Kirby, 2002) and the "Romanow Report" (Romanow, 2002), both calling for more efficient and responsive health care for Canadians (see Peachey, Hicks, & Adams, 2013). The Standing Senate Committee's report "Out of the Shadows at Last" highlighted the need for increased focus on mental health issues, and recommended a reorganization of the mental health system, endorsing a shared-care approach between mental health professionals with primary health care services providing the majority of mental health care, in order to improve accessibility (Kirby & Keon, 2006; Peachey et al., 2013). The Mental Health Commission of Canada has also published a mental health strategy (Mental Health Commission of Canada, 2012) with key recommendations for increasing accessibility to evidence-based psychotherapies, including expanding the role of primary health care in meeting mental health needs, as well as increasing the availability and coordination of mental health services in the community (see also Peachey et al., 2013). At a provincial level, Quebec's Mental Health Action Plan 2005-2010 (see Ministère de la Santé et des Services Sociaux, 2005) proposed organizational changes throughout the province, to enhance mental health care delivery through primary care. Although implementation has been somewhat successful, financial and human service shortages have been labeled as barriers in this process (see http://www.blog.qualaxia.org/2013/03/26/implementation-of-the-mhap-2005-2010-a-work-in-progress/). As the recognition of the importance of mental health treatment in Canada was coming to the forefront, evidence of the cost-effectiveness of psychological treatments for mental health problems became increasingly available. Hunsley (2002) outlines the compelling

evidence of the cost-effectiveness of psychological treatments, indicating that these treatments may be more cost-effective than most pharmacological treatments, and that successfully treated patients use less health care services, therefore resulting in less cost to the health care system.

Efforts to make mental health care more accessible have been implemented internationally in the United Kingdom (UK) and Australian health care systems, as well as the Netherlands and Finland, through government-funded services (Australian Government Department of Health, 2015a, 2015b; Clark, Layard, Smithies, Richards, Suckling, & Wright, 2009; Hickie & Groom, 2002; Peachey et al., 2013). As recently as May 2, 2013, a report to the Canadian Psychological Association concerning the mental health accessibility crisis in Canada was published, entitled "An Imperative for Change: Access to Psychological Services for Canada" (Peachey et al., 2013), which describes the lack of accessibility in Canada as a silent crisis, and proposes possible action that could be taken to achieve increased accessibility. This comprehensive report outlines the current state of mental health care delivery, reporting that the current coverage of psychologists' services "tends to be fragmented, at best, and frequently non-existent" (Peachey et al., 2013, p. 1). The report comments on the need for increased government funding to cover the costs associated with psychological treatment, as one in five individuals are affected by mental health problems (with an annual societal cost of $50 billion) (Mental Health Commission of Canada, 2012). Furthermore, many individuals go untreated, as family physicians in Canada are overrun with prevalent mental health problems and lack appropriate methods of consulting and referring to qualified mental health professionals (Peachey et al., 2013). The report made recommendations to increase government-funded psychological services in Canada, including the adaptation of the UK's 'Improving Access to Psychological Therapies' (IAPT) program at a provincial level. Other recommendations

included: integrating psychologists on primary care teams, including psychologists on specialist care teams in secondary and tertiary care facilities, and finally, expanding private insurance coverage and promoting employer support for psychological treatments (Peachey et al., 2013). Both the UK and Australian mental health accessibility initiatives share similar principles, have been successful in increasing access to mental health care, and have been shown to be cost-effective; however the means with which services are delivered vary.

The UK's IAPT program was designed to offer evidence-based therapies, as outlined in the National Institute for Health and Care Excellence (NICE) guidelines, for effective treatment of depression and anxiety disorders (e.g., Clark, 2011; Clark et al., 2009). This generally involves a stepped-care approach, such that those with mild to moderate depression and specific anxiety disorders can receive low intensity treatments, whereas those with severe depression and specific anxiety disorders can receive face-to-face psychotherapy or "high intensity" treatment (Clark, 2011; Clark et al., 2009; Department of Health, 2008a). Primary Care Trusts (PCTs) that are responsible for the health care of their local residents are provided with funding to recruit and train workers in the use of cognitive behavioural oriented therapies (CBT) for anxiety disorders and depression (see Clark, 2011; Clark et al., 2009). Individuals can only access government-funded psychotherapy through their PCT, and can be referred to the program through a General Practitioner (GP), an employment support agency, other health professionals, or through self-referral. Clinicians must be hired by the IAPT program in order to offer government-funded psychotherapy.

A unique feature of this program is the large amount of session-by-session outcome data that has been accumulated. At every session, patients are required to complete a standardized measure of either depression or anxiety (Patient Health Questionnaire Depression Scale- PHQ-9,

and the Generalized Anxiety Disorder 7- GAD-7) (Clark, 2011; Clark et al., 2009), as well as an employment questionnaire (Clark, 2011; Clark et al., 2009). The core principles of the program include outcome tracking, a focus on clients returning to or maintaining employment (as employment assistance and debt counselling are offered through the IAPT program), as well as adherence to the NICE guidelines. Furthermore, training and regular supervision are offered by the IAPT program (Clark, 2011). The program has been successful in increasing availability of treatment; specific details outlining the success of the program are outlined by the Department of Health (2008e).

Over ten years ago an initiative to improve mental health care service delivery began in Australia with the government-funded Better Outcomes in Mental Health Care (BOiMHC) program (Hickie & Groom, 2002; Pirkis, et al., 2006a, 2006b). The objective of this program was to increase treatment rates of common psychological problems such as anxiety and depression. There are several components to the program, the first being the Access to Allied Psychological Services (ATAPS), which provides funding to Divisions of General Practice in order for GPs to refer patients to allied mental health professionals who deliver evidence-based focused psychological strategies, such as CBT and interpersonal therapy (Australian Government Department of Health, 2015a; Pirkis et al., 2006a, 2006b). These allied professionals can be hired by each Division, or can be contracted on a session-to-session basis (Pirkis et al., 2006a, 2006b). By GP referral only, individuals can receive up to 12-individual therapy session per calendar year (with a progress report given to the GP to decide further course of treatment), with the possibility of more sessions in special circumstances (Australian Government Department of Health, 2015a). In addition to 12 individual sessions, patients can also receive 12 group therapy sessions per calendar year.

The ATAPS program functions in conjunction with the Better Access initiative, introduced in 2006, which gives medical rebates for mental health services sought in the private sector with registered professionals through the Medicare Benefits Schedule (10 individual sessions/10 group therapy sessions per calendar year) (Australian Government Department of Health, 2015b). To access the Better Access services, a GP, psychiatrist or pediatrician must refer the client, and the referring physician must complete a mental health assessment and prepare a Mental Health Treatment Plan (guidelines for appropriate treatment) before referring out (Australian Government Department of Health, 2015b). The types of treatments offered through the Better Access program include psycho-education, CBT, relaxation therapy, and interpersonal therapy, for a range of mental health problems (e.g., psychotic disorders, eating disorders, depression, anxiety, drug use problems, among others) (Australian Government Department of Health, 2015b; Pirkis et al., 2011). The Better Access initiative has been successful in helping to meet the unmet mental health care needs in Australian communities (Pirkis et al., 2011). An individual can receive mental health services from both the ATAPS and Better Access programs as long as they do not exceed the established number of sessions per calendar year, and they are not referred through both programs simultaneously.

It is evident that the GP plays an integral role throughout the treatment process in both the ATAPS and Better Access initiatives, with referral to these programs through the GP, the GP reviewing treatment progress mid-way through treatment to decide treatment length, conducting mental health assessments and preparing Mental Health Action Plans. An additional component of the Australian initiative is education and training for GPs to enhance their knowledge and skills in the assessment and diagnosis of mental health problems, preparation of a mental health

plans, and training in delivering focused psychological strategies (Australian Government Department of Health, 2015a; 2015b).

Many recommendations are being made within the Canadian context as to how to move forward in increasing accessibility to mental health care, some suggesting the adaptation of the IAPT model at a provincial level (Peachey et al., 2013), while others comment on the similarities between the Australia and Canadian healthcare systems and present a rationale as to why initiatives in Canada to increase accessibility should mirror those of the Australian programs (Moulding, Grenier, Blashki, Ritchie, Pirkis, & Chomienne, 2009). To better inform these initiatives, it is integral to gain a greater understanding from the perspective of psychologists and psychotherapists, as to those elements that are perceived as fundamental for increasing accessibility, and well as possible barriers or components that may be unfavourable within a Canadian context. The objective of the current study was to document the attitudes of psychologists and psychotherapists in Quebec toward accessibility to psychotherapy, and government-funded psychotherapy programs, particularly focusing on the principles and components of the UK's IAPT program and the Australian ATAPS and Better Access programs.

Method

Participants

Psychotherapy is a reserved activity that can be practiced by psychologists, psychotherapists and physicians (see https://www3.ordrepsy.qc.ca/en/obtenir-un-permis/index.sn) in Quebec. To participate in the current study one had to be licensed under the title of 'psychologist' or 'psychotherapist' with the *Ordre des Psychologues du Québec* (OPQ), the regulatory and licensing body, and currently be in active psychotherapy practice in either the public or private sector. Participants were recruited through an e-mail request sent by the OPQ,

as per their policy on the support of research projects. The email request was sent in November 2013 to 4542 psychologists and 512 psychotherapists whom were French-speaking, as well as 559 psychologists and 88 psychotherapists whom were English-speaking, asking for participation in an anonymous survey. The sample consists of 1462 participants who completed the survey, representing a 26% return rate. Sixty-seven percent (67%) of the sample identified as female, 33% male. The majority of the sample (89%) completed the survey in French and 11% in English. The majority of the participants, 86%, were licensed psychologists, and 14% were psychotherapists. Participants' ages ranged from 25-34 (13%), 35-44 (28%), 45-54 (24%), 55-64 (25%) and finally above 65 (10%). In terms of education, 63% of the sample reported a master's degree as their highest academic degree, 22% a doctoral degree[1], 12% a Psy. D, 2% a bachelor's degree, and 1% indicated 'other'. In terms of psychotherapy experience, 30% of participants were in the first ten years of practicing psychotherapy, 33% between eleven and twenty years, 37% had more than 20 years of practice. The majority of the sample, 87%, reported providing psychotherapy services to adults (age 31-64), 84% to young adults (age 18-30), 51% to older adults (age 65+), 44% to adolescents (age 13-17), and 29% to children (younger than 12). Information pertaining to primary and secondary work setting, as well as primary and secondary theoretical orientation can be found in Table 1.

Survey

Prior to the development of the survey, a thorough literature search was conducted to identify seminal documents related to the development and implementation of government funded mental health care programs in other countries, predominantly from the UK and Australia. A team of three members of the *McGill Psychotherapy Process Research Group*

[1] The doctoral degree became the required level of education in Quebec in 2006.

(www.mpprg.mcgill.ca) reviewed the seminal documents independently and identified the core principles and practical components (e.g., General Practitioner referral; mandatory use of clinical guidelines) of these government-funded programs. Those components agreed upon in consensus meetings were used in developing the survey. Expert consensus was also sought from professionals involved in and knowledgeable of the programs that were in place in the UK and Australia, as well as Canadian researchers, provincial and national psychology associations and the Quebec psychology regulatory body, members of community mental health organizations, individuals involved in policy making, as well as members of the Institut National d'Excellence en Santé et en Services Sociaux (INESSS). The survey consisted of various items related to the structure of government funded psychotherapy, such as how to prioritize services, which mental health problems to be included and prioritized, which age groups to be prioritized, what modalities of treatment should be offered (e.g., individual therapy, group therapy), and how many sessions should be funded per year. Another section of the survey focused on clinician choice or discretion in terms of psychotherapy approach and materials to be used in treatment, the role of the family physician in deciding the course of treatment, and tracking professional competencies, treatment outcome and client satisfaction with the services. One of the final sections included questions concerning the workforce of professionals offering services, the work setting (public *vs*. private), and psychotherapy service fees and payment (for a list of the majority of the survey questions please see Tables 1 through 6). Most questions asked participants to rate their agreement on a 5-point Likert scale, 1 being '*strongly disagree*' and 5 being '*strongly agree*', or to rank their preferences in descending order. The final section included the demographic questions.

Data Analysis

The dataset was screened for errors, and outliers were removed (Cousineau & Chartier, 2010; Tabachnick & Fidell, 2007). The majority of the variables were within the acceptable range of missing data (less than 5%); those variables with more than 5% missing data were imputed through expectation maximization (Graham, 2009; Tabachnick & Fidell, 2007). The frequencies were calculated for each survey item and can be found in Tables 2 through 7.

Results and Discussion

Results indicated that the clinicians in this study echo the belief that accessibility to psychotherapy is a concern, with 77% of the sample indicating '*strongly agree*', and 16% '*agree*' that access to psychotherapy services should be increased. There was stronger reported agreement for partial rather than full government coverage of psychotherapy services with more than 95% of the sample indicating '*strongly agree*' or '*agree*' for partial coverage, and 56% for full coverage. Furthermore, there appears to be favourable attitudes towards both increasing access in the public sector, as well as funding services in the private sector, mirroring the structure of the Australian programs (Australian Government Department of Health, 2015a, 2015b; Pirkis et al., 2006a, 2006b).

Mental Health Concerns

Diagnosable disorders (such as those found in the Diagnostic and Statistical Manual of Mental Disorder; DSM), health-related problems, and family problems were most frequently rated as the mental health problems to be included in a government funded psychotherapy program (See Table 3); these were also most highly ranked as the problems to prioritize (see Table 4). This is an interesting finding, as focusing on psychological distress in relation to health problems was not an initial core principle of either the IAPT or the Australian ATAPS or Better

Access programs. This may be a result of the increasing recognition in Canada of the integral role that mental health professionals play in the treatment of major health problems (Graff, Kaoukis, Vincent, Piotrowski, & Edigar, 2012). Additionally, there was strong agreement that anxiety and mood disorders should be included and prioritized within a government-funded psychotherapy program, followed by schizophrenia and other psychotic disorders (see Tables 3 and 4).

Anxiety and mood disorders are among the most highly prevalent mental health disorders in the Canadian population (Cohen & Peachey, 2014; Roberge, 2014). Prioritizing these disorders is in line with both the UK and Australian models of prioritizing high prevalence disorders. However, treatment of schizophrenia and other psychotic disorders was not initially prioritized in the current established government-funded models of psychotherapy. Prioritizing services is a difficult task for any healthcare program. Although prevalent disorders were rated most frequently to be included in a government-funded psychotherapy program, when asked how services should be prioritized, severity of the mental health problem was rated most strongly (47%) as the means to prioritize services. Prioritizing services based on prevalence of the mental health problem also received strong support (38%), but to a lesser degree. The endorsement of prioritizing services based on severity of illness from this sample may explain why schizophrenia and other psychotic disorders were ranked so highly.

Prioritizing services based on age groups did not receive much agreement (15%). When asked to prioritize age groups to receive services at the outset of government-funded program, adolescents (age 13-17) received the highest ranking, followed by young adults (18 to 30) and finally children (younger than 12) (see Table 4). There appears to be the belief among clinicians that early interventions are important. With approximately 70% of mental health problems

having their onset in childhood or adolescence (Government of Canada, 2006), targeting mental health problems at these ages may be the most beneficial course of action; however, within this sample the idea of prioritizing services based on age does not override the concepts of severity and prevalence of the mental health concern. In both the UK and Australian models, the services first targeted the adult population, with efforts to expand services to other age populations as the program unfolds (see Department of Health, 2008b). As seen in Table 3, pervasive developmental disorders, and attention deficit hyperactivity disorder (ADHD) and disruptive behavioural disorders were both ranked highly in terms of prioritizing mental health problems. The previous investigation into services offered in private practice in Quebec indicated that in the private sector children and adolescents were among the least served populations (along with the elderly), and disorders such as pervasive developmental disorders, ADHD and disruptive behavioural disorders, and schizophrenia and other psychotic disorders were not frequently treated. There appears to be an understanding of those populations being underserved in the private sector at least, which may be contributing to targeting these populations in the current study.

Type of Treatment

Individual therapy received the most favourable ratings as the psychotherapy modality to be offered in a government-funded psychotherapy program, followed by family therapy (Table 2). This is not surprising given that many previous studies have shown that individual therapy has historically been the most frequently offered psychotherapy modality (Bradley et al., 2016a; Hunsley et al., 2013; Ionita & Fitzpatrick, 2014; Norcross & Karpiak, 2012). Furthermore, DSM diagnoses as well as family problems were both given high ratings for prioritization by the current sample. When asked how many sessions should be funded per year by the government-

funded psychotherapy program, 20% indicated between 5 and 10 sessions, 26% between 11 and 16, 20% between 17-22, 24% believed more than 23 sessions should be covered, and 9% reported that the session number should be unlimited (not reported in the tables). This represents quite a range of opinion. Both the UK IAPT program and the Australian programs aim to offer short-term treatment between approximately 6 and 10 sessions, with additional sessions only for unique circumstances. Offering employment assistance/vocational counselling in conjunction with psychotherapy is a component of the UK's IAPT program; more than half of the sample agreed with including this component (see Table 2).

Clinician Choice and Discretion

Over the past 15 years there has been a shift in the field in the implementation of manual-based or evidence-based practices (see Chambless & Ollendick, 2001; Hunsley, Dobson, Johnston, & Mikail, 1999), as these have received praise for their association with positive outcomes for a variety of disorders (Chambless & Ollendick, 2001; Schulte, Kunzel, Pepping, & Schulte-Bahrenberg, 1992). Both the UK and Australian programs rely heavily on the use of evidence-based treatments, particularly the UK's IAPT program, as the only treatments offered are those that adhere to the NICE guidelines. In addressing the choice of treatment to be offered by the clinicians in our sample, and the written materials/literature to be used in treatment (e.g., psycho-educational handouts, self-help books), there was strong agreement that clinicians should choose any psychotherapy approach or materials they deemed appropriate, showcasing the belief in clinician autonomy (see Table 6). However, there was also strong support for the idea of choosing only treatments considered evidence-based by a neutral agency after a review of the scientific literature, with a majority being in favour of this. This is possibly a reflection of the clinician's positive attitudes towards evidence-based practices. Finally, there was less support

for the idea of offering *only pre-approved treatments*, or using treatment material/literature *approved* by the government program (see Table 6). The strongest disagreement appeared when respondents were asked about written materials/literature *mandated by* the government program; 69% of the participants were in opposition to this.

In both the UK and Australian government-funded psychotherapy programs, the GP/family physician plays an integral role, particularly in the Australian programs, as the family physician is not only the gatekeeper, but can also perform assessments and develop treatments plans, make decisions regarding treatment length, and with training can offer psychological treatment (Australian Government Department of Health, 2015a; 2015b). In addressing the role of family physicians referring clients for psychotherapy treatment, there was strong support for the treating psychologist/psychotherapist deciding the type (CBT, EFT) and length of psychotherapy treatment. As shown in Table 6, there was strong disagreement that these should be decided by the referring family physician. Similarly, there was strong agreement that a follow-up meeting after treatment termination should be conducted by the psychologist/psychotherapist, not the family physician. There were mixed attitudes about providing a progress report to the family physician mid-way through the treatment (see Table 6). There was less opposition to this idea as opposed to the previous ones, possibly indicating openness on the part of the clinicians for collaboration with family physicians, without losing their primary role in the treatment decision-making process. In terms of accessing government-funded psychotherapy services, formal requests for services from psychologists and psychiatrists were rated most frequently by the sample, followed by family physicians, social workers and self-referral (Table 6). When examining these results it becomes clear that these professionals

are in favour of using multiple points of referral for government-funded services, as opposed to limited referral avenues, as is done in Australia's ATAPS and Better Access programs.

Tracking Outcome, Satisfaction and Competency

There has been a recent shift in clinical practice towards the monitoring and tracking of treatment progress and outcome using standardized measures (e.g., Lambert & Shimokawa, 2011; Overington & Ionita, 2012), as tracking progress and monitoring treatment response has been shown to lead to better outcomes for non-responsive clients (Overington & Ionita, 2012; Shimokawa, Lambert, & Smart, 2010). The IAPT program aims to use outcome measures at every session. Within the current sample, slightly more than half were in favour of tracking treatment outcome using validated measures (see Table 7). It is encouraging to see some favourability towards these measures, yet somewhat surprising, as these are not often used in routine clinical practice (see Hatfield & Ogles, 2004; Hatfield & Ogles, 2007; Ionita & Fitzpatrick, 2014). As shown in Table 7, 83% of the sample '*agreed*' or '*strongly agreed'* with tracking client satisfaction with the psychotherapy services, showcasing the difference in the clinicians' comfort level with tracking satisfaction over treatment outcome. Approximately half of the sample was in favour of communicating both anonymous treatment outcome results, as well as satisfaction results, to the public. Similarly, when asked about assessing clinician treatment competency on a regular basis, there were mixed attitudes towards this, with approximately half of the sample in favour of this, but one third in opposition of it. This may be a reflection of clinician comfort level with external parties monitoring competency and effectiveness. However, there was support that regular supervision offered by the government program should be mandated for those offering government-funded psychotherapy, with two thirds of the sample being in favour of this (see Table 7).

The Professionals, the Work Environment, and Payment

As can be seen in Table 7, clinicians in this sample indicated support or agreement for government-funded services to be offered across diverse work settings (i.e., private practice, hospital setting). In terms of those who could offer government-funded services, the strongest agreement was with the idea of individual professionals being pre-approved and registered with the government program, as opposed to certain work settings being pre-approved and offering government-funded psychotherapy, as in the UK model (see Table 7). The idea of being paid on a session-to-session basis (i.e., fee for service), such as in the Australian models, was rated most favourably. Additionally, there was strong favourability towards clinicians determining their own fee, as opposed to the government determining a set hourly fee per psychotherapy session. Clinicians were also asked the minimum fee they would accept as a predetermined fee set by the government (not reported in the tables); $87 (*SD* = 15.21) was the average amount in Canadian dollars for one hour of psychotherapy service. This is low compared to the recommended rates across Canada from psychology licensing and regulatory boards for what one should expect to pay for an hour of psychotherapy treatment (see Bradley et al., 2016a). When clinicians could determine their own fee, the average amount in dollars was $100 (*SD* = 17.79); when asked how much the government should reimburse per psychotherapy hour, the average was $71 (*SD* = 19.94).

Being hired full or part-time by the government program and receiving a salary was not particularly appealing to the respondents, as there was quite a neutral or mixed response to this (see Table 7). This may be a reflection of the clinicians' desire for flexibility or autonomy.

Conclusion

It is clear from the results of the current study that psychologists and psychotherapists practicing in Quebec strongly believe that there is a need for increased access to psychotherapy services. Like the government-funded psychotherapy programs in place in the UK and Australia, clinicians in this study see a need for services for individuals with anxiety and depression, as well as schizophrenia, health-related problems, and family-related problems. Many of the components that were favourable to the clinicians in this sample mirror those of the Australian ATAPS and Better Access programs, such as being paid on a session-to-session basis, offering services from a variety of work settings (both public and private), partial reimbursement for services, support for the use of evidence-based practices while maintaining clinician choice in deciding treatment approach and materials. However, the central role of the family physician as a gatekeeper and overseer of psychotherapy treatment in the Australian programs was not rated favourably in this study. Like the UK's IAPT program, clinicians in the current study were in favour of having multiple sources of referral, regular supervision, as well as including employment assistance with psychotherapy treatment. Additionally, there was some openness to the concept of psychotherapy treatment progress and outcome tracking.

In structuring government funded-psychotherapy programs at the provincial level in Quebec, it is integral to inform these programs with information provided by the clinicians themselves, so as to enhance clinician buy-in.

Limitations and Future Directions

There are a number of limitations to consider in this study. Firstly, a response rate of 26% is somewhat modest. While the current sample size of psychologists is considered generalizable in terms of the target population, a slightly larger sample size of psychotherapists (234 compared

to the current 198) would have been an ideal sample size to represent the target psychotherapist population (Direction Research, 2011). The sample appears generally representative in terms of demographic characteristics such as level of education, as the doctoral degree only became the required level of education in the last ten years, gender and theoretical orientation (Jaimes, La Rose-Herbert, & Moreau, 2015; Ordre des Psychologues du Québec, 2015). While it is a methodological strength of the recruitment process that all licensed psychologists and psychotherapists with a functioning email address available to the OPQ were sent the invitation to participate in the study it is not possible to document the differences between those who responded to the survey invitation and those who did not. There is the potential for response bias.

Documentation of the perspectives of clinicians practicing in other Canadian provinces is still needed to inform accessibility initiatives and potential government-funded services in other provinces. As Quebec has a unique political and cultural climate, as well as unique psychology practice characteristics (the largest psychologist work force in Canada, the recent change to doctoral level licensure, and slightly higher representation of psychodynamic practitioners compared to other Canadian samples, see Hunsley et al., 2013; Ionita & Fitzpatrick, 2014) the current results may not generalize to the perspectives of psychology clinicians in other provinces. As there are often differences found among psychology clinicians based on demographic and clinical characteristics such as years of experience, work setting and level of education (e.g., Hunsley et al., 2013, Ionita & Fitzpatrick, 2014) it is important to compare the perspectives of clinicians based on such characteristics. This will allow for a unique glimpse into differences among subgroups of clinicians, and potentially serve to generalize to similar subgroups groups in other provinces (e.g., those with a doctoral degree, or those in private practice).

Finally, family physicians in Canada currently have a large role in mental health treatment and are a main source of service contact for many Canadians. Furthermore, in other government-funded models of psychotherapy, family physicians are given a predominant role in clinical decision-making and psychotherapy service access. It would be of value to investigate the perspectives of family physicians in the Quebec context, as well as the larger Canadian context, to have a better understanding of their perspectives so as to tailor their role in a government-funded model of psychotherapy treatment appropriately.

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Table 1. *Demographic Characteristics: Work Setting and Theoretical Orientation*

Theoretical Orientation	**Cognitive-Behavioural**	**Psychoanalytic/ Psychodynamic**	**Humanistic/ Existential**	**Integrative/ Eclectic**	**Systems/Family Systems**	**Other**
Primary Orientation	35%	25%	20%	14%	6%	1%
Secondary Orientation	21%	11%	16%	17%	13%	3%
Primary Work Setting		**Secondary Work Setting**				
Independent Private Practice	37%	18%				
Group Private Practice	12%	8%				
Medical Clinic	2%	3%				
*CIUSSS/CISSS**	18%	1%				
School	6%	1%				
General Hospital	4%	0%				
Psychiatric Hospital	6%	1%				
Outpatient Clinic	0%	1%				
University Counselling Centre	2%	0%				
University Psychology Department	3%	2%				
Other	11%	0%				

Note: * CIUSSS: Integrated University Health and Social Services Centres; CISSS: Integrated Health and Social Services Centres

Table 2. *Survey Items Concerning Government-Funded Psychotherapy Services*

Survey Item	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Access to psychotherapy services should be increased in Quebec*	4.8%	.3%	1.4%	16.2%	77.2%
Psychotherapy services should be partially funded by the government*	0%	0%	3.2%	48.2%	48.7%
Psychotherapy services should be fully funded by the government	6.4%	16.7%	20.9%	34.1%	21.9%
Access to psychotherapy services should be increased by:					
Creating new positions for clinicians in the public sector*	0%	3.4%	5.5%	40.5%	50.6%
Funding services offered in the private sector with government funds	3.6%	6.5%	6.6%	36.4%	47%
The following services should be covered in a new government-funded psychotherapy system:					
Couple Therapy	4.9%	10.7%	24%	31.5%	29%
Group Therapy*	0%	7.2%	23.7%	37.7%	31.4%
Family Therapy*	0%	0%	11.1%	43.7%	45.2 %
Individual Therapy	0%	0%	2.6%	26.3%	71.1%
In a new government funded psychotherapy system:					
A client must meet the criteria for a diagnosable mental health disorder (DSM, ICD) in order to receive psychotherapy services	13.4%	24.7%	10%	30%	21.9%
A mandatory face-to-face psychological assessment must be completed prior to offering any psychotherapy treatment	0%	8.3%	8.2%	31.8%	51.7%
A mandatory follow-up session must be completed following treatment	5%	14%	27.2%	31.1%	22.7%
Client preferences should be considered in choosing a psychotherapy treatment modality	0%	6.9%	11.2%	41.3%	40.6%
The following services should be offered concurrently with psychotherapy in a new government- funded psychotherapy program:					
Debt Counselling	7.3%	13.6%	33.9%	31.9%	13.3%
Employment Assistance and/or Vocational Counselling	4.8%	9.2%	24.3%	43.4%	18.3%

Note. * Variables with imputed missing data.

Table 3. *Survey Items Concerning Mental Health Problems and Mental Health Diagnoses*

Within a new government-funded psychotherapy system, treatment for which of the following mental health problems should be paid for through government funding? (Please select as many as you see fit)	
Couple/Marital difficulties	53.3%
Disorders found in the DSM, ICD, or another established classification of mental disorders	92.4%
Family Difficulties	72%
Interpersonal difficulties	56.7%
Personal problems (e.g., existential problems)	47%
Professional difficulties	57.1%
Psychological functioning related to problems in health, injury, or illness	86.9%
Within a new government-funded psychotherapy system, treatment for which of the following mental health disorders should be paid for through government funding? (Please select as many as you see fit)	
Anxiety Disorders	91.3%
ADHD and Disruptive Behavioural Disorders	77.8%
Eating Disorders	75.2%
Mood Disorders	90.2%
Personality Disorders	78.8%
Pervasive Developmental Disorders	78.8%
Schizophrenia and other Psychotic Disorders	82.8%
Sexual Disorders	54.6%
Sleep Disorders	65.5%
Somatoform Disorders	63.9%
Substance Abuse	73.5%

Table 4. *Survey Items Concerning the Prioritization of Psychotherapy Services*

If government-funded psychotherapy had to be implemented in phases or steps over a period of time (months or years), in what order would you prioritize treatment for the following mental health problems? (Rank top three only)	**1**	**2**	**3**	**Total**
Couple/Marital difficulties	1.4%	5.3%	6.2%	12.9%
Disorders found in the DSM, ICD, or another established classification of mental disorders	65.3%	12.1%	7.2%	84.5%
Family Difficulties	7.2%	18.7%	25.1%	51%
Interpersonal difficulties	2.4%	7.5%	12.2%	22%
Personal problems (e.g., existential problems)	3.9%	7.7%	7.7%	19.4%
Professional difficulties	2.3%	8.2%	16.9%	27.4%
Psychological functioning related to problems in health, injury, or illness	13.4%	37.6%	18.5%	69.6%

If government-funded psychotherapy had to be implemented in phases or steps over a period of time (months or years), in what order would you prioritize treatment for the following mental health disorders? (Rank top 5 only)	**1**	**2**	**3**	**4**	**5**	**Total**
Anxiety Disorders	19.1%	27.8%	14%	11.1%	7.9%	79.8%
ADHD and Disruptive Behavioural Disorders	3.6%	6.4%	11.4%	8.7%	10.7%	40.8%
Eating Disorders	0%	2.5%	5.6%	8.6%	9.2%	26%
Mood Disorders	26.3%	24.7%	15%	10.2%	6.2%	82.3%
Personality Disorders	6.9%	8.7%	15.9%	11.3%	10.2%	53%
Pervasive Developmental Disorders	7.8%	10.6%	8.2%	7.5%	9.1%	43.2%

Schizophrenia and other Psychotic Disorders	28.7%	8.7%	7.3%	7.4%	6.2%	58.2%
Sexual Disorders	.1%	.4%	0%	.7%	2.8%	3.9%
Sleep Disorders	0%	0%	6.1%	6.1%	6.3%	18.4%
Somatoform Disorders	.3%	0%	3.1%	3.6%	4.9%	11.8%
Substance Abuse	5.3%	8%	12.5%	10%	9.9%	45.7%
If government-funded psychotherapy had to be implemented in phases or steps over a period of time (months or years), in what order would you prioritize treatment for the following age groups? (Rank top 3 only)	**1**	**2**	**3**	**Total**		
Children (12 and under)	60%	6.4%	7.5%	73.9%		
Adolescents (13 to 17)	9.8%	58.4%	17.4%	85.6%		
Young Adults (18 to 30)	15.8%	18.6%	43.3%	77.8%		
Adults (31 to 64)	13.3%	13.3%	18.5%	45.1%		
Older Adults (66+)	1.1%	3.1%	12.9%	17.2%		
If the government is allocating funding for psychotherapy services, prioritization should be given by (select one):						
Age group	14.8%					
Severity of mental health problem	46.8%					
Prevalence of mental health problem	38.4%					

Table 5. *The Role of Professionals*

To gain access to government-funded psychotherapy services, a formal request for services could come from:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
Client's Employer*	14.7%	27.6%	24.3%	22%	11.4%
Client (self-referral) and/or client's family	0%	7.2%	7.8%	33.2%	51.8%
Community Organization (e.g., Ami-Quebec)*	0%	8.4%	21.8%	42.2%	27.6%
Family Physician	0%	0%	3.5%	32%	64.5%
Guidance Counsellor (school setting)*	0%	5.1%	12.1%	46.9%	36%
Paediatrician	1.7%	0%	3.1%	33%	62.3%
Psychiatrist	1.3%	1%	2%	26%	69.6%
Psychologist	1.1%	0%	2.1%	27.8%	69%
Social Worker	0%	0%	5.3%	35.6%	59.1%
If a family physician referred a client to a psychologist/psychotherapist for psychotherapy:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
The psychologist/psychotherapist should be responsible for deciding the type of psychotherapy treatment (i.e., CBT, Humanistic)	.5%	0%	0%	20.8%	78.7%
The family physician should be responsible for deciding the type of psychotherapy treatment (i.e., CBT, Humanistic)	59.4%	33.2%	4.8%	2.2%	.4%
The psychologist/psychotherapist should be responsible for deciding the length of treatment	0%	0%	3.4%	34.9%	61.7%
The family physician should be responsible for deciding the length of treatment	62.2%	32.8%	4.6%	0%	.4%
The family physician should receive a progress report from the psychologist/ psychotherapist mid-way through treatment	13.6%	16.4%	21.1%	37.6%	11.3%
The psychologist/psychotherapist should be responsible for conducting a follow-up meeting with the client after treatment termination	0%	5%	16.2%	38.1%	40.7%
The family physician should be responsible for conducting a follow-up meeting with the client after treatment termination	22%	24.9%	27.2%	19.5%	6.5%

Table 6. *Clinician Treatment Choice*

In a new government funded psychotherapy system the psychologist/psychotherapist offering a psychotherapy should be allowed to choose and to offer:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
Any psychotherapy approach (e.g., emotion-focused therapy, interpersonal psychotherapy) he/she deems appropriate	0%	10.2%	8.9%	34.1%	46.9%
Any psychotherapy approach considered to be evidence-based by a neutral agency after a review of the scientific evidence	6.4%	13.8%	15.4%	29.2%	35%
Any psychotherapy approach pre-approved by the government program	12.1%	17.9%	15.8%	30.5%	23.7%
When written material (e.g., psycho-educational handout) is given to clients, the psychologist/psychotherapist offering a treatment within the new government-funded psychotherapy program should:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
Be able to choose any treatment materials/ literature he/she deems appropriate	0%	5.5%	6.6%	35.3%	52.6%
Use treatment materials/ literature only if they have been approved by the program	22.5%	39.5%	17.4%	14.3%	6.3%
Use treatment materials/literature that are mandated by the program (e.g., specific self-help books)*	30.5%	38.4%	19.4%	11.7%	0%

Note. * Variables with imputed missing data.

Table 7. *The Structure of the Workforce*

Clinicians offering government-funded psychotherapy services should:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
Be hired full-time by the program, and receive a yearly salary*	18.1%	24.4%	26.2%	17.9%	13.3%
Be hired part-time by the program, and receive a yearly salary*	17.3%	23.4%	29.1%	20.5%	9.7%
Receive payment from the program on a session-to-session basis (i.e., fee for service)	0%	5.3%	8.2%	31%	55.6%
In a new government-funded psychotherapy system, psychotherapy services should be offered by a clinician who:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
Works in independent private practice (a solo clinician)	0%	4.6%	13.3%	37.3%	44.8%
Works in a private psychotherapy clinic (group practice)	0%	2.4%	11.8%	38.1%	47.8%
Works within a government-owned and operated facility (e.g., hospital, CSSS/CLSC, etc.)	0%	3.4%	10%	33.6%	53%
Works in a medical clinic	0%	2.3%	14.3%	38.3%	45.1%
Has been chosen by a client for psychotherapy, regardless of their work setting	0%	6.8%	9.6%	27.8%	55.8%
Clinicians offering government-funded psychotherapy services should:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
Charge a session fee predetermined by the government program (e.g., government reimburses the clinician a set fee per hour)	11.1%	19.4%	16.6%	30.4%	22.5%
Determine their own fee, a portion of which would be covered by the government	5.6%	12.5%	11%	30.6%	40.2%
In a new government-funded psychotherapy system:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
The individual psychologist/ psychotherapist should be pre-approved and registered with the government program in order to offer psychotherapy	8%	11.7%	11.9%	29.3%	39.2%
The site/work-setting should be pre-approved and registered with the government program in order to offer psychotherapy	9.5%	14.2%	15.8%	27.7%	32.8%
Any licensed psychologist/ psychotherapist could offer psychotherapy	5.3%	16.3%	15.3%	21.5%	41.7%

Regular psychotherapy supervision offered through the program should be mandated for all those offering government-funded psychotherapy	5.7%	11.9%	15.2%	35.7%	31.6%
Clinicians offering government-funded psychotherapy services should be assessed for treatment competency on a regular basis	11.5%	19.8%	22.4%	29.8%	16.5%
In a new government-funded psychotherapy system:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
Treatment outcome should be assessed using validated measures	6.1%	18.7%	22.2%	38.4%	14.7%
Validated measures that focus on symptoms (e.g., GAD, BDI) should be used to track outcome	8.2%	21%	26.8%	34.5%	9.6%
Validated measures that focus on global functioning should be used to track outcome	6%	13.8%	23.5%	42%	14.6%
Non-identifiable outcome data (e.g., treatment success or failure) should be published and made available to the public	14.8%	20.7%	26.1%	26.1%	12.3%
Client satisfaction with the psychotherapy services offered should be formally assessed	0%	5.1%	11.9%	49.2%	33.8%
Client satisfaction ratings should be published and made available to the public	11.2%	15%	21.9%	32.4%	19.6%

Note. *Variables with imputed missing data.

Transition from Chapter 4 to Chapter 5

Chapter 4 presented a survey study focusing on the attitudes of psychologists and psychotherapists in Quebec concerning components of government-funded models of psychotherapy that are currently established in other countries. This study outlined those components that were perceived as favourable to the psychotherapy practitioners in Quebec, as well as the components that received less favourable ratings. This information is vital for informing psychotherapy accessibility initiatives in the future.

We now transition to the final manuscript found in Chapter 5. This final study investigates the differences in attitudes concerning a government-funded model of psychotherapy among practitioners of different years of experience, level of education, and work setting (private versus public practice). Again, as the psychotherapy workforce is made up of practitioners of varying characteristics, it is important to gain a specific understanding of the attitudes of subgroups of practitioners in order to better inform psychotherapy initiatives in the future. The implications of the differences found among practitioners of different levels of education, years of experience and work setting are discussed in terms of structuring a government-funded model of psychotherapy and how to best tailor these initiatives based on these differences.

CHAPTER 5: Increasing Access to Psychotherapy through Government-funding: Differences in Attitudes of Psychology Practitioners based on Level of Education, Years of Experience and Work Setting

Bradley, S., & Drapeau, M. (2016). *Increasing access to psychotherapy through government funding: Differences in attitudes of psychology practitioners based on level of education, years of experience and work setting.* Manuscript submitted for publication.

Abstract

Initiatives in the broader Canadian context (see Peachey et al., 2013), as well as specifically in Quebec (see Drapeau, 2014) have recently been focused on increasing access to psychotherapy treatments. Internationally, both the United Kingdom (UK) and Australian health care systems have sought to increase access to these services through government funding (Clark et al., 2009; Pirkis et al., 2011). The aim of the present study was to investigate the differences in attitudes of psychology practitioners (psychologists and psychotherapists) licensed to practice in Quebec toward accessibility to psychotherapy, and government-funded psychotherapy programs based on their level of education, years of experience and work setting (public versus private). Participants (N = 1462) completed an online survey focused on components of government-funded psychotherapy models currently in place, and the differences in their responses were analyzed. Results indicated that there was stronger agreement from those in private practice, those with more years of experience, and those with a doctoral degree, that clinicians working within a government-funded psychotherapy program should be paid on a session-to-session basis as opposed to receiving a yearly salary and should be able to set their own psychotherapy fee. These groups of clinicians also reported a higher acceptable fees compared to those working in the public sector, those in their early years of practice and those with a master's degree. Those with less years of experience, those at the doctoral level and those in the public sector indicated more favourable attitudes towards the use of validated measures to track treatment outcome. Other results concerning the structure of a government-funded psychotherapy program, and the services to be covered are discussed, as well as the implications for increasing access to psychotherapy services in the Quebec context.

Key words: psychotherapy; accessibility; psychotherapist; psychologist; survey; public; private; education; years of practice

Increasing Access to Psychotherapy through Government-funding: Differences in Attitudes of Psychology Practitioners based on Level of Education, Years of Experience and Work Setting

The call for increased accessibility to mental health care services has never been louder in the Canadian context. Recently organizations such as the Canadian Psychological Association (CPA) (Peachey et al., 2013), the Mood Disorders Society of Canada (2015), and the newly developed Coalition for Access to Psychotherapy (CAP) in Quebec (see http://capqc.ca) have worked to shed light on the dire situation many Canadians face in seeking appropriate mental health care treatment. A special issue of *Canadian Psychology* highlights recent research, initiatives and discussions focused on increasing access to appropriate mental health care in Canada (see Bradley & Drapeau, 2014; Cavaliere, 2014; Cohen & Peachey, 2014; Drapeau, 2014). Additionally, the CPA's report on mental health care accessibility, "An Imperative for Change: Access to Psychological Services for Canada" provides an extensive discussion of the lack of accessibility in the Canadian health care system, and proposes possible actions to be taken to enhance effective accessible treatments (see Peachey et al., 2013).

Untreated mental health problems result in devastating social and economic costs, such as higher rates of unemployment (Centre for Addictions and Mental Health, 2012; Dewa & McDaid, 2010), higher rates of homelessness among those with severe mental illness (Canadian Institute for Health Information, 2007) and being one of the primary causes of disability in Canada (Centre for Addictions and Mental Health, 2012). The Mood Disorders Society of Canada's (2015) recent Mental Health Care System study outlines that in terms of improving our mental health care system, the primary critical area of focus is access to mental health care professionals. More than two thirds (68%) of Canadians in this study reported facing cost barriers in terms of treatment; and for those with private insurance (57%) over half of these

individuals reported that their current private insurance is inadequate for their mental health care needs. What is most striking about the information gathered through this study was the overall perception of the lack of prioritization, respect and empathy, and the generally unfair treatment of those with mental health problems in Canada (see Mood Disorders Society of Canada, 2015).

Initiatives to increase access to mental health care have been put in place internationally through government-funded psychotherapy programs. The UK's Improving Access to Psychological Therapies (IAPT) is based on a stepped-care system in which individuals with mild to moderate mental health problems, such as anxiety and mood disorders, receive evidence-based low intensity treatments (e.g., guided self-help, computerized CBT) as outlined in the National Institute for Health and Care Excellence (NICE) guidelines (see Clark, 2011; Department of Health, 2008c; INESSS, 2015). Those not responding to the low intensity treatments and those with chronic and/or severe mental health problems receive high intensity treatments, such as individual psychotherapy with a clinical psychologist (e.g., CBT, interpersonal therapy, couples therapy) (see Department of Health, 2008d). This program includes tracking treatment progress by using outcome measures at every session (see Clark, 2011; INESSS, 2015). With a focus on the adult working population, services such as debt counselling and employment counselling, are also included (Clark, 2011). Although not a focus at the outset of the program, since 2011 plans were put in place to initiate services for children, youth and the elderly, and to develop models of care for those with severe mental illness as well as chronic health problems (see Department of Health, 2008e; INESSS, 2015; Thornicroft, 2011). Estimations of recovery rates for those completing treatment through the IAPT program are approximately 45%; in terms of economic gain, in the first three years of the program 45,000 treated individuals are no longer on sick pay and/or benefits (Department of Health, 2008e).

In Australia two government-funded programs to increase access to psychotherapy treatments function in parallel, the Better Outcomes in Mental Health Care (BOiMHC) program (see Australian Government Department of Health, 2015a; Hickie & Groom, 2002) and the Better Access initiative (Australian Government Department of Health, 2015b; Pirkis et al., 2011). Under the Better Outcomes program there is the Access to Allied Psychological Services (ATAPS), which enables family physicians to refer individuals to receive evidence-based focused psychological strategies conducted by allied mental health professionals. The focus of this program is on high prevalence disorders such as anxiety and depression. An individual can receive up to 12-individual therapy sessions per calendar year; however, the family physician evaluates after 6 sessions to decide if further treatment is warranted, and in special circumstances there is the potential for up to 18 sessions per calendar year (Hickie & Groom, 2002; Australian Government Department of Health, 2015a; Fletcher et al., 2012; Pirkis et al., 2006a, 2006b). Twelve sessions of group therapy per year are also included. The Better Outcomes program also allows for family physicians to receive additional training in mental health assessment and diagnosis, mental health treatment planning, and specific training in conducting focused psychological strategies. Furthermore, family physicians are provided with access to psychiatrists for mental health treatment consultation within a 24-hour period (Australian Government Department of Health, 2015a; Pirkis et al., 2006a, 2006b)

The Better Access initiative functions alongside the Better Outcomes program and allows for medical rebates for mental health treatment through the Medicare Benefits Schedule (Australian Government Department of Health, 2015b). To be able to receive treatment through the Better Access initiative (up to 10 individual sessions or 10 group sessions per year), a referral must come from a family physician, psychiatrist or paediatrician. Additionally, the referrer must

conduct a mental health assessment and complete a Mental Health Treatment Plan outlining the appropriate psychological treatment (Australian Government Department of Health, 2015b). An individual cannot be referred through both programs concurrently, but can receive treatment from both the Better Outcomes program and the Better Access initiative as long as they are within the limits of sessions available per year.

The Local Context

Specifically in the Quebec context, the Quebec Health and Welfare Commissioner's report, *For More Equity and Results in Mental Health*, called for a solution to the inequality in accessing psychological services in Quebec (Commissaire à la santé et au bien-être du Québec, 2012), with suggestions to include psychotherapy treatment in the public health insurance program. The Institut National d'Excellence en Santé et en Services Sociaux (INESSS; 2015) issued a report on equitable access to psychotherapy services. In this report there was recognition of the efficacy and cost-effectiveness of psychotherapy treatment, and an acknowledgement that access to competent professionals delivering evidence-based psychotherapy treatments is limited. These treatments are often sought privately, and only accessible to those able to pay out-of-pocket, or those with private insurance (INESSS, 2015). Finally, as Cavaliere (2014) outlines, the Coalition for Access to Psychotherapy (CAP) is made up of a group of individuals across diverse social and health services, as well as academic researchers, all dedicated to initiatives to increase access to psychotherapy in Quebec. CAP is currently working to investigate ways of integrating psychotherapy services into the public health care system, exploring appropriate care structures and financial models, and working to increase awareness in the importance of accessible psychotherapy treatment (Cavaliere, 2014). Results of our previous investigation of the perceived favourable components of a government-

funded model in Quebec from the perspective of psychologists and psychotherapists, as well as the results of the present study exploring differences among licensed practitioners in terms of their attitudes concerning government-funded psychotherapy, are in support of the CAP's initiatives.

As has been seen in previous studies surveying psychological practitioners (e.g., Aarons, 2004; Addis & Krasnow, 2000; Bradley, Service, Roberge, Vasiliadis & Drapeau, 2016b; Hunsley et al., 2013; Ionita & Fitzpatrick, 2014; Wallace & von Ranson; 2011), differences are often found in terms of the attitudes and practice characteristics of those offering psychotherapy treatment based on practitioner demographics and clinical characteristics (e.g., use of manualized treatments, knowledge of outcome tracking measures, work activities, and populations treated). Our previous investigation of differences in private practice among those of differing levels of education, years of experience and theoretical orientation highlighted important trends in practice such as differences in psychotherapy fees, age populations treated, as well as use of validated clinical tools (see Bradley et al., 2016b).

Given that licensed psychological practitioners in Quebec present diverse characteristics (e.g., work setting, training background, years of experience), and that often differences are found based on these characteristics, it is our aim in the present study to investigate possible differences found among these practitioners in Quebec concerning attitudes towards a government-funded model of psychotherapy. For the scope of the current investigation, we will be focusing on differences based on level of education, years of experience, as well as work setting (public versus private).

Method

Survey

A thorough literature search was performed to identify seminal documents related to the development and implementation of government funded mental health care programs in other countries (e.g., UK and Australia) prior to developing the survey themes and items. A team of three members of the *McGill Psychotherapy Process Research Group* (www.mpprg.mcgill.ca) independently identified, then came to consensus, on the core principles and practical components of these government-funded programs. These components were used in developing the survey items. For a detailed description of the survey development process please see Bradley and Drapeau (2014) found in Chapter 4. The survey consisted of various items related to the structure of government funded psychotherapy, (e.g., how to prioritize services, the mental health problems to be included and prioritized, the age groups to be prioritized, the modalities of treatment), and the number of sessions to be funded per year. Another section included items pertaining to clinician choice or discretion in terms of psychotherapy treatment approach and materials, tracking professional competencies, treatment outcome and client satisfaction with the services, as well as the role of the family physician in making treatment decisions. A final section included questions concerning the work setting (public *vs*. private), the workforce of professionals offering services, and psychotherapy service fees and payment. Most survey items asked participants to rate their agreement on a 5-point Likert scale, 1 being '*strongly disagree*' and 5 being '*strongly agree*', or to rank their preferences in descending order. A section focusing on demographic items was included at the end of the survey.

Participants

The participants in this study were psychologists and psychotherapists licensed to practice psychotherapy with the *Ordre des Psychologues du Québec* (OPQ) in current active psychotherapy practice in either the public or private sector. An e-mail request was sent to all members licensed to practice psychotherapy. The recruitment email asking for participation in the anonymous survey was sent in November 2013 to 4542 psychologists and 512 psychotherapists whom were French-speaking, and 559 psychologists and 88 psychotherapists whom were English-speaking. The sample consists of 1462 participants who completed the survey, representing a 26% return rate. All demographic information can be found in Table 1.

Data Analysis

The dataset was screened for errors and outliers were removed prior to data analysis (Tabachnick & Fidell, 2007). The majority of the survey items were within the acceptable range of missing data (less than 5%), however missing data in access of 5% were imputed through expectation maximization methods (Graham, 2009; Tabachnick & Fidell, 2007). Specific survey items of interest were compared across years of experience (10 or fewer years of practice, 11-20 years, and finally 20 or more years), between those with a master's degree and those with a doctoral degree (both PhD and PsyD), and finally across work setting (public *vs.* private). Mann-Whitney *U* tests and Kruskal-Wallis tests were used in analyzing ordinal variables, as well as continuous variables when the assumption of normality was violated. A Bonferroni correction was applied to control for Type 1 errors in the cases of multiple comparisons (Tabachnick & Fidell, 2007).

Results and Discussion

As there are many variables of interest, only those comparisons resulting in significant

differences across the groups of interest (i.e., education, years of experience and work setting) are reported in Tables 2 - 4.

Education

The Structure of the Workforce

As indicated in Table 2, master's level practitioners more strongly believed that *any* licensed psychologist or psychotherapist should be able to offer services in a new government-funded model of psychotherapy, as opposed to having to be *specifically registered to do so*. Master's level practitioners also had more favourable attitudes towards a referring family physician being responsible for deciding the type and length of psychotherapy treatment to be offered by the treating psychologist or psychotherapist, compared to those at the doctoral level. In line with this, those at the doctoral level were more strongly in favour of the treating psychologist or psychotherapist deciding the type of treatment. This shows a greater sense of autonomy, or perhaps confidence, in clinical decision-making on the part of those with a doctoral degree, who have more training than master level practitioners. Furthermore, in Murdoch, Gregory and Eggleton's (2015) examination of the hours of mental health training received by different mental health professionals, including physicians, it is clear that doctoral level psychologists have far and above the most knowledge and hands-on mental health training. Most medical programs require less than 300 hours of hands-on clinical mental health training, master's level psychology programs require on average between 1000 – 1500 training hours, whereas most doctoral training programs require on average between 1900 and 2600 hours. Given the years of specialized training in psychotherapy treatment planning and intervention, and particularly the hours devoted to hands-on clinical training, it is not surprising that psychologists, particularly those at the doctoral level, believe they are best suited for making

these treatment decisions.

Services Offered

Those with a doctoral degree more strongly believed in including both individual and group psychotherapy in a government-funded model compared to those at the master's level (see Table 2). As doctoral students complete considerably more clinical training than master's level clinicians, this may allow for increased exposure to diverse therapy modalities. Therefore these professionals may be more familiar with group modalities and the research supporting these. Many accredited pre-doctoral internship sites stress the importance of exposure to both individual and group formats for their trainees as a means of ensuring breadth of clinical skills (e.g., Centre for Addictions and Mental Health, 2015). Group interventions should be seriously considered as a viable means for providing treatment services, as they are often as effective as individual interventions (e.g., Anderson & Rees, 2007; Wergeland et al., 2014), and can be an economical use of resources for many disorders and levels of severity, as more individuals can receive services per hour per practitioner at a lower cost per patient.

In terms of prioritizing services based on populations in a new government-funded psychotherapy program, those with a master's degree more strongly prioritized children compared to those with a doctoral degree, whereas those with a doctoral degree more strongly prioritized the adult population. This is an interesting finding; as seen in the previous similar sample of Quebec psychologists and psychotherapists in private practice (see Bradley at al., 2016b), those at the doctoral level reported treating children more frequently than those at the master's level, and those with a master's degree reported treating adults more frequently. It would appear that professionals are not prioritizing those populations that they serve more frequently, but rather those populations that they see less frequently. While these two samples

are not the same, they are both generally representative of practitioners in Quebec. Perhaps, these practitioners believe the populations that they themselves see less frequently do not have as much access to services and therefore should be prioritized.

When investigating what should be included in the psychotherapy program, those with a master's degree compared to those with a doctoral degree more strongly believed in offering debt counselling to individuals along with psychotherapy. This, along with employment counselling, is part of the UK's IAPT program (Clark, 2011). As had been seen from the results of the private practice survey (see Bradley et al., 2016b), those at the master's level reported treating adjustment to life stressors, and work/vocational difficulties more frequently than those at the doctoral level, while those at the doctoral level reported treating DSM diagnosable disorders more frequently. This could potentially explain why those with a master's degree were more strongly in favour of including such services as debt counselling, as financial or work-related stress may been seen more frequently in the clients presenting to this group. As doctoral clinicians treat diagnosable disorders more frequently, life stressors such as financial concerns may not be as singularly a focus in the treatment, and therefore may be less prioritized.

Those with a doctoral degree reported a higher number of yearly sessions to be covered compared to those with a master's degree, and also more strongly believed that a face-to-face assessment be conducted prior to offering psychotherapy treatment. This is perhaps an indication of the training emphasis, or confidence, in conducting assessments and diagnosis at the doctoral level.

Evidence-Based Practice (EBP) and Treatment Accountability

In terms of tracking treatment progress and outcome using validated measures, those at the doctoral level were more in favour of this than those at the master's level (see Table 2). Others

have noted that those trained at the doctoral level had greater awareness of progress-monitoring measures (Ionita & Fitzpatrick, 2014) and had more favourable attitudes towards evidence-based practices (Aarons, 2004). The influence of greater exposure or awareness at the doctoral level may explain the increased favourability among these practitioners in the current study. In addition to tracking individual patient outcome, participants were asked about publishing non-identifiable (protection of patient privacy) treatment outcomes (aggregated data on treatment progress) to the public. Those with a doctoral degree were more in favour of this than those with a master's degree. Again, this may be hinting at a sense of confidence in practice, a stronger belief in evidence based practice or perhaps an ingrained sense of treatment accountability in terms of tracking outcomes and making these data available. As tracking progress in therapy is an ingrained part of evidence-based practice (EBP) according to the CPA definition (see Dozois et al., 2014), and as the evidence builds for routine client feedback leading to improved outcomes (e.g., Lambert & Shimokawa, 2011; Reese, Toland, Slone, & Norsworthy, 2010), it makes sense to build this into a government-funded program. Further to this is the idea of accountability to the public; if this program is to be funded through public funding, it makes sense that it be transparent at the program level in terms of evaluating the efficiency and effectiveness of the program.

Hiring and Payment

Finally, as outlined in Table 2, when comparing attitudes towards payment for government-funded services, those with a master's degree were more favourable towards the idea of charging a predetermined psychotherapy fee set by the government than those with a doctoral degree. As was seen in our investigation of private practice, those at the master's level reported receiving significantly more referrals from EAPs (see Bradley et al., 2016b). We

hypothesize that this is due in part to EAPs seeking out practitioners willing to accept a predetermined fee. Furthermore, those with a doctoral degree reported significantly higher psychotherapy fees, both if predetermined within a future government-funded program, as well as if independently determined by the clinician. This is in line with the significantly higher fees reported by those with a doctoral degree in private practice compared to those at the master's level (Bradley et al., 2016b). Therefore, these practitioners are essentially demanding to be paid comparably to what they are paid now. By investigating the current state of practice (Bradley et al., 2016a; Bradley et al., 2016b) as well as the professionals' expectations if psychotherapy were to be covered by a universal insurance (Bradley & Drapeau, 2014), we were able to determine that their expectations are congruent with their current working conditions; put differently, the respondents did not use the survey on government-funded psychotherapy as an opportunity to propose an increase in their fees.

Work Setting: Public *vs.* Private

Interesting results came from comparing practitioners predominantly working in private practice and those in the public sector, particularly in terms of autonomy or flexibility on the part of those in private practice and a sense of accepting conditions or restrictions in those in the public sector. These results can be found in Table 3.

The Structure of the Workforce

Those in the public sector compared to those in private practice were more strongly in favour of full financial coverage of psychotherapy fees by the government, and rated increasing the number of positions in the public sector in a new government-funded psychotherapy program more favourably than those in private practice. Not surprisingly, those currently in private practice rated reimbursing private psychotherapy services through government funding more

favourably than those in the public sector. Rating one's own sector favourably was also shown in asking the types of work settings that government-funded services could be offered in. Those currently in the public sector rated a public setting more favourably, and those currently in private practice rated a private setting (independent or group practice) more favourably. Another concept that was investigated was the idea of a work setting being pre-approved and registered with the government-program to offer covered services, or an individual practitioner being preapproved and registered with the government-program to offer funded services. Those currently in the public setting were more in favour of both of these registration concepts compared to those in private practice, indicating a greater sense of discomfort with restrictions or regulations on the part of those in private practice. In line with this, those in private practice compared to those in the public setting were more strongly in favour of any licensed psychologist or psychotherapist being able to offer government-funded services without any other type of registration within the program. Furthermore, those in private practice were more strongly in favour of the client having autonomy in choosing any psychologist or psychotherapist regardless of work setting to receive government-funded treatment. In a sense this prioritizes client choice and autonomy, rather than fitting the client into a pre-determined setting or structure.

It would be advantageous to have multiple points of access, both publicly and privately. The UK's IAPT program allows for multiple referral sources, and the Australian programs allow for multiple access points. With all of the challenges faced in terms of access to mental health care for Canadians, we need to build up access points both publicly and privately, and allow for referral from multiple sources, particularly self-referral.

Lastly, the participants were asked about the role of a referring family physician, and as

can be seen in Chapter 4, the current sample is generally strongly in favour of the treating psychologist or psychotherapist having the responsibility in terms of treatment decisions (e.g., psychotherapy approach, length of treatment). However, our further investigation shows that those in the public sector had more favourable attitudes than those in private practice for sending the referring family physician a mid-treatment progress report. This is potentially a reflection of the culture of collaborative practice or documentation in the public system. However, those in the public system compared to those in private practice were also more favourable of the family physician conducting the follow-up session after treatment termination, which indicates less comfort or desire on the part of those in private practice in terms of other professionals having a larger role in the treatment process. However, if the follow-up session's purpose is the further continuity of care post treatment for the patient in an environment of collaboration between equal partners in health care provision (psychologists/psychotherapists and family physicians), psychologists/psychotherapists in general and those in private practice might be more positive about follow-up sessions by the family physician.

Services Offered and Referral Sources

Those in the private sector had more favourable attitudes towards including couple therapy as a government-funded service compared to those in the public sector. However, those is the public sector compared to private practitioners were more favourable of including group therapy as a government-funded treatment to be covered. These results are in line with Hunsley and colleagues' (2013) data showing that in Canada those in private psychotherapy practice conduct significantly more couple therapy and those in the public setting conduct significantly more group therapy. Additionally, as shown in Bradley and colleagues (2016a) couple therapy is the second most frequently practiced format, following individual therapy in private practice.

Those in the private setting were more in favour of multiple sources of referral into the government-funded program (see Table 3), such as self-referral, employer referral, and referral from a community organization. The only source of referral rated more favourably by those in the public sector was referral from a psychiatrist. Those in the private sector were also more in favour of including both debt counselling and employment/vocational counselling into the government-funded psychotherapy program. Additionally, those in the private sector were less in favour of clients needing to meet the criteria of a diagnosable mental health disorder in order to receive services, and also less in favour of the need for a face-to-face assessment prior to offering psychotherapy services. Perhaps the culture of private practice instills a sense of flexibility or less formality. Fewer conditions, such as meeting certain diagnostic criteria, would allow for easier access to treatment. Furthermore, as access to mental health services is such a challenge (see Peachey et al., 2013), and even accessing a family physician specifically in the Quebec context is challenging for many (Forget, 2014), having fewer barriers in terms of referral pathways will further help remedy obstacles to accessing treatment.

Evidence-Based Practice (EBP) and Treatment Accountability

In terms of choice in psychotherapy approach, those is the public sector were more favourable of using only evidence-based practices based on scientific evidence as assessed by a neutral agency, as well as being mandated to use only those psychotherapy approaches approved by the government program (e.g., the mandated use of NICE guideline recommended treatments in the UK's IAPT program). Those in the private sector more strongly rated the use of any psychotherapy approach deemed appropriate by the licensed psychologist or psychotherapist. This shows a comfort level with restriction in terms of choice in psychotherapy approach among those in the public sector, but also highlights openness to EBPs. The openness to the use of

EBPs was also evident in those currently working in the public sector being more favourable of the use of validated measure to track treatment progress and outcome than those in the private sector. Ionita and Fitzpatrick (2014) discuss the difficulty of isolated private practice and the challenge of translating knowledge and implementation of validated measures to track treatment progress to those in the private setting. Along with openness in the use of EBPs, there was also more favourability among those in the public sector in terms of treatment accountability. Those in the public sector compared to those in private practice were more favourable of mandated supervision for psychologists and psychotherapists offering government-funded psychotherapy services and more favourable of evaluating the treatment competency of those offering government-funded psychotherapy services. If these components are valued in terms of developing a government-funded program efforts need to be put forth in order to get greater buy-in from those in the private sector.

Hiring and Payment

Those in private practice were more favourable of being paid on a session-to-session basis (e.g., fee for service) in a new government-funded psychotherapy program compared to those in the public system. Not surprisingly, those in the public system rated being paid on a part-time or full-time salaried basis more favourably than those in the private sector. Furthermore, autonomy in terms of fee-setting was the preference of those in private practice as they more strongly valued that the psychologist and psychotherapist should determine their own fee, a portion of which is reimbursed by the government-funded program to the client, compared to those in the public sector. Additionally, those in the public sector compared to those in private practice had more favourable attitudes in terms of accepting a predetermined hourly psychotherapy fee set by the government program. Finally, those in private practice indicated higher fees, whether

independently set or the minimum predetermined amount deemed acceptable from the government-funded program, than those in the public sector.

Years of Experience

The current results of differences across years of experience point to some overlapping themes in those working in the private sector and those with the most years of experience. It is worth considering the overlap in respondents in their later years of practice and those practicing in the private sector. Results from Bradley and colleagues (2016b) on private practice indicated that those with the most years of experience offered significantly more sessions privately per week than those with less experience. Furthermore, in the current sample, 67% of those with more than 21 years, 54% of those between 11 and 20 years and only 40% of those with less than 10 years of experience primarily practice in the private sector.

The Structure of the Work force

Those with the most years of experience (more than 21 years) were more in favour of reimbursing services offered in the private sector in a government-funded psychotherapy program compared to those with less than ten years of experience (see Table 4). Furthermore in asking participants in which work settings psychologists and psychotherapists could offer government-funded services, those with the most years of experience had more favourable attitudes for services offered by practitioners in independent private practice compared to those with less than ten years of experience. Additionally, those with the most years of experience compared to those with the least years of experience had more favourability towards the idea of clients choosing their psychologists and psychotherapist regardless of work setting to receive government-funded services, by such mirroring the results shown previously for those in private practice.

In terms of the role of a referring family physician, those with the most years of experience (more than 21 years) had more favourable attitudes towards the treating psychologist conducting the follow-up session with clients after treatment termination. In terms of giving this responsibility to the family physician, those again with the most years of experience had stronger disagreement that a follow-up session should be conducted by the referring family physician, compared to those with less years of experience. This is perhaps indicative of a sense of confidence or autonomy in those with more years of experience, or perhaps a greater sense of collaboration or comfort in others having a larger role in the treatment process among those with less years of experience.

Services Offered and Referral Sources

Similar to the results found in those practicing in the private sector (Bradley et al., 2016b), those with the most years of experience more strongly agreed with including couple therapy in a government-funded model of psychotherapy compared to those with the least years of experience. Those with the least years of experience had stronger agreement with the inclusion of group therapy in a government-funded psychotherapy program. Those with more than 21 years of experience, compared to those with the least experience (10 years or less) more strongly agreed that individuals should meet the criteria for a mental health diagnosis in order to receive government-funded psychotherapy services. Furthermore, those with more than 21 years of experience also more strongly agreed with using only written materials (i.e., psychoeducation materials) that were either approved, or mandated, by the government-funded program. As can be seen in Table 2, those with a master's degree were also more favourable of using mandated written materials. Again there may be overlap in these groups in terms of education level and years of experience, as within this sample only 46% of those in their first 10 years of practice are

licensed at the master's level, whereas 68% of those with 21 or more years of practice are licensed at the master's level.

As indicated in Table 4, in terms of referral sources, those with 11 to 20 years of experience compared to those with more than 21 years more strongly agreed with multiple sources of referral into the government-funded psychotherapy program (e.g., social worker, family doctor, psychiatrist, paediatrician). Again, as access to mental health services is so challenging, and access to a family physician can be a challenge for many in the Quebec context (Forget, 2014), having multiple referral sources to get psychotherapy services is needed to break down the barriers to treatment. Narrowing referral sources counters the fundamental principle of increasing access to psychotherapy. Finally, those with less years of experience compared to those with the most years of experience were more favourable to mandated psychotherapy supervision within the government-funded program (see Table 4), which is potentially a reflection of the natural openness to, and routine nature, of supervision early in one's career.

Hiring and Payment

Those with less years of experience had more favourable attitudes towards being hired on a full and/or part-time salaried basis compared to those with more years of experience (see Table 4). Those with more years of experience (11 to 20 years, and more than 21 years) had more favourability towards being paid on a session-to-session basis compared to those with the least years of experience (less than 10 years), again highlighting a sense of independence in later years of practice. Finally, those with more years of psychotherapy experience reported a higher acceptable minimum psychotherapy session fee if predetermined by the government program, as well as a higher fee if autonomously determined, than those with less years of experience (see Table 4), again mirroring the trend of significantly higher fees in private practice in those with

more years of experience.

Future analyses could investigate which characteristics, work setting, education or years of experience, account for the levels of variance in over lapping themes of interest (i.e., higher fees, being paid on a fee for service basis).

Implications

In looking forward to the potential development of government-funded psychotherapy services, the specific attitudes of different groups of psychology practitioners must be taken into consideration in order for these professionals to buy into the conditions of these services. For example, private practitioners and those with the more years of practice are more favourable of services being offered in the private sector, whereas those in their early years of practice and those currently working in the public system are more open to services being offered in the public setting. To encapsulate a broad range of practitioners, offering government-funded services across multiple work settings is ideal. Additionally, while being paid on a session-to-session basis, and practitioners determining their own fee, were generally rated most favourably by the current sample (see Bradley & Drapeau, 2014), this was especially the case for those in the private sector as well as senior practitioners with the more years of practice. Furthermore, the acceptable fees to be paid per psychotherapy hour were higher for those in private practice, those at the doctoral level and those with the most years of experience. If these practitioners are to be included in the pool of professionals offering these services, their expectations for payment need to be a consideration.

Generally speaking, across many concepts such as the need for psychologists or psychotherapists to be registered with the government-funded program, the need for mandatory clinical supervision for those offering services, or being evaluated for treatment competency,

those in the public sector were more open to these conditions compared to those in the private sector. This is perhaps a reflection in the differences in the culture of public versus private or independent practice. If conditions such as these are important and are to be included in a government-funded psychotherapy program these may be easier to put in place with those currently in the public setting. Collaborating with those currently in private practice and providing sound rationales for components such as supervision and competency assessment may be needed for those less favourable of such conditions of practice. Alternatively, those in private practice appear to have a more flexible attitude in terms of the structure of the program. For example, being more favourable of multiple sources of referral, the inclusion of debt counselling and employment assistance, and less favourable of the need for a formal mental health diagnosis. Again, this potentially reflects the more flexible structure of independent practice and also an easier buy-in for the aforementioned components compared to those in the public sector.

Across education, years of experience and work setting, the results highlighted important differences in terms of the primary role of the treating psychologist or psychotherapist in relation to the referring family physician, the integration of EBPs, as well as practitioner choice of therapeutic interventions. These differences have important implications in terms of developing a government-funded psychotherapy program, but also important implications for education and training. Generally, all the practitioners in the sample were more in favour of the central role of the treating psychologist and psychotherapist in clinical decision-making (see Bradley & Drapeau, 2014). Therefore, placing these practitioners at the helm of the treatment process is important for the Quebec context. However, those with a doctoral degree, those with more years of experience and those in the private sector were particularly less favourable of the family physician having a primary role in treatment decisions (e.g., deciding length and/or type of

treatment, conducting follow-up sessions). This is an interesting phenomenon and may reflect a sense of competence or autonomy in those in private practice, at the doctoral level and with more years of experience. Training programs and professional psychology associations and regulatory boards must take into consideration the beliefs created around the role of psychologists and psychotherapists in service delivery. Murdoch, Gregory and Eggleton (2015) reviewed the amount of mental health training across diverse professions, such as medicine, psychology, nursing and social work, and it is clear that psychologists are overwhelmingly the most trained professionals in the provision of psychological services and hands on mental health treatment. We must continue to consciously decide where our place is in the decision-making role of psychotherapy service and put this into action. If we see that a sense of autonomy and competence in decision-making is stronger is sub-populations of our professionals, we must decide if action is needed to bolster this in all of our licensed professionals. With the doctoral degree now being mandatory for registration as a psychologist in Quebec it is reasonable to anticipate shifts in the culture of the field, which may include an increased sense of ownership in clinical decisions and confidence in clinical competency.

In looking to the results concerning the use of evidence-based psychotherapy treatments and validated tools to track treatment progress and outcome, those at the doctoral level, those in public practice and those with less years of experience had more favourable attitudes towards the implementation of these in a government-funded psychotherapy program. This is not surprising given that less years of experience and doctoral level training were also related to increased use of validated treatment tools in our sample of private practitioners in Quebec (see Bradley et al., 2016a), and have been shown to be related to greater awareness of progress monitoring measures (Ionita & Fitzpatrick, 2014). Furthermore, those with doctoral level training and less years of

experience have been shown to have greater openness to EBPs, and the use of manualized treatments (Aarons, 2004; Addis & Krasnow, 2000; Wallace & von Ranson, 2011). Finally, others have noted the challenge of increasing awareness and integration of such tools as progress and outcome monitoring measures to those in independent practice, as knowledge and use of these among the private population is particularly low (Bradley et al., 2016a; Hatfield & Ogles, 2004; Ionita & Fitzpatrick, 2014).

The current data identified the sub-populations of psychology practitioners who are less open to the use of evidence-based practices and validated tools to track treatment progress. This information can allow for initiatives to be tailored to these subgroups of practitioners in order to enhance knowledge and use of these tools. Providing those in the private sector, those at the master's level as well as those who have been practicing for many years with training and knowledge in the implementation of these tools will only serve to enhance a government-funded program grounded in evidence-based practice and accountable outcome tracking.

Limitations and Future Directions

In interpreting the results of the current study one must consider a number of limitations. As the invitation email highlighted accessibility to psychotherapy services, responders may be particularly interested in this topic compared to non-responders. While the sample is generally representative of those licensed with the OPQ (Jaimes, La Rose-Herbert, & Moreau, 2015; Ordre des Psychologues du Québec, 2015), a larger response rate from psychotherapists would have allowed for more ideal generalizability to the population of licensed psychotherapists (see Chapter 4 for further discussion).

The current study is specifically informative of the attitudes of subgroups of psychological practitioners in Quebec, and the investigation of these subgroups allows for the potential to

generalize to similar groups in other provinces (e.g., those in private practice, those trained at the doctoral level). However, it would be important for future investigations to include the attitudes of clinicians licensed in other jurisdictions in order to document specific regional attitudes in terms of the role of psychological practitioners in offering government-funded services and the acceptable conditions for buy-in from these practitioners. Quebec has a unique psychology climate, with overwhelmingly the most licensed psychologists in any province in Canada, a larger representation of those endorsing a psychodynamic orientation (Jaimes et al., 2015), and the requirement of functional bilingualism. Therefore, investigations into the perspectives of those practicing across Canada could potentially better inform initiatives beyond the Quebec context.

As discussed previously, there is much overlap in the characteristics of interest in the current study, such as those in private practice and those with many years of experience, or those with a master's degree and those with many years of experience. Further investigation into the specific clinical characteristics that account for the variance in attitudes concerning such things as the role of psychologists and psychotherapists in a new government-funded psychotherapy program, the hiring structure, and acceptable payment rates is warranted.

Finally, as psychologists and psychotherapists are two different groups of professionals with different educational and training backgrounds, having an understanding of the differences found between these two groups is important. While it is beyond the scope of the present study, results comparing these two groups of professionals can be found in Bradley and colleagues (2016c) investigation.

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Table 1. *Demographic Information*

Sex	**Female**	**Male**			
	67%	33%			
License	**Psychologist**	**Psychotherapist**			
	86%	14%			
Language	**French**	**English**			
	89%	11%			
Age	**25-34**	**35-44**	**45-54**	**55-64**	**65+**
	13%	28%	24%	25%	10%
Academic Degree*	**Bachelor's Degree**	**Master's Degree**	**Doctoral Degree**	**Psy. D**	**Other**
	2%	63%	22%	12%	1%
Years of Practice	**0-10**	**11-20**	**21+**		
	30%	33%	37%		
Populations Treated	**Children (12 & under)**	**Adolescents (13-17)**	**Young Adults (18-30)**	**Adults (31-64)**	**Older Adults (65+)**
	29%	44%	84%	87%	51%

Theoretical Orientation	**Cognitive-Behavioural**	**Psychoanalytic/ Psychodynamic**	**Humanistic/ Existential**	**Integrative/ Eclectic**	**Systems/Family Systems**	**Other**
Primary Orientation	35%	25%	20%	14%	6%	1%
Secondary Orientation	21%	11%	16%	17%	13%	3%

Primary Work Setting		**Secondary Work Setting**
Independent Private Practice	37%	18%
Group Private Practice	12%	8%
Medical Clinic	2%	3%
*CIUSSS/CISSS**	18%	1%
School	6%	1%
General Hospital	4%	0%
Psychiatric	6%	1%

Hospital		
Outpatient Clinic	0%	1%
University Counselling Centre	2%	0%
University Psychology Department	3%	2%
Other	11%	0%

Note: * CIUSSS: Integrated University Health and Social Services Centres; CISSS: Integrated Health and Social Services Centres

Table 2. Significant Results (p < .01) when Comparing Level of Education

	Master's			Phd/Psy.D					
Survey Items	***Median***	***Mean Rank***	***SD***	***Median***	***Mean Rank***	***SD***	***U***	***z***	***r***
The following services should be covered under a new government-funded psychotherapy system:									
Group Therapy	4.00	622	.90	4.00	**695**	.94	212, 400	3.51	.09
Individual Therapy	5.00	637	.51	5.00	**688**	.49	209, 601	2.94	.08
In total, regardless of how the treatment is delivered (individual, group, couple or family), how many hours of psychotherapy should be available to an individual and paid for by the government each year?	4.00	643	1.54	4.00	**727**	1.57	230, 091	3.88	.10
If government-funded psychotherapy had to be implemented in phases or steps over a period of time (months or years), in what order would you prioritize treatment for the following age groups? (Rank top 3 only)									
Children (12 and younger)	1.00	**678**	1.35	1.00	625	1.25	180, 927	2.75	.07
Adults (31 to 65)	4.00	640	1.10	4.00	**699**	1.05	215, 005	2.95	.08
Debt counselling should be offered concurrently with psychotherapy in a new government- funded psychotherapy program.	3.00	**676**	1.08	3.00	633	1.05	185, 271	2.04	.05
In a new government funded psychotherapy system a mandatory face-to-face psychological assessment must be completed prior to offering any psychotherapy treatment.	4.00	622	.93	5.00	**697**	.83	212, 469	3.81	.10

If a family physician referred a client to a psychologist/psychotherapist for psychotherapy:									
The family physician should be responsible for deciding the type of psychotherapy treatment (i.e., CBT, Humanistic).	1.00	**688**	.71	1.00	632	.66	185, 272	2.89	.08
The psychologist/psychotherapist should be responsible for deciding the length of treatment.	5.00	633	.56	5.00	**682**	.55	206, 230	2.63	.07
The family physician should be responsible for deciding the length of treatment.	1.00	**673**	.65	1.00	611	.53	173, 233	3.33	.09
When written material (e.g., psycho-educational handout) is given to clients, the psychologist/ psychotherapist offering a treatment within the new government-funded psychotherapy program should use treatment materials/literature that are mandated by the program (e.g., specific self-help books).	2.00	**692**	.98	2.00	646	.97	192, 570	2.19	.06
In a new government-funded psychotherapy system any licensed psychologist/ psychotherapist could offer psychotherapy.	4.00	**685**	1.23	4.00	625	1.32	182, 024	2.80	.07
In a new government-funded psychotherapy system, psychotherapy services should be offered by a clinician who works within a government-owned and operated facility (e.g., hospital, CSSS/CLSC, etc.)	5.00	635	.80	5.00	**679**	.74	205, 585	2.23	.06
In a new government-funded psychotherapy system:									
Treatment outcome should be assessed using validated measures	4.00	637	1.05	4.00	**711**	1.13	221, 575	3.49	.09
Validated measures that focus on symptoms (e.g., GAD, BDI) should be used to track outcome	3.00	643	1.06	4.00	**693**	1.12	213, 575	2.35	.06
Non-identifiable outcome data (e.g., treatment success or failure) should be published and made available to the public	3.00	638	1.20	3.00	**705**	1.25	218, 781	3.12	.08

Clinicians offering government-funded psychotherapy services should charge a session fee predetermined by the government program (e.g., government reimburses the clinician a set fee per hour).	4.00	**669**	1.24	3.00	627	1.35	181, 815	1.96	.05
If the government set a predetermined fee, what is the minimum payment you would accept from the new government-funded psychotherapy program for one hour of psychotherapy services?	85.00	626	14.34	**90.00**	701	15.37	214, 185	3.49	.09
If you were to set your own fee, a portion of which would be covered by the government, what would your total session fee be in dollars per hour of psychotherapy?	100.00	635	16.04	**100.00**	736	19.09	232, 997	4.64	.12

Note. * Bolded numbers indicate the group with the higher mean rank or median score.

Table 3. Significant Results (p < .01) when Comparing Work Setting

Survey Items	Public			Private					
	Median	*Mean Rank*	*SD*	*Median*	*Mean Rank*	*SD*	*U*	*z*	*r*
Psychotherapy services should be fully funded by the government.	4.00	**660**	1.09	4.00	598	1.14	213, 239	3.13	.08
Access to psychotherapy services should be increased by:									
Creating new positions for clinicians in the public sector	5.00	**676**	.66	4.00	549	.80	221, 665	7.04	.18
Funding services offered in the private sector with government funds	4.00	517	.95	5.00	**662**	.80	132, 971	7.90	.21
The following services should be covered under a new government-funded psychotherapy system:									
Couple Therapy	4.00	564	1.02	4.00	**634**	1.06	158, 768	3.63	.09
Group Therapy	4.00	**634**	.91	4.00	570	.95	196, 731	3.35	.09
If government-funded psychotherapy had to be implemented in phases or steps over a period of time (months or years), in what order would you prioritize treatment for the following age groups? (Rank top three only)									
Adults (31 to 65)	4.00	**633**	1.06	4.00	588	1.13	197, 254	2.48	.06
The following services should be offered concurrently with psychotherapy in a new government- funded psychotherapy program.									
Debt counselling	3.00	592	1.00	4.00	**630**	1.02	174, 247	1.98	.05
Employment Assistance and/or Vocational Counselling	4.00	599	.92	4.00	**640**	.94	178, 501	2.11	.06

In a new government funded psychotherapy system:									
A client must meet the criteria for a diagnosable mental health disorder (DSM, ICD) in order to receive psychotherapy services	4.00	**678**	1.27	3.00	573	1.31	223, 263	5.28	.12
A mandatory face-to-face psychological assessment must be completed prior to offering any psychotherapy treatment	5.00	**643**	.84	4.00	558	1.01	202, 447	4.66	.12
Client preferences should be considered in choosing a psychotherapy treatment modality	4.00	590	.86	4.00	**630**	.80	173, 255	2.12	.06
To gain access to government-funded psychotherapy services, a formal request for services could come from:									
Client's Employer	3.00	597	1.13	3.00	**650**	1.22	177, 386	2.68	.07
Client (self-referral) and/or client's family	4.00	560	.91	5.00	**615**	.86	155, 991	3.05	.08
Community Organization (e.g., Ami-Quebec)	4.00	561	.87	4.00	**632**	.86	156, 732	3.78	.10
Guidance counsellor (school)	4.00	578	.67	4.00	**626**	.77	166, 605	2.56	.07
Psychiatrist	5.00	**629**	.50	5.00	590	.49	195, 064	2.40	.06
If a family physician referred a client to a psychologist/psychotherapist for psychotherapy:									
The family physician should receive a progress report from the psychologist/ psychotherapist mid-way through treatment.	3.00	**646**	1.14	3.00	595	1.21	204, 668	2.58	.07
The family physician should be responsible for conducting a follow-up meeting with the client after treatment termination.	3.00	**644**	1.15	3.00	596	1.15	204, 138	2.45	.06

In a new government funded psychotherapy system the psychologist/psychotherapist offering a psychotherapy should be allowed to choose and to offer:									
Any psychotherapy approach (e.g., emotion-focused therapy, interpersonal psychotherapy) he/she deems appropriate	4.00	599	.94	5.00	**648**	.91	178, 855	2.58	.07
Any psychotherapy approach considered to be evidence-based by a neutral agency after a review of the scientific evidence	4.00	**666**	1.11	4.00	560	1.22	216, 021	5.50	.14
Any psychotherapy approach pre-approved by the government program	4.00	**643**	1.26	4.00	575	1.36	202, 682	3.49	.09
In a new government-funded psychotherapy system, psychotherapy services should be offered by a clinician who:									
Works in independent private practice (a solo clinician)	4.00	504	.90	5.00	**671**	.65	126, 384	9.02	.23
Works in a private psychotherapy clinic (group practice)	4.00	540	.81	5.00	**655**	.67	145, 416	6.25	.16
Works within a government-owned and operated facility (e.g., hospital, CISSS, etc.)	5.00	**636**	.71	5.00	569	.78	199, 098	3.72	.10
Has been chosen by a client for psychotherapy, regardless of their work setting	4.00	507	.97	5.00	**665**	.70	127, 918	8.81	.23
In a new government-funded psychotherapy system:									
The individual psychologist/ psychotherapist should be pre-approved and registered with the government program in order to offer psychotherapy	4.00	**666**	1.12	4.00	570	1.32	215, 918	4.94	.13

The site/work-setting should be pre-approved and registered with the government program in order to offer psychotherapy	4.00	**676**	1.17	4.00	562	1.32	221, 105	5.08	.13
Any licensed psychologist/ psychotherapist could offer psychotherapy	4.00	534	1.23	5.00	**680**	1.09	142, 291	7.58	.20
Regular psychotherapy supervision offered through the program should be mandated for all those offering government-funded psychotherapy	4.00	**684**	1.04	4.00	570	1.18	226, 229	5.80	.15
Clinicians offering government-funded psychotherapy services should be assessed for treatment competency on a regular basis	3.00	**669**	1.19	3.00	581	1.20	217, 743	4.38	.11
In a new government-funded psychotherapy system:									
Treatment outcome should be assessed using validated measures	4.00	**669**	1.03	3.00	567	1.10	217, 697	5.27	.14
Validated measures that focus on symptoms (e.g., GAD, BDI) should be used to track outcome	3.00	**643**	1.05	3.00	585	1.05	202, 404	2.96	.08
Clinicians offering government-funded psychotherapy services should:									
Be hired full-time by the program, and receive a yearly salary	3.00	**743**	1.21	2.00	529	1.17	260, 228	10.66	.28
Be hired part-time by the program, and receive a yearly salary	3.00	**708**	1.15	3.00	558	1.16	240, 378	7.48	.19
Receive payment from the program on a session-to-session basis (i.e., fee for service)	4.00	539	.95	5.00	**651**	.66	144, 775	6.29	.16
Clinicians offering government-funded psychotherapy services should:									
Charge a session fee predetermined by the government program (e.g., government reimburses	4.00	**651**	1.19	3.00	568	1.28	206, 462	4.24	.11

the clinician a set fee per hour)									
Determine their own fee, a portion of which would be covered by the government	4.00	563	1.15	4.00	**659**	1.07	158, 276	4.99	.13
If the government set a predetermined fee, what is the minimum payment (in dollars) you would accept from the new government-funded psychotherapy program for one hour of psychotherapy services?	85.00	562	14.44	90.00	**641**	14.85	157, 674	3.96	.11
If you were to set your own fee, a portion of which would be covered by the government, what would your total session fee be in dollars per hour of psychotherapy?	95.00	585	15.89	100.00	**651**	18.20	170, 682	3.30	.90

Note. * Bolded numbers indicate the group with the higher mean rank or median score.

Table 4. Significant Results ($p < .01$) when Comparing Years of Experience

Survey Items	Group 1: 10 Years or Less		Group 2: 11 – 20 Years		Group 3: 20+ Years		χ^2	Post-hoc Analysis
	Median	*Mean Rank*	*Median*	*Mean Rank*	*Median*	*Mean Rank*		
Access to psychotherapy services should be increased by funding services offered in the private sector with government funds	4.00	629	4.00	676	5.00	712	12.10	Group 3 > Group 1
The following services should be covered under a new government-funded psychotherapy system:								
Couple Therapy	4.00	664	4.00	653	4.00	720	8.42	Group 3 > Group 2
Group Therapy	4.00	738	4.00	670	4.00	635	17.69	Group 1 > Group 2 Group 1 > Group 3
If government-funded psychotherapy had to be implemented in phases or steps over a period of time (months or years), in what order would you prioritize treatment for the following age groups? (Rank top 3 only)								
Adolescents (13 to 17)	2.00	697	2.00	655	2.00	730	11.19	Group 3 > Group 2
In a new government funded psychotherapy system, a client must meet the criteria for a diagnosable mental health disorder (DSM, ICD) in order to receive psychotherapy services.	3.00	625	4.00	745	4.00	730	24.15	Group 2 > Group 1 Group 3 > Group 1
When written material (e.g., psycho-educational handout) is given to clients, the psychologist/psychotherapist offering a treatment within the new government-funded psychotherapy program should:								
Use treatment materials/ literature only if they have been approved by the program	2.00	646	2.00	706	2.00	709	7.69	Group 3 > Group 1

Use treatment materials/literature that are mandated by the program (e.g., specific self-help books)	2.00	661	2.00	698	2.00	754	13.57	Group 3 > Group 1
To gain access to government-funded psychotherapy services, a formal request for services could come from:								
Family Doctor	5.00	662	5.00	721	5.00	636	16.85	Group 2 > Group 1 Group 2 > Group 3
Guidance counsellor (school)	4.00	647	4.00	720	4.00	682	8.71	Group 2 > Group 1
Paediatrician	5.00	675	5.00	729	5.00	642	16.07	Group 2 > Group 3
Psychiatrist	5.00	691	5.00	733	5.00	646	17.59	Group 2 > Group 3
Psychologist	5.00	687	5.00	727	5.00	649	14.35	Group 2 > Group 3
Social Worker	5.00	641	5.00	695	5.00	641	7.90	Group 2 > Group 3
If a family physician referred a client to a psychologist/psychotherapist for psychotherapy:								
The psychologist/psychotherapist should be responsible for conducting a follow-up meeting with the client after treatment termination	4.00	655	4.00	686	4.00	733	10.40	Group 3 > Group 1
The family physician should be responsible for conducting a follow-up meeting with the client after treatment termination	3.00	759	3.00	706	2.00	642	20.95	Group 1 > Group 3 Group 2 > Group 3
In a new government-funded psychotherapy system, psychotherapy services should be offered by a clinician who:								
Works in independent private practice.	4.00	626	4.00	690	4.00	700	10.75	Group 2 > Group 1 Group 3 > Group 1
Has been chosen by a client for psychotherapy, regardless of their work setting	4.00	626	5.00	686	5.00	697	10.33	Group 2 > Group 1 Group 3 > Group 1

In a new government-funded psychotherapy system:								
Any licensed psychologist/ psychotherapist could offer psychotherapy	4.00	644	4.00	686	4.00	729	7.05	Group 3 > Group 1
Regular psychotherapy supervision offered through the program should be mandated for all those offering government-funded psychotherapy	4.00	749	4.00	728	4.00	639	22.08	Group 1 > Group 3 Group 2 > Group 3
Clinicians offering government-funded psychotherapy services should:								
Be hired full-time by the program, and receive a yearly salary	3.00	765	3.00	686	3.00	680	12.72	Group 1 > Group 2 Group 1 > Group 3
Be hired part-time by the program, and receive a yearly salary	3.00	758	3.00	675	3.00	696	10.30	Group 1 > Group 2
Receive payment from the program on a session-to-session basis (i.e., fee for service)	4.00	619	5.00	699	5.00	711	17.55	Group 2 > Group 1 Group 3 > Group 1
If the government set a predetermined fee, what is the minimum payment (in dollars) you would accept from the new government-funded psychotherapy program for one hour of psychotherapy services?	80.00	582	90.00	682	90.00	767	50.96	Group 2 > Group 1 Group 3 > Group 1 Group 3 > Group 2
If you were to set your own fee, a portion of which would be covered by the government, what would your total session fee be in dollars per hour of psychotherapy?	90.00	590	100.00	706	100.00	790	58.81	Group 2 > Group 1 Group 3 > Group 1 Group 3 > Group 2

Chapter 6: Summary and Conclusion: The Practice of Psychotherapy in Quebec: What Have We Learned From Clinicians?

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Abstract

As the acknowledgement for effective and accessible psychotherapy services is coming to the forefront of health care issues in Canada, the timing is apt to document the current practices of psychologists and psychotherapists. This serves to aid in informing their continued and potentially enhanced role in mental health service delivery in Canada. The following paper amalgamates data from a series of survey studies targetting psychologists and psychotherapists licensed to practice psychotherapy in Quebec. These studies taken together highlight important themes and challenges in the field of psychology and in the practice of psychotherapy. The first survey study documented the practice characteristics of psychologists and psychotherapists currently in private psychotherapy practice (N = 641). This study provided a snapshot of the current populations being served, the cost and length of treatment, the clinical tools being used in practice, current referral routes and collaboration with other health professionals, among other variables. The second survey study focused on the future of psychotherapy service delivery and documented psychologist and psychotherapist attitudes toward a potential government-funded model of psychotherapy (N = 1462). Comparisons were made within each study looking at differences in attitudes and practice characteristics among respondents of different subgroups (e.g., level of education, theoretical orientation, years of experience). Important themes and clinician characteristics were identified across the studies, such as the use of evidenced-based practices now and in a potential future government-funded psychotherapy model; autonomy in clinical decision making; collaborative practices; differences in compensation; and gaps in service delivery. Opportunities and challenges presented by these themes are discussed in the context of policy development, training initiatives, and in the role of professional associations.

Key words: **psychotherapy; service delivery; professional psychology; survey; psychologist; psychotherapist**

The Practice of Psychotherapy in Quebec: What Have We Learned From Clinicians?

The field of psychology in Canada in embarking on an important time, as mental health problems of the Canadian population and the lack of accessible and sufficient treatment services have increasingly taken on greater public awareness. Psychology is a multifaceted and dynamic discipline, with the greatest number of licensed specialized mental health professionals in Canada (Ronson, Cohen, & Hunsley, 2011). These highly trained professionals are experts in the delivery of evidence-based psychotherapy treatments for diverse mental health problems. It is becoming widely acknowledged that gaining access to these mental health specialists is a serious problem in our current health care system (Peachey, Hicks, & Adams, 2013). Furthermore, primary care physicians are often over-loaded with highly prevalent disorders such as anxiety and mood disorders, with insufficient referral options for psychological treatment due to barriers such as cost (Grenier, Chomienne, Gaboury, Ritchie, & Hogg, 2008). The 2014 Survey on Living With Chronic Diseases in Canada (Public Health Agency of Canada, 2014) states that approximately 12% of Canadians have a mood or anxiety disorder, with 93% being prescribed medication and only 20% receiving a psychological intervention. This finding seems unbalanced in terms of treatments offered, as psychotherapy is recommended as a first line intervention in clinical practice guidelines for mood and anxiety disorders. Additionally, approximately 65% of Canadians with a mood or anxiety disorder reported consulting their family doctor for treatment, approximately 20% a psychiatrist, and only 35% consulted other health professionals (e.g., psychologist, social worker, psychotherapist). When members of the public were surveyed by the Ordre des Psychologues du Quebéc (OPQ) in 2012 concerning psychotherapy treatment, 32% reported that psychotherapy alone would be the treatment of choice for depression, with an additional 46% reporting a combination of medication and

psychotherapy (Ordre des Psychologues du Quebéc, 2012). Only 6% indicated medication alone as the treatment of choice. Again in the Quebec context, when members of the public were asked which professionals should be consulted for treatment for anxiety, 59% of respondents rated psychologists first (this number rises to 73% for those under the age of 35) (Ordre des Psychologues du Quebéc, 2012). In terms of treatment for depression, 50% indicated psychologists (again this number rises to 65% for those under the age of 35) (Ordre des Psychologues du Quebéc, 2012). Therefore there is a mismatch in not only the need for front-line psychotherapy services, but also the public's desire for this.

Results of the 2011 EKOS survey of members of the Canadian public concerning psychotherapy treatment and access to services show that the majority of respondents (approximately 75%) reported that the high cost and lack of coverage of psychotherapy services were 'significant' or 'very significant' barriers to accessing services (EKOS, 2011). Similarly, specifically in the Quebec context, when members of the public were surveyed by the OPQ, 61% indicated the cost of psychotherapy as a barrier to seeking treatment (Ordre des Psychologues du Quebéc, 2012). Efforts are now underway to explore options for increasing access to psychotherapy services (Bradley & Drapeau, 2014; Cohen & Peachey, 2014; Drapeau, 2014), and the time has come for psychology to take a unified stand and have a louder voice in determining its role in this process.

However, to know where our discipline stands in the future of mental health care, we first have to understand where we currently are. Psychology in Canada has lagged behind in terms of tracking trends in professional activities and characteristics, with a two-decade gap in our documentation of the nature and characteristics of the practices of psychologists (see Hunsley & Lefebvre, 1990; Hunsley, Ronson, & Cohen, 2013). This is now being remedied with recent

investigations of psychological practice in Canada (e.g., Hunsley, Ronson, Cohen, & Lee, 2014; Ionita & Fitzpatrick, 2014; Jaimes, La-Rose-Herbert, & Moreau, 2015), including by our research group (Bradley, Doucet, Kohler, & Drapeau, 2016c; Bradley & Drapeau, 2014).

The series of studies in this dissertation first documented the current state of affairs in private psychotherapy practice ($N = 641$) among licensed psychologists and psychotherapists practicing in Quebec, such as the populations being served, the length and cost of treatments, the use of clinical tools in practice, and the collaborative relationships of private practitioners and other health professionals (see Bradley, Service, Roberge, Vasiliadis, & Drapeau, 2016a). Due to the diversity of practitioners in psychotherapy, we highlighted differences across subgroups of practitioners in terms of level of education, years of experience, and theoretical orientation (see Bradley, Service, Roberge, Vasiliadis & Drapeau, 2016b). In addition to providing important information, these studies on the current state of affairs in practice help to contextualize the results of our next studies on the perspective of psychology practitioners concerning a government-funded program for psychotherapy. These next studies documented the attitudes of psychologists and psychotherapists concerning a government-funded model of psychotherapy treatment as a means of increasing accessibility to services for those in need. Government-funded models of psychotherapy currently operating in the UK and Australia were used to inform this investigation (see Australian Government Department of Health, 2015a; Australian Government Department of Health, 2015b; Clark, 2011; Department of Health, 2008a; Department of Health, 2008b). Results of this latter accessibility survey study of licensed psychologists and psychotherapists in Quebec ($N = 1462$) indicated that the majority of these practitioners strongly believed that accessibility to psychotherapy should be increased. There was slightly stronger agreement for partial coverage of psychotherapy fees through government

funded rather than full coverage of psychotherapy fees. Again, we also examined the differences in attitudes among subgroups of clinicians such as those practicing at the master's versus doctoral level, those in the public versus private sector, and those of differing years of experience.

Taken together these investigations have produced insights into the attitudes of psychology professionals and the state of private psychotherapy services. Overlapping themes were highlighted across the series of these studies that have implications for provincial licensing boards, associations, policy initiatives, training institutions, and those offering continued education. The following discussion underlines these themes and their implications and presents opportunities and challenges that currently exist in the practice of psychology. Furthermore, in amalgamating these data we are better able to highlight where we may experience potential difficulties and shortages in service delivery if a government-funded model of psychotherapy is to be developed in the future.

Characteristics of Psychotherapy Practice: Today and Tomorrow

The survey study of 641 psychologists and psychotherapists working in private practice in Quebec (see Bradley et al., 2016a) indicated that these practitioners offer a range of hours in the private sector (from 1 to 50 client contact hours), with 57% of participants offering 20 hours or less a week. Those with more years of experience reported treating more clients per week in private practice compared to those with less years of practice. Because the number of positions in the public sector has not decreased in such a way that would explain this difference between junior and senior practitioners, this finding may be an indicator of senior practitioners increasingly shifting their work into the private sphere. Losing experienced practitioners to the private setting in other contexts has been discussed as a potential problem in other jurisdictions

such as Australia (see Forsyth, 2009; Gleeson & Brewer, 2008). If such is the case, we must consider what this means in terms of retaining experienced practitioners in the public sector, both as a means of being service providers, but also serving as supervisors and trainers of psychology trainees. Exploring this phenomenon further, and documenting the rationale for increased private work in experienced clinicians is an important endeavour. One possible useful avenue of investigation with future studies is the working conditions of psychologists in the Quebec public system, which many consider inadequate and as such may encourage practitioners to migrate toward the private sector once they have established their clientele and reputation (see Bradley et al., 2016c). Furthermore, results of our recent studies appear to show a greater sense of practice autonomy or independence among those in private practice, and those with many years of experience. This may contribute to the move away from public practice. This is discussed in more detail in the section below entitled *Practice Autonomy in Psychotherapy.*

Psychotherapy Populations

Where We Stand Now: Current Practice Trends.

In our investigation of private psychotherapy practice in Quebec, individual therapy was most commonly offered (81% of the sample reported that more than 80% of their psychotherapy treatments are in individual therapy), whereas group and family therapies were offered very infrequently in the private sector (96% and 73%, respectively, reported devoting none of their psychotherapy time to these modalities). The most served population was adults (approximately 58% of the sample indicated spending more than 60% of their psychotherapy time with adults), and the least served were children (72% indicated providing no treatment hours with children), adolescents (49% indicated no treatment hours with adolescents), and the elderly (48% indicated no treatment time with the elderly). Those with a doctoral degree reported treating children and

adolescents significantly more frequently. Additionally, those with the least years of experience reported treating adolescents and young adults significantly more frequently than those with 21 or more years of experience, and those with 21 or more years of experience reported treating the adult and elderly population more frequently. With self-referral being the number one source of referral within this sample, it appears there may be a trend of choosing a therapist closer to one's age group (a similar characteristic to years of practice), with practitioners in the early phases of their career serving younger people, and those in the latter years of their career serving older adults and the elderly (see Bradley et al., 2016b).

Looking to a Future Government-funded Model

In asking participants about prioritizing services in a government-funded model of psychotherapy, adolescents were chosen as the top ranked population to prioritize. This may be a potential challenge going forward because, as is stated above, adolescents are not frequently served in private practice. Furthermore, although those with a doctoral degree reported treating children and adolescents more frequently in private practice, it was those with a master's degree who more strongly rated prioritizing children in a government-funded model of psychotherapy. It appears clinicians are not simply indicating to prioritize those populations they themselves treat most frequently. All of this may be indicative of the recognition by these practitioners of the unmet need for psychotherapy services for young people. Mental health problems frequently present early in life, and without proper treatment these can often persist into adulthood (Waddell, Hua, Garland, Peters, & McEwen, 2007). The government-funded programs in both the UK and Australia have placed adults as the core population to receive treatment. After rolling out the initial core programs targeting adults, there has then been a focus on incorporating services specifically targeting the youth populations (Bassilios, Nicholas, Reifels, & Pirkis,

2014; Department of Health, 2008c). In conceptualizing a model in the local context, it will be important to consider the unmet needs of the youth population, and the overall social and economic benefit of early detection, prevention and treatment of mental health problems in children and adolescents. The call for increased attention to the treatment of childhood mental health problems in the Canadian context as a means of preventative treatment has been made for many years (e.g., Waddell et al., 2007), and this needs to continue in order to effectively inform new government-funded psychotherapy initiatives.

Mental Health Problems and Diagnoses

Where We Stand Now: Current Treatment in Private Practice.

Respondents (Bradley et al., 2016a) indicated that anxiety and mood disorders, as well as interpersonal problems and adjustment to life stressors were most commonly treated in private practice. Psychosis, pervasive developmental delays, and gender and/or sexuality related difficulties were seldom treated (with over 70% of the sample reporting 'never' or 'rarely' treating these). Additionally, it was not commonly reported in the private setting for clients to have a comorbid health conditions (approximately half of the surveyed sample reported 'none' or 'few' of their clients have a comorbid health condition). It is a challenge to know if comorbid health conditions are being underreported by the clients, or if health conditions are not the focus of treatment and intervention and therefore not being captured in the present sample.

In looking at differences in the diagnoses and mental health problems treated by practitioners of differing levels of education, those with a doctoral degree reported treating diagnosable mental disorders and comorbid mental health problems more frequently (Bradley et al., 2016b). This may be indicative of differences in training, comfort level and competency in terms of severity of illnesses treated by those with different levels of education. Furthermore, in

looking at the influence of training, those endorsing a CBT orientation reported treating more anxiety and mood disorders, whereas psychodynamic practitioners reported treating more personality disorders, and humanistic clinicians more couple/marital problems (Bradley et al., 2016b). These are important findings in terms of understanding the influence of the training lens and how this translates to routine practice. It is unclear, however, if the theoretical lens influences how one tends to categorize or diagnose presenting problems, if those with certain problems self-refer to certain types of therapists, or if certain therapists self-select clients thereby tending to treat patients with specific disorders. How one markets their competencies and treatment expertise could also be an important factor.

The Future: Prioritization of Mental Health Problems in a Government-funded Model.

In terms of prioritizing treatment based on mental health problem, diagnosable disorders, difficulties related to health problems and family difficulties were ranked most highly. This is interesting as family problems, and health-related difficulties are not prioritized in other government-funded programs in the UK and Australia, and these are also not frequently treated in the private sector. One might hypothesize that there may be a recognition of these treatment needs not being met privately, therefore leading to their prioritization. In terms of specific disorders, anxiety and mood disorders were prioritized, which is not surprising given their high prevalence rates (Statistics Canada, 2012) and the efficacy of psychotherapy treatment for these disorders. However, schizophrenia and other psychotic disorders, which have low prevalence rates and are infrequently seen privately, were ranked third in terms of prioritization. This is possibly in recognition of the lack of services for these conditions or the recognition of their

severity, as this sample of practitioners indicated that services should predominantly be prioritized based on problem severity.

Length of Treatment

Where We Stand Now: Current Practices in Treatment Duration.

The average treatment length in private practice was approximately 20 sessions, although there was much variation (M = 23.35, Mdn = 18, SD = 20.82). Those espousing a CBT orientation had a lower average number of treatment sessions (this is not surprising as many CBT-based treatments emphasize shorter treatment length), and those with the most years of experience had a higher number of average treatment sessions than those with less years of experience. There may be overlap in these groups of individuals, as the CBT orientation has gained in influence over the past two decades, whereas those with the most years of experience may have been influenced by a psychodynamic orientation.

Number of Treatment Sessions to be Funded in a Government-funded Model

Approximately one quarter (26%) of the sample indicated that between 11 and 16 sessions should be covered per year, and 24% reported more than 23 sessions should be covered. Twenty percent (20%) indicated between 5-10 session, and another 20% indicated between 17-22 sessions. These figures mirror the range found in private psychotherapy practice generally (see Bradley et al., 2016a). Interestingly, the UK IAPT program (Clark, 2011) and the Australia government-funded programs (Australian Government Department of Health, 2015a; Australian Government Department of Health, 2015b) offer treatments in the range of approximately 6-12 sessions, with average session lengths usually being approximately five sessions (see Richards & Suckling, 2009). Many have benefitted from these treatments (Department of Health, 2008c; Pirkis et al., 2011), and therefore this may be an acceptable amount of treatment; however our

data point to a higher average treatment length in routine private practice. This raises the question as to whether a government-funded model should mirror already existing practices and therefore offer more than 12 sessions in routine care. Furthermore, while many have benefitted from the IAPT program, only 45% of those who received treatment have been considered 'successful outcomes' (Department of Health, 2008c), which may suggest that, among other things, too few sessions were offered. In building a government-funded model of mental health care, there needs to be an integration of the data supporting the use of time-limited treatment, with the data representing routine session length in present clinical practice.

Referral Routes

Where We Stand Now: Current Practice Trends with Regards to Referrals.

Self-referral was overwhelmingly the most common source of referral (64% of practitioners reporting that 'all' or 'most' clients self-refer and 30% reported that 'some' self-refer), followed by referrals from family physicians (18% reported that 'most' and 60% reported that some of their clients are referred by family physician) and employee assistance programs (EAP; 17% reporting 'most' and 39% reporting 'some' of their clients are referred by EAPs). Master's level practitioners received more referrals from EAPs which is potentially related to those at the master's level being willing to accept a lower fee, as EAPs often refer to clinicians who will work for a set, often low, fee. The results of the private practice survey indicated that those at the master's level charge less than those at the doctoral level (Bradley et al., 2016b), and also would accept lower fees in a government-funded model of psychotherapy (Bradley & Drapeau, 2016; see also section below entitled *Money Matters*).

Referral Routes in a Government-funded Model

In terms of being referred for services in a government-funded model of psychotherapy, participants showed agreement with having multiple points of referral (e.g., self, family doctor, social worker). This mirrors the UK IAPT model of service entry (Clark, 2011), and is much more open and flexible than that of the government-funded programs in Australia where a referral must come from a physician (Australian Government Department of Health, 2015a; Australian Government Department of Health, 2015b). As self-referral is a primary means for individuals to enter services in the private sector, it seems it would be beneficial for potential service users to have this as an option in a future government-funded system. Furthermore, as seen in the Ordre des Psychologues du Quebéc (2012) psychotherapy survey, the general population believes that psychologists should be consulted foremost for anxiety and depression. Additionally, 76% of the surveyed general population in Quebec indicated that a referral from a family physician should not be required for access to psychotherapy. Therefore, given both the previous data concerning public attitudes, as well as the present data indicating support for multiple points of referral, this is an important consideration in developing a government-funded psychotherapy model.

Money Matters

Psychotherapy Fees

Where We Stand Now: Psychotherapy Fees.

Results from our study concerning private practice indicated that individual therapy fees ranged from $45.00 to $160.00 per hour, with an average of $95.10 (*Mdn* = 87.50; *SD* = 16.69) for individual therapy, and an average of $107 (*Mdn* = 90; *SD* = 29.40) for couple therapy (Bradley et al., 2016a). These are generally lower than what is found in other provinces,

potentially due to the very dense population of psychologists in Quebec, leading to competitive rates, or it may be part of a larger trend of health professionals being paid less in Quebec (see Bradley et al., 2016a; Canadian Institute for Health Information, 2013). These lower fees may however have the advantage of facilitating access to services by individuals who have lower incomes. According to the OPQ, individuals should expect to pay between $80 to $120 per (therapy) session (see www.ordrepsy.qc.ca/pdf/Brochure_Psychotherapy_Asking_the_right_questions.pdf). This estimate of the OPQ, which is not grounded in evidence gathered from a systematic data collection, roughly falls within one standard deviation of the actual rates reported by practitioners, and as such excludes over 30% of practitioners. Our data indicated that fees between approximately $60 and $130 would include 95% of practitioners; as such, the rates reported by the OPQ may be somewhat misleading to the public, as services are available at a much lower rate than what they report. It remains to be seen if these lower rates are tied to practices outside urban areas. Our data do show, however, that the rates are related to level of training and years of experience. Respondents with a doctoral degree reported charging more per hour for both individual and couple therapy in their private practice (Bradley et al., 2016b). While the difference between master and doctoral level practitioners was significant, it remained quite small, with those at a master's level indicating $90.00 per hour as the median amount for individual therapy and $100 dollars for couple therapy, and those at the doctoral level charging $100 as the median amount for individual therapy and $120 for couple therapy (Bradley et al., 2016b). Years of experience was also found to be related to fees, with those with the least years of practice (less than 10), and those with between 11 and 20 years of practice charging significantly less per hour for private individual therapy than those with 20 or more years of

practice. Again this difference was significant but was small (median amounts of $90 versus $100). Other differences included those with a CBT orientation reporting higher fees for individual therapy in private practice than those of a humanistic or psychodynamic orientation (Bradley et al., 2016b).

The Future: Fees in a Government-funded Model.

When asked what the lowest fee that would be acceptable if predetermined by the government, the average was $87 (*SD* = 13.94), whereas when asked what the participants would charge if they were to determine their own fee, the average was $98 (*SD* = 16.79) (Bradley & Drapeau, 2014). These results suggest that respondents have expectations that are closely related to their current work conditions, as the fee they would demand is comparable to the rates they normally charge in private practice.

Marginal differences between groups within the sample were found. In comparing participants working in a public versus a private setting, those in a private setting reported a higher predetermined minimum hourly fee (median of $90 versus $85) and independently determined fee (median of $100 versus $95) in a government-funded model of psychotherapy. Those with a doctoral degree reported a higher acceptable predetermined fee in a government-funded model of psychotherapy (median $90 versus $85) as well as a higher fee if determined by the practitioner (Bradley & Drapeau, 2016). This is to be expected as doctoral level psychologists have completed significantly longer training than master's level psychologists and have as a result greater expertise in diverse areas, thereby justifying a higher fee. Those with the least years of practice (less than 10) indicated a lower acceptable fee compared to those with more experience in a government-funded model of psychotherapy, both if predetermined by the government-funded program (median of $80 versus $90), and if determined independently by the

practitioner (median of $90 versus $100) (Bradley & Drapeau, 2016). This again mirrors the higher private practice fees found in those with more years of experience.

Evidence-Based Practice (EBP)

Where We Stand Now: EBP.

The use of evidence-based practices (EBPs) has become a core principle in the practice of psychotherapy over the last 15 years (Drapeau & Hunsley, 2014; Hunsley, Elliot, & Therrien, 2014; Kazdin, 2008), as has the translation and implementation of research into the clinicians' therapy rooms (Beauchamp, Drapeau, & Dionne, 2015; Stamoulos, Reyes, Trepanier, & Drapeau, 2014; Tasca, Grenon, Fortin-Langelier, & Chyurlia, 2014). Results from our investigation of psychologists and psychotherapists in private practice in Quebec indicated a low level of use of evidence-based clinical tools such as validated measures to track treatment progress (e.g., Beck Depression Inventory, PCOMMS, OQ-45) and manualized treatments, established clinical guidelines, and validated assessments tools (personality inventories, formal diagnostic inventories, projective tests) (see Bradley et al., 2016a). Two thirds of this sample reported to 'never' or 'rarely' use any of the aforementioned clinical tools. This is not surprising as rates of implementing clinical tools such as progress/outcome tracking measures and particularly clinical guidelines remain low (see Hatfield & Ogles, 2004; Mullen & Bacon, 2004), and others have commented on the increased difficulty of translating tools such as progress monitoring measures into private practice (Ionita & Fitzpatrick, 2014). Results of these studies serve as another indicator of the level of implementation of tools to enhance EBP. Drapeau and Hunsley's (2014) comprehensive editorial on the state of scientifically informed clinical practice highlights the many challenges and present shortcomings in this area. Particularly of note is the lack of available high quality clinical guidelines that amalgamate and recommend clinical

interventions based on the best available research evidence. It is recommended by the CPA Task Force on EBP (see Dozois et al., 2014) that clinicians use the best available research to inform all stages of clinical practice, however this can be an overwhelming task for individual clinicians (Drapeau & Hunsley, 2014). Best practice guidelines would therefore lessen this burden, as practitioners could find the best available clinical recommendations based on scientific rigour all in one place. This begs the question why our field has fallen behind others, such as medicine, in implementing the use of best practice clinical guidelines. Perhaps psychology practitioners are not aware of best practice guidelines or that these are not developed and promoted in an easily accessible way. Stamoulous and colleagues (2014) reviewed the clinical guidelines developed by the OPQ and found that these guidelines were of low quality and not developed based on a rigorous review of the literature on best practices. This lack of rigor undercuts the very nature of scientifically informed best practices. While the field of psychology in name and principle is based on rigorous science, in order to translate this to the everyday clinician the scientific literature not only needs to be utilized, but be made easily accessible in a format that maintains scientific rigour. Furthermore, scientifically informed practice needs to be present at all levels, including that of the organizational bodies producing the recommended best practices.

Our data also indicate that the most frequently used clinical tool in our survey of private practice was a 'self-developed assessment inventory', which is presumably not validated (Bradley et al., 2016a). This is problematic as it raises questions in terms of the validity and reliability of the tools being used and the scientific rigour that practitioners bring to their clinical services. If our field wants to move more in the direction of evidence-informed practice, integrating scientifically validated tools for assessment and diagnosis is an important component. Without accurate assessment and diagnosis, we are not able to properly document the

populations being served. Furthermore, the CPA Taskforce on EBP includes in its definition the monitoring and evaluation of clinical services. Without validated measures to track treatment progress and outcome we cannot formally measure treatment success or failure.

Doctoral level private practitioners reported using validated clinical treatment tools (e.g., progress tracking measures, manualized treatments, formal diagnostic inventories, personality inventories) significantly more frequently than those with a master's degree (see Bradley et al., 2016b). Similarly, practitioners with fewer than 10 years of practice reported more usage. This trend may also be linked to level of training since in our sample 78% of those with more than 21 years of practice were at the master's level and only 48% of those in their first 10 years of practice are at the master's level. Highlighting scientifically informed practice is potentially a core difference in the training of those at the doctoral and master's level or an indication of a cultural change in the training of new professionals compared to training over twenty years ago.

Similar results related to differences in level of education in the use of manualized treatments, attitudes toward evidence-based practices and awareness of progress monitoring measures can be found in the literature (Aarons, 2004; Ionita & Fitzpatrick, 2014; Wallace & von Ranson, 2011). Furthermore, increased years since graduation has been found to be related to less awareness of progress monitoring measures (Ionita & Fitzpatrick, 2014), and those with fewer years of experience have been found to have moderately more favourable attitudes toward evidence-based practices (Addis & Krasnow, 2000).

Finally, in comparing theoretical orientation, those endorsing a CBT orientation reported more frequent use of many of the aforementioned validated clinical tools (e.g., manualized treatments, validated assessment and diagnostic inventories, and validated progress tracking measures) than those of a psychodynamic and humanistic orientation (see Bradley et al., 2016b).

Endorsing a CBT framework has also previously been seen as a factor related to increased acceptance and use of manualized treatments and openness to evidence-based practices (Addis & Krasnow's, 2000; Becker, Smith, & Jensen-Doss, 2013; Stewart & Chambless, 2007). This again may be an indicator of the cultural change in terms of training new practitioners, as the influence of CBT has been steadily rising (see Norcross & Karpiak, 2012). Getting buy-in for the use of validated tools in treatment may be easier with those endorsing a CBT framework.

The Future: Evidence-based Practice in a Future Government-funded Model.

Progress and Outcome Tracking using Validated Measures.

In addressing attitudes towards the components of a future government-funded model of psychotherapy (see Bradley & Drapeau, 2014), practicing clinicians licensed in Quebec, in both the public and private sectors, were asked to indicate their favourability toward the use of mandatory outcome tracking, and making non-identifiable outcome data (treatment success or failure) available to the public. This is a core component of the government-funded psychotherapy model in the UK (Clark, 2011) and is also included in the Australian government-funded mental health programs (Australian Government Department of Health, 2015a; Australian Government Department of Health, 2015b; Pirkis et al., 2011). Only slightly more than half of the Quebec sample were in favour of outcome tracking, and attitudes toward tracking and publishing treatment *satisfaction* were more favourable. This indicates some openness to accountability in offering psychotherapy services, but also some hesitation or resistance.

Similar to the trends listed above, those at the doctoral level had more favourable attitudes toward the use of validated scales to track treatment outcome in a government-funded psychotherapy model (see Bradley et al., 2016b). Additionally, those with less years of experience had more favourable attitudes toward the use of validated outcome tracking tools to

measure global functioning in a government-funded model of psychotherapy. Interestingly, those with the most years of experience, compared to those with the least years, were more in favour of assessing treatment satisfaction in a government-funded psychotherapy model. This is a perplexing finding, as those with the most experience were less open to formal outcome tracking, but more in favour of tracking treatment satisfaction. This may be due to the lack of exposure to these validated outcome measures. Those with the most experience seem to be indicating openness to treatment accountability; however this is through treatment satisfaction as opposed to formal outcome tracking. This potentially reflects a difference in terms of current versus past training of psychologists and psychotherapists. It is possible that the profession has become more medicalized, focusing more on formal outcomes that track symptoms and less on the opinion and satisfaction of the client.

Finally, those in the public sector were more in favour of formally evaluating practitioner competency, and using validated tools to assess treatment progress and outcome than those in the private sector. This shows more of an openness or comfort level with accountability and formal tracking of progress among those working publicly, or potentially highlights the differences in terms of the culture of documentation in the public versus the private system. Therefore, it would seem that buy-in for using these tools to track progress and outcome would more easily come from those working publicly, and there may be more resistance from those in private.

Evidence-based Treatments and Clinician Choice in a Government-funded Model.

Attitudes about clinician choice in determining the treatment approach to be used in practice in a government-funded model were assessed. Current government-funded models, such as the IAPT program in the UK, mandate the use of treatments recommended through the NICE guidelines (Department of Health, 2008d; Department of Health, 2008e) and the

Australian programs place the use of evidence-based practices at the forefront of their models (Australian Government Department of Health, 2015a; Australian Government Department of Health, 2015b). In our sample, the participants most strongly agreed with the clinician choosing any treatment approach and treatment materials he/she deemed appropriate, indicating a sense of autonomous decision-making in clinical practice. While the majority (64%) also indicated agreement with only using treatments deemed evidence-based as assessed by a neutral agency based on scientific evidence, this had less favourable agreement than total clinician choice. Furthermore, choosing only among psychotherapy approaches that are preapproved by the government-funded program (such as the NICE guidelines in the UK model) received the least favourability, with 54% being in favour of this. There was strong resistance to using treatment materials preapproved or mandated by a government-program (e.g., specific psychoeducation material, self-help books). Taken together with the results from the private practice survey on the use of validated clinical tools, these results generally indicated the current minimal use of manualized treatments, and validated assessment and progress/outcome tracking tools, as well as the mixed attitudes toward the use of specific evidenced-based treatments and outcome/progress tracking measures.

Finally, those in the private sector, compared to the public were in stronger agreement that treating clinicians in a government-funded model of psychotherapy should choose any psychotherapy approach they deemed appropriate. Those in the public sector compared to private had more favourable attitudes to only being able to use treatments approved by the government, and using treatments that were evidence-based. Again, we may be tapping into a phenomenon of comfort with accountability, restriction, or regulation among those in the public sector and a sense of autonomy and choice in those working privately.

We now turn our attention to the idea of autonomy in practice, as evidenced through the attitudes of practitioners concerning aspects of a future government-funded model. Specifically, the results in terms of the role of the treating practitioner in relation to a referring family physician, as well as attitudes about payment and hiring structure, provide insight into psychologists' and psychotherapists' sense of independence, or autonomy, in their psychotherapy practice.

Practice Autonomy in Psychotherapy: Looking to a Future Model

Interesting themes were apparent in the examination of the results of the two survey studies in terms of a sense of practice autonomy, particularly in the differences among practitioners based on level of education, work setting, and years of experience. A greater sense of autonomy, or independence in clinical decision-making, across multiple variables were seen in those in their later years of practice, those practicing privately and those with a doctoral degree. In conjunction with this, we saw that those in the public system and those earlier in their practice were more comfortable with what we may consider 'regulations', restrictions or predetermined aspects of psychotherapy practice (e.g., lower predetermined fees, predetermined treatment approaches, use of specific measures).

The Role of the Psychologist/Psychotherapist

Attitudes toward the role of family physicians in a government-funded model of psychotherapy were assessed. The family physician plays an integral role in the UK model (Clark, 2011), and particularly in the Australia government-funded psychotherapy models (e.g., referral must come from a physician, and the family physician can make decisions regarding the treatment plan and length of treatment) (Australian Government Department of Health, 2015a; Australian Government Department of Health, 2015b). Generally speaking, the psychologists

and psychotherapists in our sample were in strong agreement that it is to the discretion of the treating psychologist/psychotherapist, not the referring family physician, to decide the type and length of treatment, and to conduct a follow up meeting after treatment termination (see Bradley & Drapeau, 2014). It is not surprising that the practitioners in our sample believe that clinical decision-making regarding psychotherapy treatment should be the responsibility of the treating psychology practitioner, given the years of specialized training in the provision of psychotherapy treatment. As outlined by Murdoch, Gregory, and Eggleton (2015) clinical and counselling psychologists have substantially more training in the foundational knowledge of psychological science, and substantially more practical hands-on training in mental health care than physicians. In Canada, most medical programs require approximately 275 training hours in mental health, as opposed to the 1500 – 3000 hours required by doctoral psychology programs. It therefore comes as no surprise that often physicians feel ill equipped to manage mental health concerns in general practice settings (see Murdoch et al., 2015). In addition to this, psychologists working within the ATAPS program in Australia have commented negatively about the decision-making power given to family physicians in making treatment decisions and have voiced concerns that decisions regarding treatment should be left to the treating clinician (Pirkis et al., 2006b). This has been ameliorated in some cases by having the treating psychologist present with the family physician when doing the review meeting for deciding about additional sessions, and making this decision jointly. This information, along with the attitudes of psychology practitioners needs to be integrated into building the structure of a future government-funded psychotherapy model. Interestingly, the strong agreement with psychology practitioners having a leading decision-making role in the recent survey study was stronger in some groups of practitioners than others.

Differences Based on Education.

Those with a master's degree were more open to the referring family physician deciding the type and length of treatment and conducting a follow-up session after treatment termination compared to those with a doctoral degree, whereas those with a doctoral degree had stronger opinions that the treating clinician should decide the type of treatment (see Bradley & Drapeau, 2016). One has to wonder if this is a difference in competency in psychotherapy treatment based on training, or simply a difference in confidence and autonomy in decision-making. Regardless if there are true differences in competency of delivering treatments, what this could indicate is a greater sense of ownership in treatment decisions that may be engrained through the greater number of training years for those at the doctoral level. However, we must also consider the idea of greater openness to collaboration with other health professionals. Results of the private practice survey indicated that those with a master's degree were more likely to refer to a medical professional to rule out medical causes of anxiety and depression, which is congruent with best practices (Bradley et al., 2016a). These results indicate openness for collaboration, which aid in providing effective well-rounded care. However, taken together with the results of the role of the family physician in a government-funded model, this may also point to a comfort with other health professionals making important psychotherapy treatment decisions. Given the limited training other health professionals receive in regards to psychological science and hands on clinical training, this is concerning in the delivery of mental health care (see Murdoch et al., 2015).

Differences Based on Years of Experience.

Practitioners with twenty or more years of experience more strongly agreed that the treating psychologist should conduct a follow-up session, and more strongly disagreed that this

should be conducted by the referring family physician, compared to those in their first ten years of practice (Bradley & Drapeau, 2016). It is not surprising that after two decades of practice, participants in this group would feel strongly about the central role of the treating psychologist or psychotherapist. However, we must also consider a possible cultural change in our field towards more openness to collaborative practice between health workers. It is possible that a sense of collaboration with others is being instilled in the generation of practitioners in their early years of practice.

Differences Based on Work Setting.

Those working in a public setting had more favourable attitudes toward providing a mid-treatment report to the referring family physician, as well as the family physician conducting the follow-up session in a government-funded model of psychotherapy, whereas those in a private setting compared to the public, more strongly believed that the treating psychologist/psychotherapist should conduct the follow-up (Bradley & Drapeau, 2016). This potentially highlights the culture of collaboration, and multidisciplinary treatment that may be more greatly instilled in the public system as opposed to the private system where collaboration is particularly difficult. As seen from the results of the private practice survey, the need for access to psychiatrists and family doctors for referral and consultation is high among private practitioners (Bradley et al., 2016a). It is a challenge for collaborative needs to be met in the private sector, and the availability of other health professionals in a public practice team may foster collaboration between psychologists and psychotherapists and other health professionals.

Payment and Hiring Structure

A potential hiring and fee structure for a government-funded model of psychotherapy, such as being hired on a salaried basis to offer services or reimbursing clients that seek services

privately, was assessed. Generally speaking, there was agreement that services should be offered across diverse work settings (i.e., independent private practice, public setting). We could see a trend of those working publicly having stronger agreement with services being offered in public settings, and conversely stronger attitudes for services being offered privately among those currently in private practice (Bradley & Drapeau, 2016). Generally there was more favourability for the individual practitioners to be preapproved and registered to offer services through a government-funded psychotherapy model, as opposed to certain work sites being preapproved and registered. This speaks to the idea that independent practitioners want to be included in the government-funded program, but want to maintain their current independent work conditions and not necessarily be registered with a certain work setting. Generally, among all participants there was more favourability in being paid on a session-to-session basis, as opposed to being hired full or part-time by the government-funded program, and more favourability in the practitioner's determining their own fee. This is another indicator of the expectations around compensation and autonomy in delivering services.

Differences based on Work Setting and Years of Experience.

Those working privately and those with more years of experience showed a greater sense of independence in practice, and more resistance to being hired on salaried basis. These two groups of practitioners had stronger agreement that a government-funded psychotherapy program should include services offered in independent private practice than those with less years of experience and those currently working publicly. Participants in private practice and with the most years of experience rated being paid on a session-to-session basis more favourably than those working publicly and those with less years of experience. Conversely, those with less years of experience and those currently working in the public sector rated being hired part or full

time on a salaried basis more favourably compared to those working privately, and those with more years of experience. Additionally, private practitioners were less in favour of a predetermined set fee in a government-funded model of psychotherapy (if paid on session-to-session basis), and had stronger attitudes towards setting their own fee than those currently working publicly. This again speaks to the potential acceptance or comfort level in those in the public setting for systemic 'conditions' or 'restrictions' in terms of practice. While there was generally favourability in being paid on a session-to-session basis and in determining one's own fee, we see that this sense of autonomy in terms of hiring and rate setting was more pronounced in those working privately and those with more years of experience. Essentially, these practitioners want more control over setting their own fee and being paid on a fee for service basis.

The theme of corresponding attitudes between practitioners with more years of experience, and those in the private sector is not surprising, as there is overlap in these groups (67% of those with more than 21 years of experience are primarily in private practice; 54% of those with between 11 and 20 years of experience are primarily in private practice, and only 40% of those in in their first 10 years of practice are primarily in the private sector; see Bradley & Drapeau, 2016). Furthermore, results from our survey on private practice indicated that those with the most years of experience spent significantly more time in private practice per week than those with less experience, again potentially pointing to a link between more years of practice and a move to increased private work (see Bradley et al., 2016b). Further investigation could examine which characteristics, work setting or years of experience, better account for the levels of variance in the overlapping themes found in these groups (i.e., higher fees, being paid on a fee for service basis).

Summary Discussion of Highlights and Current Challenges

Taken together these results are an important snapshot of the current culture of psychotherapy practice in Quebec. Psychologists and psychotherapists strongly believe in the need for increased access to their services, and believe that these services should be partially or fully paid for through government funding. They also believe that they should have a central role in clinical decision making within a government-funded model of psychotherapy, while also showing openness to collaborate with others, and to be informed by evidence-based practice.

The information concerning private practice indicated that some populations, such as children and youth and the elderly are underserved, and that there is a need for increased collaboration between private practitioners and medical doctors. We see that family and group therapy are not the mainstays of private services (see Bradley et al., 2016a). We also see that many individuals that do receive any psychotherapy services privately often self-refer and have insurance to partially or fully cover their services. Finally, along with these general themes we see that education, years of experience, work setting and theoretical orientation influence such things as the populations served, openness and use of validated clinical tools, differences in psychotherapy fees, and differences in beliefs about autonomy in practice. While differences are expected, these can also point to challenges or implications for the development of policy initiatives surrounding mental health service delivery, the principles and initiatives of our professional psychology organizations, and in shaping training programs and continuing education.

Implications for Public Policy and Accessibility Initiatives

A government-funded model of psychotherapy must take into account the needs, attitudes, and current practice characteristics of psychologists and psychotherapists. This includes

information concerning the current rates of private psychotherapy services, and what would be considered acceptable in terms of a payment structure. We see that psychologists and psychotherapists are more in favour of setting their own fees, and being paid on a session-to-session basis, with some also being open to being hired full or part time on a salaried basis. It is important to take into account that many psychologists and psychotherapists currently offer services privately and that there is strong agreement in offering government-funded services in both a public and private settings. This mirrors the models developed in the Australian context (Australian Government Department of Health, 2015a, 2015b; INESSS, 2015). Also, multiple points of referral to receive government-funded services are favoured by these practitioners, not solely through a physician, which in turn in more related to the UK's IAPT model.

Developers and funders of government-funded programs must look to the information concerning the number of sessions psychologists believe should be covered annually, which our data represent as a wide range, such as five sessions and up to twenty-two sessions. However, the data from private practice indicate that typical treatments can last up to approximately twenty sessions, which is more than what is typically covered in the programs in the UK and Australia (Department of Health, 2008b; Pirkis et al., 2011).

Looking to the information psychology practitioners provide in terms of prioritizing services, such as the mental health problems and age groups to be prioritized (e.g., anxiety and mood disorders; adolescents), is important. However, looking to the populations not being served routinely in private practice (e.g., children and the elderly, those with psychosis and pervasive developmental delays) and may be in great need for services, is equally as important.

Finally, much information was provided through these studies that relate to the types of psychotherapy treatments to be offered if funded by the government. Evidence-based treatments

outlined in the NICE clinical guidelines for stepped care treatment of mood and anxiety disorders are at the core of the UK model of government-funded psychotherapy (Clark, 2011; Department of Health, 2008a). The models in Australia are also guided by evidence-based practices (see Bradley & Drapeau, 2014, for discussion of these models). Another important cornerstone of these programs is tracking treatment progress and outcome (Clark, 2011; Pirkis et al., 2011). In our samples the use of manualized treatments, clinical guidelines, and validated measures to assess and diagnose as well as track treatment outcome and progress is infrequent in private practice. However, psychologists and psychotherapists indicated some openness to the use of evidence-based practices in a government-funded psychotherapy model, and outcome tracking. This openness was balanced by the fact that there is also a strong belief in clinician choice of treatment. If these models are to be founded on evidence-based practices and if accountability through outcome tracking is to be a core principle, how can we get buy-in from the practitioners? Increased training on outcome tracking, and increased knowledge and dissemination of clinical guidelines or manualized treatments may be necessary. This may be promising, as we have seen that many are open to evidence-based practices. However, practitioners must also have a sense that they have some autonomy in terms of clinical decision-making. This would include deciding the type and length of treatment and not leaving this to the discretion of the family physician.

The Impact of Differences Among Psychology Practitioners.

In terms of incorporating evidence-based practices and using treatment progress and outcome tracking measures and validated clinical tools, we can see that practitioners at the doctoral level, those in their earlier years of practice, and those endorsing a CBT orientation use these tools more frequently. Along with those working in the public sector, these practitioners

are also more favourable of the use of outcome tracking measures in a government-funded model of psychotherapy. These findings point to fundamental differences in approaches to evidence-based treatments. As more professionals are being trained at the doctoral level, as well as the rise in the influence of CBT, we can see the influence of these trends on new practitioners. In order to incorporate those with more years of experience, those working privately, and those at the master's level into a model focused on evidence-based treatments, initiatives need to be put in place to increase the knowledge and use of these tools. Developers of a government-funded psychotherapy model must take into consideration those practitioners with less knowledge, use and openness to these and have creative means to get buy-in from these practitioners.

As highlighted earlier, increased treatment autonomy in terms of clinical decisions, setting fees, and being paid on a fee-for-service basis was seen in those with more years of experience and those in private practice. This is important to consider if there is a hope of incorporating those currently in private practice and those with many years of clinical experience into government-funded initiatives. Furthermore, these practitioners, as well as those with a doctoral degree have stronger beliefs in terms of the integral role of the treating clinician over that of the referring physician. Honouring this sense of treatment autonomy among these practitioners will be an important component of a successful model, particularly as we see more and more experienced clinicians taking on more private work (see Bradley et al., 2016b).

Conversely, as those in the public sector are currently more open to the idea of approved treatments or treatments that are evidence-based, as well as being more open to a predetermined fee, and more open to being hired on a salaried basis, it may be easier to recruit these practitioners into a model under these conditions. Also, those with a master's degree and less years of experience currently charge less privately. Furthermore, these practitioners, as well as

those currently working publicly, are more accepting of a lower fee if paid through government funding. While this may seem advantageous to funders and developers, this must be balanced with other information concerning these practitioners, such as less use of evidenced-based clinical tools in those with a master's degree, and simply less years of experience.

Implications for Professional Psychology and Training

Across the results of these studies we see a phenomenon that we may label as autonomy or independence versus complacency or collaboration. Those with more years of experience, those with a doctoral degree, and those currently working in the private sector have showcased this sense of autonomy across variables such as clinical decision-making and fee setting. Those at the master's level and particularly those currently working publicly have shown more openness to others having decision-making power over them, such as a predetermined fee, physicians making important treatment decisions, using mandatory outcome tracking measures, or being open to having certain treatments preapproved for a government-funded program. The only caveat is that those at the doctoral level are more open to using validated measures to track treatment.

These differences have advantages and disadvantages. While it may seem that those with less years of experience and with a master's degree are more open to collaboration and understanding of restrictions within a public model, this may also indicate complacency or a sense of disempowerment. The willingness to accept lower fees, and to fit one's clinical decision making into a predetermined model may also reflect a loss in sense of autonomy and a state of passivity among these practitioners. The public health system in Quebec in the recent past has seen backlash from health practitioners, including psychologists, in terms of compensation and work conditions (see www.apqc.ca). If we are to retain doctoral level and

experienced practitioners in a public system, autonomy and proper compensation in practice must be considered (Bradley et al., 2016c).

On the other side of this is the tendency for those in private and those with many years of experience to gravitate toward increased autonomy and to demand higher compensation. While this is positive in terms of showcasing the confidence in the training and skills of psychology practitioners, is it possible that this sense of autonomy can also work against best practices, such as incorporating outcome tracking and using evidence-based treatments. Additionally, we must consider the fact that many private practitioners face barriers in terms of collaboration with physicians, therefore potentially forcing a sense of autonomy, as there is no other choice. We must find a way to strike a balance in our field in terms of complacency or submissiveness and over-confidence in one's independent decision making. We must focus on fostering a sense of confidence in clinical decision-making as well as enhance collaboration and multi-disciplinary care and the use of evidence-based practices for all of our practitioners.

Fostering a sense of confidence in the role of the psychologist or psychotherapist may need to begin at the training level, or be fostered through continuing education initiatives. We saw from our previous investigation into private practice that those at the master's level and those at the doctoral level differed in their frequency of treating certain disorders (master's level treating DSM disorders less frequently, and treating comorbid conditions less frequently; Bradley et al, 2016b). What this tells us, along with the differences in use of validated clinical tools (diagnostic, assessment, progress monitoring tools), is that the scope of practice may be different between these two groups of practitioners. This needs to be investigated further to gain a greater understanding. If the scope of practice is different, and can lead to differences in terms of confidence in a psychologists or psychotherapists role in psychotherapy treatment, the

profession needs to address this. Perhaps providing mandatory continued training concerning assessment and diagnosis and the use of evidence-based clinical tools to those with a master's degree.

Additionally, targeting those in their later years of practice and those in private practice to provide training and increased incentives in the use of evidence-based practices and outcome/progress monitoring may be necessary. If these are to be core components of publicly funded psychotherapy, getting buy-in from these professionals is imperative. More generally, beyond the scope of publicly funded psychotherapy, perhaps our psychology boards and associations should work to increase knowledge and use of evidence-based clinical tools, particularly among those populations using these infrequently in the name of scientifically informed practice.

Finally, as a profession, our professional associations and training institutions need to work to increase collaborative care, particularly for those in private practice. Others in the medical field have highlighted the need for increased collaboration and coordination between physicians and mental health care workers in Quebec (Fleury, Bamvita, Farand, & Tremblay, 2008). It has been found that 50% of family physicians in Quebec have no contact with resources in mental health, and factors related to fostering coordination with mental health services include working in hospital settings and having informal relationships with mental health professionals (Fleury, Farand, Aube, & Imboua, 2012). Craven and Bland (2006) have also found that pre-existing relationships and in-person contact between professionals can enhance collaboration. Within our training programs, continuing education opportunities and involvement with psychology associations we must work to increase face-to-face communication and interaction between psychology practitioners and family physicians and psychiatrists,

particularly for those in private practice as these professionals are increasingly isolated from collaborative care.

Limitations and Future Directions

There are a number of limitations to be considered in the four studies. While it is a strength of the recruitment process of these survey studies that all individuals meeting the criteria of the two survey studies with a functioning email address were sent the recruitment email, there is the potential for response bias. There may be differences in those who chose not to respond to the private practice survey or accessibility survey that are not captured in the present studies.

Generally speaking the two samples captured in the two survey investigations were generally representative of those practicing in Quebec (see Bradley & Drapeau, 2016; Bradley et al., 2016a; 2016b). However, the private practice survey had a response rate of approximately 20% (Bradley et al., 2016a) and the accessibility survey had a response rate of 26% (Bradley & Drapeau, 2016). While email recruitment for survey research tends to have a range of response rates (24%-76%; see Sue & Ritter, 2007), it would have been ideal to have a slighter greater response rate specifically for psychotherapists in order to be wholly generalizable (Bradley & Drapeau, 2016; Bradley et al., 2016a; Direction Research, 2011).

Further investigations into psychological practice in the broader Canadian context are needed as the present data are focused on the Quebec climate and may be difficult to translate to other settings. As outlined in Bradley and colleagues (2016a, 2016b) and Bradley and Drapeau (2016), Quebec has a unique social and clinical context, with the most licensed psychologists in any province in Canada, a larger representation of those espousing a psychodynamic orientation (Jaimes et al., 2015), lower psychotherapy fees compared to other provinces, and the requirement of functional French to become licensed. To gain a better understanding of private practice

across Canada, and attitudes towards favourable models of government-funded mental health care, as well as any differences based on regional jurisdictions, further research is needed.

Additionally, as the current investigations of documenting psychotherapy practice have focused on the private sector, exploring the treatments offered, length of treatment, use of evidence-based practices and clinical tools, as well as the collaborative relationships within the public sector is important to gain a holistic picture of psychotherapy practice in Quebec. It would be important to examine the differences that exist currently in public and private practice and the implications of these differences. Furthermore, investigating differences in the practice of psychotherapy between rural versus urban settings could provide insight into the specific trends and needs in rural practice to better tailor resources and initiatives to meet needs in these areas. Finally, as family physicians play a central role in current mental health care in Canada, documenting their perspectives on their role in a government-funded model of psychotherapy treatment can only serve to better inform the development of programs such as these.

Through the integration of information gathered in the current studies, as well as future investigations focused on psychotherapy practice and service delivery models, a greater understanding can be gained of the psychological workforce and the current nature of psychotherapy treatment. This can only serve to further inform initiatives targeted at meeting the mental health needs of those in Quebec, and the greater Canadian context.

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Appendix A: Manuscript 1 & Manuscript 2 Recruitment Email

PSYCHOTHERAPY IN PRIVATE PRACTICE

Dear colleagues,

We are writing to ask for your participation in a very important survey on the **practice of psychotherapy in the private sector**. Currently, there is little documentation of the characteristics of psychotherapy treatment in the private sector. As a licensed clinician who currently offers psychotherapy, we are hoping you will be able to provide such crucial information. Your input is of great value.

To participate in this study, you must be a **licensed psychologist or psychotherapist currently offering services (part-time OR full-time) in the private sector.**

This is a **short** survey estimated to take approximately **10 minutes** to complete. To thank you for your participation you can be entered into a draw to win 1 of 3 **Apple Ipad Minis**, valued at approximately $380.00 (odds of winning are ~ 1/150). Please click on the link below, or cut and paste the entire URL into your browser to access the survey.

Survey link: https://mcgilluecp.az1.qualtrics.com/SE/?SID=SV_82KHdSrF4xgquxL

Your participation is completely voluntary, and no identifying information will be included in any reports or communications of the survey data.

This project is part of a doctoral dissertation conducted under the supervision of Dr. Martin Drapeau at McGill University. Dr. Drapeau can be reached at 514-398-4904 or at martin.drapeau@mcgill.ca. If you have any questions about the survey or experience technical difficulties in accessing or submitting the survey please contact Stacy Bradley at stacy.bradley@mail.mcgill.ca.

Sincerely,

Stacy Bradley, MA
PhD Candidate, McGill University
McGill Psychotherapy Process Research Group
Homepage: http://mpprg.mcgill.ca/

Appendix B: Manuscript 1 and Manuscript 2 Informed Consent

The Purpose of the Study
The goal of this study is to gather information concerning the **practice of psychotherapy in the PRIVATE SECTOR in Quebec**. Your participation in this study will contribute greatly to this objective.

Informed Consent to Participate in Research
The current study "Psychotherapy in the Private Sector: The Quebec Context" is being conducted by Stacy Bradley, MA, PhD Candidate, under the supervision of Martin Drapeau, PhD. This study has received ethical approval by the McGill Research Ethics Board (REB Certificate- 170-1013).

What to Expect If You Participate in the Study
Your participation will involve the completion of a **~10 minute survey**. To thank you for your participation, you can be entered in a draw to win **1 of 6 Apple Ipad Minis**, valued at $380.00 (odds of winning estimated at 1/150).

Potential Risk
There are no foreseeable risks associated with participating in this study. Your participation is entirely voluntary and you may withdraw from the study at any time without penalty. If you do not feel comfortable answering a question, you have the option to skip it. As no identifying information is linked to survey responses, any survey data cannot be withdrawn once submitted.

Confidentiality and Privacy
To ensure confidentiality, no identifying information will be downloaded from the survey with your survey data. Your contact information (if provided for the chance to win an Apple Mini Ipad) will be stored separately from the survey data, and all electronic files will be stored on a password-protected computer, only accessible by the Principle Investigator Stacy Bradley, and supervisor Dr. Martin Drapeau.

The results of the current study will be written within a doctoral dissertation, and may be published in scholarly journals or at research conferences, or presented to social service organizations. **No identifying information will be published.** We encourage you to print a copy of the consent for your records.

Contact Information
If you have any questions or concerns, please contact the principal investigator: stacy.bradley@mail.mcgill.ca or Dr. Martin Drapeau: martin.drapeau@mcgill.ca. If you have any questions or concerns regarding your rights or welfare as a participant in this research study, please contact the McGill Ethics Officer at: (514) 398-6831 or lynda.mcneil@mcgill.ca.

__ I accept
__ I do not accept

Appendix C: Manuscript 3 and Manuscript 4 Recruitment Email

Should everyone have access to psychotherapy? If so, under what conditions? Should psychotherapy in private practice be reimbursed?

Dear colleague,

We are writing to ask for your participation in a very important **pilot projec**t concerning the perceptions of psychologists and psychotherapists licensed with the Ordre des Psychologues du Québec toward **accessibility to mental health care and government-funded psychotherapy**. As you may know, the Commissaire à la santé et au bien-être du Québec recently recommended increasing access to psychotherapy for those in need. Initiatives to increase access to psychotherapy have been successful in Australia and the U.K. and we are curious as to how this could be done in a Quebec context.

This is a **short** survey estimated to take approximately **10 minutes** to complete. To thank you for your participation you can be entered into a draw to win 1 of 6 **Apple Ipad Minis**, valued at approximately $380.00 (odds of winning are ~ 1/150). Please click on the link below, or cut and paste the entire URL into your browser to access the survey.
Survey link: https://mcgilluecp.qualtrics.com/SE/?SID=SV_bEGc46HeqkIDRjL

Your participation is completely voluntary, and no identifying information will be included in any reports or communications of the survey data.

This project is part of a doctoral dissertation conducted under the supervision of Dr. Martin Drapeau at McGill University. Dr. Drapeau can be reached at 514-398-4904 or at martin.drapeau@mcgill.ca

If you have any questions or experience technical difficulties in accessing or submitting the survey please contact Stacy Bradley at stacy.bradley@mail.mcgill.ca

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Appendix D: Manuscript 3 and Manuscript 4 Informed Consent

Informed Consent to Participate in Research
The current study "Government-Funded Psychotherapy and Mental Health Care: What Could Work in Quebec?" is being conducted by Stacy Bradley, MA (doctoral candidate at McGill University), under the supervision of Martin Drapeau, PhD. This study was approved by the McGill Research Ethics Board (REB Certificate- 145-0913).

The Purpose of the Study
The goal of this study is to gather information concerning the attitudes of clinicians licensed to practice psychotherapy in Quebec about **accessibility to mental health care and government-funded psychotherapy.** Your participation in this study will contribute greatly to this objective.

What to Expect If You Participate in the Study
Your participation will involve the completion of a **~10 minute survey**. To thank you for your participation, you can be entered in a draw to win **1 of 6 Apple Ipad Minis**, valued at $380.00 (odds of winning estimated at 1/150).

Potential Risk
There are no foreseeable risks associated with participating in this study. Your participation is entirely voluntary and you may withdraw from the study at any time without penalty. If you do not feel comfortable answering a question, you have the option to skip it. As no identifying information is linked to survey responses, any survey data cannot be withdrawn once submitted.

Confidentiality and Privacy
To ensure confidentiality, no identifying information will be downloaded from the survey with your survey data. Your contact information (if provided for the chance to win an Apple Mini Ipad) will be stored separately from the survey data, and all electronic files will be stored on a password-protected computer.

The results of the current study will be written within a doctoral dissertation, and may be published in scholarly journals or at research conferences, or presented to social service organizations. **No identifying information will be published.**

Contact Information
If you have any questions or concerns, please contact the principal investigator: stacy.bradley@mail.mcgill.ca or Dr. Martin Drapeau: martin.drapeau@mcgill.ca. If you have any questions or concerns regarding your rights or welfare as a participant in this research study, please contact the McGill Ethics Officer at: (514) 398-6831 or lynda.mcneil@mcgill.ca.

__ I accept
__ I do not accept