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A Competency Mechanism

Nick Drury 2017

Abstract

The primary purpose of the NZ Health Practitioners Competence Assurance Act (2003) is to "protect the health and safety of members of the public by providing for mechanisms to ensure that health professionals are competent and fit to practice their profession" (s3(1)). Although the NZ Association of Counsellors has voted against registration under the Act, it is exploring the development of a similar 'competency mechanism' to those developed by some registered professions. This mechanism is a form of 'panopticism', which has been subject to severe criticism by Foucault and other scholars. A review of the evidence shows neither licensing nor a 'panopticonian' mechanism of self-examination protects the public as intended; and an alternative mechanism of routine outcome monitoring is suggested. This places the practitioner more directly accountable to the client, and not a third party. It also positions counselling more favourably both economically and politically.

Key Words: Panopticism, Professional Regulation, Competence, Outcome Monitoring, Enactive Cognition, Whanaungatanga

This paper reviews the current trends within health professional regulation literature, with a primary focus on competence assurance. It will show the emergence of a new paradigm in philosophy, politics, and cognitive science that suggests a sea change in

how competency assurance might be achieved. The paper urges professional associations, such as the NZ Association of Counsellors, to adopt this change.

Historical Context

Since the 1950s union membership has been declining with a shift from production to service industries, accompanied by a growth in occupational regulation (Kleiner & Kruger, 2010). Bauman (2007) describes our rapidly changing post-industrial society as 'liquid modernity', which has been accelerating over the past 30 years due to the neoliberal agenda, which casts everyone as an entrepreneur in order to speed up the market. As Foucault (2008) foresaw, increases in entrepreneurship or market competition increases frictions, and this requires more judges to regulate the frictions (p. 139). Thus risk management has arisen to deal with these growing uncertainties (Beck, 1999; Power, 2007). Occupational regulation, as an aspect of this, has increasingly shifted from minimally restrictive forms of peer membership, to highly restrictive forms of licensing (or registration), where in the 'psy' disciplines, title and scope of practice are prescribed and monitored in some manner (Macleod & McSherry, 2007). Across the board "[o]ccupational licensing has been among the fastest growing labor market institutions in the United States since World War II" (Kleiner, 2015, p. 2).

This increasingly restrictive approach to occupational regulation would see neither Bill Gates nor Steve Jobs eligible for licensing as executives, as neither graduated from university. Closer to home, on the basis of his education Jay Haley would not be eligible for registration (or licensing) in any of the 'psy' professions, and might

struggle to gain membership of our NZ Association of Counsellors. Despite the available evidence failing to show that more highly trained ‘psy’ professionals are more effective than paraprofessionals (in some studies the paraprofessionals have done better), occupational regulations have continued to insist that continuing education makes more effective and less harmful practitioners (Malouf, 2012). Across the board, about 70 percent of all registered (licensed) occupations require continuing education, and in the health disciplines it is closer to 100 percent (Kleiner, 2015). Thus most health professions have chosen continuing education as the ‘mechanism’ for ensuring continuing competence; and although the NZ Association of Counsellors have voted not to pursue registration, they are favouring the same mechanism that other health-related registration boards have chosen.

A Protection Racket?

Tudor (2016) argues that the overprotectiveness of the “Nanny state”, such as we see in the state regulation of the psychotherapies, is an example of Eric Berne’s “protection racket”. As early as 1974 Pfeffer concluded that occupational regulation in this form is not shown by empirical evidence to be in the interests of the consumers or general public. Although we are led to believe that public outcries like the Cartwright inquiry or the Lake Alice adolescent unit scandal have driven the move to greater regulation, the initiative has more frequently come from within the professions themselves (Kleiner, 2006). Carl Rogers (1973) noted that “…tight professional standards do not, to more than a minimal degree, shut out the exploiters and the charlatans” (p. 383). Even Adam Smith (1776/2003) saw such guild activity as little more than a protection racket that claimed to protect the public but actually benefitted

the guild. He said it is “impertinent” and “oppressive” for the lawmaker to “encroach upon the just liberty” of the workman and his [sic] employer to decide whom the employer employ, and that crafts lengthen the apprenticeship to ensure higher earnings (chapter 1).

The medieval guilds were able to limit the number of individuals working in their industry, and thus drive up prices, and all evidence shows that exactly the same is occurring with this resurgence of occupational guilds. For example Milton Friedman (Friedman & Kuznets, 1945) showed that doctors, who had been able to restrict the number of practitioners, had been able to drive up their incomes in the early part of the twentieth century, compared to dentists, who hadn’t restricted their numbers. Kleiner (2015) shows the price of services increases by at least 15 percent by such restrictions, thus adding to the wealth disparity problem; which in turn is generating a lot of the social ills we are being called upon to address (Wilkinson & Pickett, 2009). Wealth disparity was at its lowest during the manufacturing era, as unions forced the sharing of profits. Kleiner and Krueger (2010) show the growth in wealth disparity matches the rise in occupational regulation. Our NZAC Code of Ethics (2002) calls upon us to “promote social justice” (5.2h), so it is difficult to see how we can justify succumbing to the current ‘group think’ on regulation.

Kleiner (2006) argued that if more regulated professionals were making fewer mistakes because of ongoing competence programmes, then their indemnity insurance would be lower. But there was no evidence that this was the case in any profession. Indeed Kleiner finds little in the way of evidence that the public are better protected by greater regulation of numerous professions, including mandatory ongoing

education requirements. Tudor (2011, p. 157) states that there “are some eleven books (and many more papers) that have rebutted this assumption” that the public of ‘psy’ services are better protected by licensing and regulation. Critics of licensing (e.g. Postle & House, 2009; Tudor, 2013) claim that those high profile public scandals, such as the Cartwright Inquiry, are better dealt with through other legislation such as the Human Rights Review Tribunal, or the Health and Disability Commissioner, as they are usually system failures rather than individual practitioner failures. Power (1999, 2007), like many family therapists, argue that current occupational regulation is just another expression of the neoliberal agenda of greater individualization and “responsibilization”, begun with Thatcher and Reagan, that shifts attention away from system failure.

Panopticism

A number of the ‘psy’ disciplines have become attracted to utilising a form of ‘panopticism’ as its mechanism for maintaining competence. These disciplines would have their members gaze into a mirror of standards or ‘core competencies’ to assess where they stand, and then make educational plans to improve their competency. The word ‘panopticism’ was coined by Foucault (1977) to describe a governance process invented by the early eighteenth century English politician and architect Jeremy Bentham. Bentham designed a prison where the guard tower was such that the guards could look into the cell of each prisoner, but the prisoners could not observe the guards. The prisoners are thus forced to gaze upon themselves, and discipline themselves, for they knew what the guards would reward and punish them for. Bentham thought it was generalizable as the perfect metaphor for the governance of

the whole population. Power (1999) claims just such a governance process became a reality by late nineteenth century as the management class entered the factories, and used forms of panopticism to regulate deviations from the most economic behavioural 'norms'. Foucault's claim is that this mechanism has been so successful we now have a self-surveilling society of 'fabricated' docile subjects monitoring ourselves for deviation from 'normalizing judgements'. These judgements are distributed in everyday conversation and institutional practices. Most counsellors have became aware of this through Narrative Therapy (White & Epston, 1989).

Some may question why Foucault (1980) called panopticism "diabolical" (p. 156); after all self-monitoring in the acquisition of most skills appears to be the usual process. Indeed, in the (Wittgenstein-inspired) five-stage model of skill acquisition developed by the Dreyfus brothers (1980, 1986), the initial stages involve the learner engaging in self-monitoring (or teacher-monitoring) activities; a constant referral to the rules. However, as expertise develops the rules are not internalised or increasingly abstracted as the earlier cognitivist paradigm of learning would have it, but replaced by perceptions (recognitions) of patterns to which the expert immediately reacts. Working memory is no longer needed (Feltovich, Prietula, & Ericsson, 2006). In other words we no longer rely on, or need conceptual or intellectual ('know that') knowledge to perform some task, but instead trust our intuition or performance ('know how') knowledge. The Dreyfus brothers (1986) demonstrated this by having a chess grandmaster playing multiple games (successfully), whilst adding numbers out loud. "Trust the force, Luke". Foucault (1977) calls panopticism a "cruel ingenious cage" (p. 383) because it traps us in a position of permanent self-monitoring; a neurosis if you like where we are constantly monitoring ourselves.

The idea that there is a widespread neurosis in western culture where we are constantly monitoring ourselves is neither new nor unique to Foucault. A century ago the first American psychoanalyst Trigant Burrow, put this idea forward in a unique and succinct form (1968). His core idea was that rather than see 'mother' as the 'love object' as Freud and company did, he saw mother as the 'love subject'. In other words he agreed with Freud and subsequent thinkers that we begin with "oceanic consciousness" or a sense of oneness or primal unity with 'mother' or the world; but differed in what was objectified. For Freud it was the breast that was objectified when it was no longer available but wanted, and hence mother became the 'love object'. The object we longed to be reunited with. But for Burrow the "Biblical fall" came when we objectified ourselves (not other), when we started developing ideas about ourselves. At that point we became divided, with part of us monitoring the rest of us. Unfortunately he saw that this division becomes permanent and chronic in most of us. He thought we still had a sense of unity or oneness with 'mother' or the world, so she remains the 'love subject' (i.e. part of us), and our task is to recognise our unity as beings. Like the Mahayana Buddhists, or the Foucault scholar Bourdieu (2000), there is a misrecognition of our collective condition, and how when we obtain mastery of something there is no longer a sense of self in the performance. As the Dreyfus brothers (1980) noted with the expert pilots: "rather than being aware they are flying an airplane, they have the experience they are flying" (p. 12). The car feels like part of me (I feel the wheels on the road) when I'm driving (Heidegger, 1962).

Bakhtin (1986), Bowen, (1978), Levinas, (1998), Merleau-ponty (1945/1996), Shotter (2016), and Wittgenstein (1958), have all proposed in their own way, the existence of

a primary intersubjectivity between us, or us and the world. They claim we have an innate disposition to bodily resonate with each other, present from birth. We don't infer someone is in pain, we see it immediately (Overgaard, 2007). We don't empathise and then react, as the simulation Theory of Mind would have it, but react immediately as if we ourselves had been hurt (Leudar & Costall, 2009). However when we develop what Merleau-ponty called our secondary intersubjectivity, our relationships become mediated through our symbols or intellect (Daly 2014). When we develop this ego or chronic self-monitoring we become less relationally responsive, and have to conduct our therapy through assessments and treatment plans, as there is no intuitive resonance with other. The parent is puzzled when the infant comes back from 'time out' and hits grandma again; the child is learning that it has the power to hurt, but the parent just sees 'good' or 'bad', 'right' or 'wrong'. If trusted, and grandma shows she's hurt, the infant will stop hitting as he recognises grandma's pain or withdrawal of coordination; for there is an innate 'ethic' to coordinate (Burrow, 1968; Levinas, 1998). Instead the infant is being taught to monitor itself, and the parents, for indications of 'right' or 'wrong' behaviour, and begins to develop an over-individuated 'self' in his desire to be a "good boy". For Levinas (1998) ethics is an innate response from within (which is obvious when we see a hurt child lying on the road), but morality is imposed from without.

Western culture rationalised this loss of primary intersubjectivity when Hobbes (1651/1996) declared that the state of nature consists of a "war of every man against every man". So Locke and Rousseau declared we begin as blank slates (i.e. no 'primary intersubjectivity'), dissociated from each other and in need of an agreement or contract to hold us together. Such social contract theories claim that we have

consented, either explicitly or tacitly, to surrender some freedoms in exchange for a society of security. But such contracts are the very thing keeping this social neurosis alive, for they are premised on the assumption of us being separate. As Tudor (2011) notes, most indigenous traditions begin with our unity with each other, our innate sociality. In Māoridom we call this ‘whanaungatanga’, our ‘us-ness’ or ‘we-ness’ if you like. It is ‘*ubuntu’* in Zulu, and in Korean “*shimcheong* means to become one in flesh and spirit” (Choi et al, 2007, p. 323). From the perspective of the Dreyfus skill acquisition model, we might say that there was a stage of awkwardness as we learnt some particular social skill, but once mastered we should have returned to a state of unity, harmony or resonance with others. However due to the constant self-judgement of panopticism we have become locked into a state of awkwardness. The social and ecological consequences are obviously now disastrous. Thus panopticism is ‘diabolical’ for it works against the generation of relationally responsive therapists (and people).

Competence and Expertise

Are competence and expertise the same? Certainly the skill acquisition model of the Dreyfus brothers indicates that mastery means achieving that state of ‘seamless’ performance where the pilot is flying, and not the plane. The tool has become an extension of the master. Similarly Polanyi (1974) saw competence defined by tacit rather than explicit knowledge, and that, like asking the millipede how it moved its 73rd leg, too much scrutiny destroys the skill (pp. 18-19). In the same vein, Wittgenstein attempted to show us that such ‘virtues’ show themselves, or are revealed in performance, far more than anything we can say about them (Moyal-

Sharrock, 2016). Alan Watts (1977) says the Taoists see the highest form of competence as a virtue called *te*, where “power is exercised without the use of force” (p. 121). He illustrates this by way of Chuang-tsu’s story of Prince Wen’s cook, who has never needed to sharpen his knife in nineteen years; for instead of cutting or hacking at the meat, he allows his knife to find it’s way through the gaps in the meat, and when it comes to a piece of gristle or bone, he allows it to slow down and find it’s way through the gaps there too. Prince Wen declares that from his cook he learns the way of life! A further example is found in Aristotle’s *Nichomachean Ethics*, where he suggests that heuristic devices such as *epistemes* (theoretical models we might say today), *technes* (rules or techniques), and *phronesis* (practical wisdom, good judgement, or prudence), are used in the acquisition of a skill. But once the skill is learnt these devices can be thrown away. In this respect, Keeney and colleagues (2012), call psychotherapy a “performative art”.

This line of thinking contrasts sharply with the more traditional western thinking of Plato, Kant, and Chomsky (amongst others) who argue that ‘expertise’ is the abstracting and internalisation of increasingly sophisticated rules. Chomsky sees tacit knowledge, not as performance knowledge (‘know how’) but as implicit rules that we are following but maybe not aware of. The metaphor of the computer is usually used in this paradigm of cognitive science, called ‘cognitivism’, which suggests there are rules in our programming, awaiting discovery. Now *cognitivism* became the model used by neoliberal risk managers in the development of ritualised procedures as a way of re-distributing responsibility and reducing the anxiety of blame. British nurses have been identified as early adapters to this transformation (Lees et al, 2013). By having all nurses completing a set of procedural tasks for all patients on a ward, and fewer by

one nurse for one patient, the nurse-patient relationship was transformed. A paint by numbers approach. This drove research in health practice towards *efficacy* rather than *effectiveness*; which meant accountability was assessed by the practitioner's adherence to 'empirically supported procedures' or 'best practice guidelines', such as those issued by the UK National Institute for Health and Care Excellence (NICE). Efficacy researchers wanted to eliminate the practitioner as a variable affecting outcome, and thus practitioners were deemed 'competent' if they did it by the numbers. This no doubt had considerable appeal to some forms of factory management. Unfortunately in mental health (especially) the person of the therapist far exceeded any method; thus demands by regulators to "excommunicate" practitioners who don't comply with empirically supported treatments (ESTs), which usually lie at the centre of efficacy studies, is not based on empirical evidence (Duncan et al., 2010; Wampold & Imel, 2015). Thus such efficacy approaches, which argue that competence is conformity with rule-based procedure, can be seen clearly as a form of defence "… to protect the organisation" (Szmukler & Rose, 2013). As such, we are ethically bound to resist this vision of 'competence', as the interests of the client are secondary to the safety of the organisation.

It is also not difficult to see how *cognitivism* or efficacy thinking has also appealed to the educators in our professions. If competence is defined as conforming with best practice standards and staying up to date with the newest treatment models, then there is opportunity to expand educational services to the industry. In a review of the outcome literature over the past 40 years, Scott Miller has found that drop out rates and number of clients getting better has not changed. He amusingly described this constant attendance to continuing education workshops as being like riding an

exercise bike, working up a sweat, but not getting anywhere (Thomas, 2014). To repeat, there is no evidence that continuing education improves effectiveness in mental health and addiction services, even if that claim can be made in mainstream medicine.

Fortunately, *cognitivism* has been superceded by the *e-cognition* paradigm in cognitive science (Menary, 2010; Noë, 2009). The "e" stands for 'enactive', 'embedded', 'embodied', and 'extended', and is the idea that as we have more nerves going to the senses than from them, we are using our senses like a blind man with his cane, to remain attuned to the task at hand. Like the Dreyfus learning model, with tasks we've mastered our attention, or 'mind' if you like, is flowing around an 'extended' circuit that includes objects in the world. There's no Cartesian 'self' standing apart from the activity. In therapy the conversation takes on a life of its own (Shotter, 2016). Competence doesn't lie in knowing how we moved our 73rd leg.

A Mechanism for Competence

Over the past fifteen years or so there has been a growing interest in client self-assessed outcome monitoring and management tools (Duncan & Reese, 2013). There is now an impressive array of empirical evidence that their use leads to massive reductions in drop out rates as well as improved outcomes for most counsellors (Duncan et al, 2010; Lambert, 2010). This evidence shows that services that utilize continuous feedback of "patient reported outcomes" (without clinician interpretation) can achieve levels of effectiveness that match or exceed those of clinical trials (Reese et al, 2014). Currently most services are not using these tools and members of the

public put at risk, as they are being led to believe by efficacy researchers that if practitioners are delivering an empirically supported treatment (EST) they have an 80% chance (or whatever the clinical trial outcome figure was) of benefitting from it; when in fact most 'real world' clinics are only achieving a 15% recovery rate on average (and some much less) (Drury, 2014). There are few pure "nails" in the 'real world'. Bohanske and Franczak (2010), who monitor most of the mental health and substance abuse practitioners in Arizona, found that eighty per cent of their practitioners showed remarkable improvements in their outcomes after these measures were introduced. As Sparks and colleagues comment, the use of these outcome management tools is in effect bringing clients to the front of the classroom as teachers of how to be more competent (effective) therapists.

With these outcome tools counsellors become more directly accountable to their clients, rather than to third party (e.g., NZAC) protocols. It's a shift from process-based accountability to outcome-based accountability. With growing emphasis on being transparent to the public (and referrers) just what our outcomes are, we are able to provide potential clients (and key stakeholders for that matter) with probably the most important informed consent information most will want; not "are you doing it by the book", but "how effective are you?". That is to say, the purpose of the Act, competence assurance, is *shown* by outcome rather than assessed by recipe compliance; for "the proof of the pudding is in the eating" (Duncan, 2010, p. 45). Brown and Minami (2010) argue that in a buyers market practitioners who offer outcome data will do better than those just offering 'compliance' data.

During this fifteen years of development of outcome-accountability, statistical techniques and computer programmes have evolved so it is now possible to generate trajectories of change on a session-by-session basis; where comparisons can be made of similar clients' progress from large databases of client change scores. Agencies, or professional organisations for that matter, can develop new outcome measures "on the trot" so to speak, which allows greater flexibility in making comparisons or dealing with specialist populations (Lambert et al., 2013). Through the use of what's called the Reliable Change Index (RCI) individual therapists can not only monitor their comparable effectiveness with colleagues, but also their own for different periods of the year or their career; or compare their effectiveness on client variables such as gender, age, or a specialist population (Lambert, 2010).

Some have expressed concern that outcome measurement is vulnerable to 'gaming' (Bevan & Hood, 2006; Mays, 2006; Hood, 2011; Saul, 2013). This is obviously considerably reduced when it is the clients who complete the outcome monitoring forms, rather than the clinicians. Nonetheless, it is a necessary consideration. If outcome management was administered by the NZAC then a further check to the system would be to implement 2- and 5-year follow-ups of outcomes, as Seikkula and his team do in their work with psychosis (Seikkula et al., 2006). Although false advertising laws and our code of ethics would cover 'gamed' results, this could be an aspect of our competency system. Sparks and Duncan (2010) claim the research shows outcome management raises the performance of the poorer performers, more than the better ones; giving all who use outcome management an edge over those who don't in the market. Thus an opportunity exists here for a profession to gain a better market position.

A possible future

Tudor (2011, 2013) argues that the argument proposed by some, that we should adopt a form of professional regulation along the lines that other professions have chosen (i.e. registration and ongoing education), or else we lose credibility, can not only be considered a form of 'group think', but also a form of professional and societal regression. As a result he calls for a greater degree of differentiation of self, to avoid being lulled into 'group think'. But from the perspective presented here, increases in secondary intersubjectivity and reduction in primary intersubjectivity is not wisdom. Conformity, as demonstrated by the likes of Milgram, Asche, or even Zimbardo, show our primary intersubjectivity, and the risks that come with it (Haslam & Smith, 2012). Our primary intersubjectivity is not something to be pathologised, as it might in an over-individuated society. A recognition of this, as advocated by Bourdieu (2000), allows us to acknowledge our propensity to resonate with each other, and find ways of dealing with the risks that being human brings.

In this vein, outcome measurement can be seen to have a conformity aspect, or a preferred 'group think' aspect, when it is seen to be an expression of empowerment theory (Perkins & Zimmermann, 1995), and what is being called the new 'sharing economy' (Botsman & Rogers, 2010; Gansky, 2010). Empowerment politics has its roots in the civil rights movement of the 1960s, and found expression in the 'psy' disciplines when Rappaport (1981) urged our professions to be "more a social movement than a profession", as we needed to keep an eye on when we became part of the problem (e.g. by fostering societal dependence as professional numbers grow

and disempowering the community from its own native skills); and thus doing what we can "to enhance the possibilities for people to control their own lives" (p. 15). Empowerment suggests a move from professional 'expert parents' instructing our 'wards', to collaborators in strengths-based conversations (Saleebey, 1996). Indeed, it was the strengths-based conference organisers that first brought Barry Duncan (of Duncan and Miller, 2010, the developers of the Outcome Rating Scale (ORS)), to Aotearoa in 2007 as part of our introduction to client-rated outcome management (Wood, 2016). In part this is because the ORS can be read as strengths assessment by the client, as much as it can be read as a deficit assessment.

The other political-economic phenomenon that outcome monitoring resonates with is the 'sharing economy', which we see in 'Uber' and 'Airbnb' and the like. Uber has become the largest taxi company in the world, without owning a single taxi; owing a great deal of its success to finding a new way of dealing with mistrust. If, say half a per cent of taxi drivers, or for that matter, hotels, dentists, or counsellors are bad or incompetent, then the old way, as we have seen, was to bring in all sorts of regulations to ensure it 'never happens again'. Ninety-nine and a half per cent are in effect penalised because of a few. As we have seen, especially through the research of Kleiner (2006, 2015), such top-down political control has not been particularly effective in its aims. In Foucault's analysis of political power, this form of control reached its peak with panopticism (1980). What Uber did was place greater trust in the market to ensure drivers would provide compelling evidence to their customers that they were competent and trustworthy; which they achieved by using a simple smart-phone app that provided feedback on the driver (and the customer). Not only is this a move to empowerment, but it can also be seen as a move to restoring

community trust or primary intersubjectivity. The ‘middle man’ has been transformed from a controller to a facilitator of collaboration. It might be noted that Adam Smith (1776/2003), who first advocated free market principles to disempower guild protection rackets all that time ago, was a pupil of the Scottish Enlightenment moral philosopher Hutcheson (1725/2004), who argued that authenticity binds us together more than calculated self-interest. It just needed a little app for Uber to bring this to fruition. The growth of the sharing economy (or “collaborative consumption” market or “digital matching firms”) is difficult to estimate, but there is no doubt it is growing rapidly to include such diverse activities as clothing exchanges, tool sharing, management professional advice, and home health aides (Schor, 2015).

The sharing economy has of course generated its own ethical problems, such as greed on the part of the app owner (which leads to exploitation of the workers), and to breaches of confidentiality of the customer data held. However this has also led to new opportunities. Schor (2015) suggests that a growing move to unionise the workers may well prevent exploitation of the workers, as well as the growing competition amongst different apps (e.g. Lyft and Blablacar compete with Uber taxi services). Schor (2014) argues that home health aides could have conditions and income improved by digital matching technology, as current agencies often take more than half the hourly fee. *Time* magazine identified the sharing economy as one of ten ideas that will change the world (Walsh, 2011). Many see in the sharing economy a counter to the excesses of individuation the ownership society has brought about; exemplified in the reticence of once common place sharing such as raking a neighbours leaves. It is bringing about a renewed sense of community trust (Putnam, 2000; Tanz, 1999). A path back to whanaungatanga.

Here in Aotearoa we have seen the growth of the 'No Cowboys' website, which recently has begun listing some health professionals (NoCowboys, 2016). It would be preferable, I suspect, for most counsellors to have such a registrar administered and monitored by the professional association. If the association was to administer a client rated outcome monitoring service numerous ethical and pragmatic issues would need to be resolved. Counsellors obtaining high recovery rates would no doubt want their outcomes to be known publically, but any restrictions they have placed on the choice of clients they see ('case mix') would also need to be transparent. Just as other sharing economy businesses have found, as their share of the market has risen, so too has harsh criticism from traditional businesses; a 'psy' discipline organization may expect similar. This may well include legal challenges.

Conclusion

The move to monitor counsellors by some form of panopticism has no empirical evidence supporting it, and represents the politics, philosophy, and cognitive style of a fading paradigm. A new paradigm is emerging in politics, philosophy, and cognitive science that empowers community trust and our sense of whanaungatanga. A central mechanism in this has been 'digital matching'; feedback data on effectiveness. This paper urges the adoption of this mechanism as the tool for ensuring professional competence and development.

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