Canadian Association for Psychodynamic Therapy

Response to the Minister of Health and Long-Term Care Concerning the Health Professions Regulatory Advisory Council's

Critical Links: Transforming and Supporting Patient Care (*January 2009*)

February 28, 2009

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Preliminary Remarks

The Canadian Association for Psychodynamic Therapy (CAPT) thanks the Minister of Health and Long-Term Care for the invitation to respond to the Health Professions Regulatory Advisory Council's (HPRAC's) *Critical Links: Transforming and Supporting Patient Care*. To contextualize our comments, we begin with a summary of our responses thus far on the subject of interprofessional collaboration as presented by HPRAC.

I. Summary of CAPT's Responses to HPRAC's Discussion Guide and Two Interim Reports of March and September 2008

CAPT has responded to the *Consultation Discussion Guide* of February 2008 and to the two Interim Reports of March and September 2008.

Concentrated as we were on issues relating to the birth of our new College of Psychotherapists and Registered Mental Health Therapists, we found it difficult to enter into the large discussion of how best to promote the interprofessional collaboration of the established health colleges.

Many of our interventions were appeals to give our new College time to achieve sturdy independence. Beyond that general point, we argued that the following issues need clarification within the yet unborn College before the general work of interprofessional collaboration can be sensibly addressed.

Clarification of Scope of Practice: First there is the need to clarify and deal ecumenically with the legislated scope of practice of psychotherapy, since it somewhat awkwardly combines a medical model of treatment by an expert with a relational model of an alliance of two agents.

Empirical Grounding for the Controlled Act: Secondly, and more seriously, the definition of the Controlled Act of Psychotherapy is seriously deficient in that unlike the thirteen other controlled acts it *alone* lacks empirical grounding. The Transitional Council of the College of

Psychotherapists and Registered Mental Health Therapists must be given time to solve these matters internally.

Regulatory Expertise – FHRCO: CAPT argued further that this internal work of the Transitional Council of our new College will best be achieved without representatives of the other health colleges. Any mentoring of the new College on matters of general regulatory expertise can be done by the Federation of Health Regulatory Colleges of Ontario (FHRCO), as was suggested by the Ministry of Health and Long-Term Care (October 31, 2007).

Use Stand-Alone Restricted Title Only for Members of New College: In defence of the legislative recognition of psychotherapy as an independent profession, CAPT argued that the title "psychotherapist" should be used without qualification *only* by members of the new College, and that it should be used after and in conjunction with the home profession title by those members of other colleges permitted to practice psychotherapy.

Confidentiality Limits to Interprofessional Collaboration: Looking ahead to interprofessional collaboration, CAPT, in its response to the *Discussion Guide*, explained the more extensive confidentiality that is specific and intrinsic to psychotherapy; and the limits this condition imposes on interprofessional communication.

II. Response to Critical Links

With the publication of *Critical Links* (January 2009), HPRAC's overall recommended plan for the health system is clearer in its implications for the College of Psychotherapists and Registered Mental Health Therapists. In what follows, CAPT will prescind from issues having to do with the regulation of Drug Lists and the access of professions to prescribing powers. We have no opinions to offer on these matters.

1. Streamlining the Regulatory Process

<u>CAPT is in favour of this recommendation (the 60-day provision)</u>.

Enabling the colleges to establish their enforceable standards of practice after 60 days without objection from the *Council on Heath Professions Regulatory Excellence (CHPRE)* or the

Minister potentially clears up the regulatory quagmire described in *New Directions* (Ch. 2.8, pp. 62-71).

2. The Establishment of a Council on Heath Professions Regulatory Excellence (CHPRE)

CAPT prefers a reformed process within the Ministry of Health and Long-Term Care to a new oversight body such as CHPRE.

What concerns us is the relation CHPRE would have to the College of Psychotherapists and Registered Mental Health Therapists and to the profession of psychotherapy as a whole. At first glance certain aspects of the proposal would seem to offer reassurance:

1. Except for the Drug List, CHPRE's whole role would be advisory. There would be no obvious increase then in the regulatory burden.
2. That none of CHPRE's members have been or would be members of a health college or council increases the likelihood that all colleges would be treated as equals.
3. That CHPRE would be at a certain arms-length from the Government could engender the hope that the Agency would transcend narrow political considerations, promote transparency and keep a constant broad horizon. Their having only advisory power might lead one to expect that their authority would derive solely from the breadth and soundness of their argument.

On the other hand, we are concerned that we may be witnessing the potential creation of a bureaucratic Goliath, an unnecessary centralization of regulation based on a judgment that a major cause of the present crisis in the health system is the lack of interprofessional collaboration among the self-regulating health colleges.

In CAPT's view this misses the central issue. We see a health system in the grip of a fundamentally flawed philosophy that every advance in knowledge, pharmacology and technology must be put into operation, even at the expense of universal health care, of modernized public health, of preventative health care across life stages, and of a health care that begins and flourishes only within a caring relationship with each person.

The organizational reform suggested by HPRAC will have little effect on this essential crisis. It is a crisis that the one central health profession is not structured, and refuses to be structured,

to serve the social goods described above. Nor is there sufficient political will or agreement to bring this about. Our energy for reform is spent in closer regulation of what we are "allowed" to regulate.

This is the crisis that is clearly before our eyes. A second motive for HPRAC's recommendations on interprofessional collaboration seems to be a prospective anxiety due to the monumental shift in the health system through the creation of four new health colleges. Whereas before one could fairly assume that all the health professions and colleges agreed on the scientific body of knowledge on which they based their practice, with the recognition of Traditional Chinese Medicine and Acupuncture, Psychotherapy with its many modalities, Naturopathy, and Homeopathy, the Government of multicultural Ontario has recognized that the citizens are using and trusting a mosaic of health professions.

The Ministry of Health and Long-Term Care, in its Compendium explaining Bill 171 in ordinary language, therefore acknowledged that it can no longer assume or legislate a uniform theory of human health:

> The Ontario legislative framework for regulated health professions is not intended to judge or compare the value of one health care profession over another or test the theory of certain health care practices over others. Through the legislative scheme, the public is protected and informed consumer choice is facilitated by assuring the public that regulated health care practitioners are qualified to practice in their particular profession and, in the event of complaints, abuse or harm, recourse is available through the College's complaints and discipline system. (*Compendium on Bill 171 December 2006, p.48)*

The recognition of this diversity seems to have evoked a desire to reaffirm some corrective measure of uniformity, motivating HPRAC's promotion of an oversight body together with their insistence on the Interprofessional Standards Committees, first imagined for Psychotherapy and Traditional Chinese Medicine. The Advisory Committee on Acupuncture is the only detailed account of such a committee in the three reports. The legislation acknowledges that there are two distinct forms of acupuncture in Ontario, requiring utterly different trainings and having different purposes and outcomes. Consequently, the only uniform standards of

practice possible to specify will bear on such matters as basic infection control, record keeping, and referral procedures. Why do these require such an elaborate structure as the Interprofessional Standards Committee?

HPRAC is clearly critical of the present system of self-regulation under the ultimate authority of the Minister. They might have advised development (or reform) of a clearly designated arm of the Ministry of Health and Long-Term Care to enhance a timely, effective regulatory process. In any case, there will have to be such a knowledgeable, designated body in the Ministry if CHPRE is to remain advisory and if the Minister is not merely there to sign off on its advice.

Could, then, HPRAC's wish to have CHPRE engaged in all the detailed work of regulation imply a lack of confidence in the Ministry?

At the other pole of self-regulation, it is hard not to see in the creation of CHPRE and especially of the Interprofessional Standards Committees an expression of a lack of confidence in the colleges and professions. CHPRE's involvement in the details of regulation and its power to demand reports and engagement from the health colleges would heavily increase the burden of work for the colleges.

CAPT is already concerned that the incardination of the psychotherapy profession into the system of the regulatory health colleges may exert financial pressure on practitioners to a degree that damages the affordability and accessibility of psychotherapy for the public. (Unregulated psychotherapy services have had an enviable record for asking relatively low fees and providing prompt referrals.) CHPRE's work between the colleges and the Ministry will demand major financing in itself and will surely, in ways hard to discern, increase the cost of being in a college for its members.

It was noted above that the absence of health professionals from membership in CHPRE could have some advantages for new or small colleges. On the contrary side, professional health praxes in their breadth and depth and networking are understood only in the doing. The wider the reach of CHPRE and the more detailed its involvement in regulation, the more apparent it will become that its members have no first-hand knowledge of the professions.

The matter is not merely hypothetical. CAPT has already experienced an example of HPRAC's disconnect from what the psychotherapy profession is like on the ground. Several times CAPT has been omitted from stakeholder discussions, most remarkably from those that preceded the consultation on interprofessional collaboration. The HPRAC that produced *New Directions* eventually knew us well and gave psychotherapy its charter as an independent profession, but HPRAC on Interprofessional Collaboration seemed not to know us. Such discontinuities have been hard to deal with in respect to HPRAC. CAPT finds it difficult to be confident that CHPRE, in the form recommended, could avoid such similar disconnection and discontinuity.

3. Interprofessional Standards Committees

CAPT is strongly opposed to the creation of Interprofessional Standards Committees, especially for Psychotherapy.

In its Proposal for Implementation, which is meant to put its implementations into legal form, HPRAC makes only one reference to Interprofessional Standards Committees:

> That as the Agency conducts scope of practice reviews or otherwise participates in conflict resolution between and among Colleges, that the Agency identifies to the Minister other instances when it would be appropriate for the regulation under one or more health profession acts to be amended to require interprofessional standards committees to be established and mandated to develop enforceable standards of practice on an interprofessional basis. *(Critical Links*, Ch. 4.11, p.100)

This implies that such advice to amend health profession acts would arise on special occasions, a concrete example of which would be conflict between or among colleges. Furthermore, in saying that such committees would be "mandated to develop enforceable standards of practice on an interprofessional basis," they leave ambiguous whether the committees' work is advisory to, or binding on, the council of the health college.

The word "enforceable" does not resolve this point. HPRAC recommends in general that in the new regulatory environment the standards of practice of every college will be "enforceable," that is, having statutory force. So if the Interprofessional Standards

Committee's role is advising, it will be advising the colleges as to what enforceable standards of practice it should adopt.

This ambiguity is not a trivial matter. An Interprofessional Standards Committee with power to impose standards of practice on a particular health college would constitute a massive diminution of the autonomy of the colleges and the precious tradition of self-government in Ontario's health colleges. The Minister's letter expressly balanced the search for interprofessional collaboration with reaffirmation of the autonomy of the colleges.

CAPT noted in our response to the *Discussion Guide*, February 2008, that HPRAC omitted reference to college autonomy from its interpretation of the Minister's request.

In its Interim Report (Phase 2 Part 1, September 2008), HPRAC states that "A key element of HPRAC's approach is the creation of new, statutory multidisciplinary Professional Standards Committees for each profession" (Ch.1, p.16). Such a committee is intended to be a "permanent multidisciplinary forum." This goes far beyond what *Critical Links* recommends as an occasional legislative response to conflict between colleges (Ch.4, p.100).

Whether the Interprofessional Standards Committee would "determine the standards" (Interim Report, Phase 2 Part 1, Ch.1, p.16) in the strong sense or in an advisory role to the college or colleges is not clear, although HPRAC anticipates the objection that the role of the Interprofessional Standards Committees will "reduce self-regulation." HPRAC argues that the "proposed model strikes a reasonable balance, requiring the colleges to develop standards, limitations and conditions with input from those with a range of relevant expertise, while at the same time not providing any one with a power of veto" (Phase 2 Part 1, Ch.1, p.17). Presumably this means no one holds a veto within the Interprofessional Standards Committees. It still does not resolve whether the Committee has power over the particular college or colleges.

The issue of power seems finally resolved in *Critical Links* (Ch. 2, p.40) where the power of the Interprofessional Standards Committees is clearly described as advisory. The council of a college appoints its Interprofessional Standards Committee and "would continue to have the power to accept, alter or reject the committee's advice" (p. 40).

This clarification, however, does not make it into the Proposals for Implementation (*Critical Links*, Ch. 4). Given that HPRAC is explicit that CHPRE's role is advisory except with regard to the Drug List, the omission of this specific qualification to the role of an Interprofessional Standards Committee leaves the impression that HPRAC would prefer to see the Committee, rather than the individual colleges, have power to determine the standards of practice for controlled acts.

This would constitute a serious blow to self-governance for any health profession, but it would be a disaster for the profession of psychotherapy and the College of Psychotherapists and Registered Mental Health Therapists.

CAPT explained its objection to this in its response to the two Interim Reports (March 2008 and September 2008). The Controlled Act of Psychotherapy is the only controlled act that includes in its name the name of a profession. To take away from the College of Psychotherapists and Registered Mental Health Therapists its prior right to define its profession and its controlled act would be a grave wound to the profession's independence and self-government.

The new College of Psychotherapists and Registered Mental Health Therapists will have to resolve internally two specific difficulties that derive from the *Psychotherapy Act*: 1) there are two models of psychotherapy in the scope of practice: a medical model of a treatment by an expert, and a relational model understood as a working alliance of two agents; and 2) the Controlled Act of Psychotherapy, unlike all the other thirteen controlled acts, is lacking in any empirical determinability. CAPT, as far as we know, is the only stakeholder to offer a solution to this problem. The Transitional Council of our own new College must have the authority to determine these matters intrinsic to the profession of psychotherapy.

The HPRAC recommendations concerning the new oversight Agency (CHPRE) are much clearer than their thinking around Interprofessional Standards Committees. In the March 2008 Interim Report, HPRAC notes that the template for such Committees was their recommendation of a permanent advisory committee for the new College of Psychotherapists and Registered Mental Health Therapists (p.30). They proceed to recommend a concrete

example of such a Committee for the College of Traditional Chinese Medicine and Acupuncture (Interim Report, March 2008, p.31). Yet the form of this Committee is such that it is really an Interprofessional Standards Committee for the Authorized Act of Acupuncture, with each college (Traditional Chinese Medicine is just one) that includes acupuncture in its practice having equal representation. Its mandate is to provide advice "to the Colleges [note the plural] to promote the development, either jointly or individually" of standards of practice.

If we followed this model, there would be an Interprofessional Standards Committee for every controlled act, with representation from all the colleges whose members practice it, plus, perhaps, representatives from colleges whose members collaborate with them. Medicine would then have fourteen Interprofessional Standards Committees advising or determining its standards of practice. The Interprofessional Standards Committee for the controlled act of communicating a diagnosis would have nine colleges represented and would be dealing with standards of practice for communicating diagnoses of diseases of the foot and for communicating diagnoses of psychological disorders. Or if each profession (college) is to have its own Interprofessional Standards Committee, Medicine would have to supply representatives to all twenty Interprofessional Standards Committees of those colleges with which it shares controlled acts.

The conclusion is forced upon us, then, that the idea of Interprofessional Standards Committees was not conceived, as HPRAC's Interim Report, September 2008 (I. II Ch. 1, p.16) seems to argue, as a key element in the whole health system, but as a specific remedy of difficulties they foresee for some new colleges (Transitional Chinese Medicine and Psychotherapy), or as a solution to conflict between particular professions (for example, eye care professions). All the more likely, then, that they would envision these special Interprofessional Standards Committees to have defining authority with respect to the particular colleges. Hence the absence of the "advisory" qualification in C*ritical Links,* "Proposals for Implementation" (Ch. 4, p.100).

The whole treatment of Interprofessional Standards Committees by HPRAC remains very confusing and inconsistent in intention. CAPT finds this recommendation unacceptable.

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CAPT especially wishes to repeat that the College of Psychotherapists and Registered Mental Health Therapists needs time to reach sturdy autonomy, time to solve the problems in the *Psychotherapy Act*, time to learn about functioning under the *Regulated Health Professions Act, 1991* (RHPA). Even an advisory form of an Interprofessional Standards Committee would likely have great moral authority with the Minister of Health and Long-Term Care and would distract from and interfere with what need to be the first tasks of the Transitional Council.

4. Summary of CAPT's Response to Critical Links

1. CAPT agrees with the recommendation to streamline the regulatory process (the 60-day provision).
2. CAPT prefers that there be a reformed process within the Ministry of Health and Long-Term Care rather than a new oversight body such as CHPRE.
3. CAPT is strongly opposed to the creation of Interprofessional Standards Committees, especially for Psychotherapy.

Thank you for the opportunity to respond to HPRAC's *Critical Links* report. We entrust our thoughts and concerns to the Minister's careful consideration. And we anticipate a continuing conversation on these important issues. CAPT welcomes any questions or comments you may have.

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