



Canadian Association for Psychodynamic Therapy

Response to the Health Professions Regulatory Advisory Council's

Consultation Discussion Guide on Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals

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PRELIMINARY REMARKS

The Canadian Association for Psychodynamic Therapy (CAPT) thanks the Health Professions Regulatory Advisory Council (HPRAC) for the opportunity to respond to the *Consultation Discussion Guide on Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals*.

CAPT will respond directly to questions selected from those posed by HPRAC, but we wish first to make some preliminary, related remarks.

Noting Cautions and Concerns

In our responses to the *Discussion Guide* on interprofessional collaboration, we wish to point out that we do not presume to speak authoritatively concerning how Colleges operate; we wish to plead our position that we have no experience, to date, with the establishment, processes, or governance of a College, because, as HPRAC is aware, the College of Psychotherapists and Registered Mental Health Therapists of Ontario (hereinafter referred to as the College of Psychotherapists) has not yet been set up. However, we speak out of firmly held positions rooted in values intrinsic to the practice of psychodynamic psychotherapy as it has developed over more than 100 years. **CAPT does have a stake in HPRAC's consultation and in whatever recommendations emerge from it, and so we wish to note certain cautions and concerns that occur to us immediately, as eventual members of the new College of Psychotherapists.** Though we do not yet have a College, CAPT is entering the conversation with our understanding of the general plan and with the intention of contributing to safeguarding the important principles for the practice of psychotherapy in Ontario.

Independent Governance by College of Psychotherapists

In his letter to HPRAC, Mr Smitherman, the Minister of Health and Long-Term Care, requested that any recommended "mechanisms to facilitate and support interprofessional collaboration between health Colleges" acknowledge that "**individual health Colleges independently govern their professions and establish the competencies for their profession.**" The College of Psychotherapists needs to be given time to do the necessary work to establish the competencies for psychotherapy BEFORE an "oversight body" begins to make determinations for it. Because the College of Psychotherapists is not yet set up, CAPT is concerned that neither an oversight body nor existing Colleges make decisions that will impact the practice of psychotherapy in

the province. **The College of Psychotherapists, as the primary College governing psychotherapy, needs to have the primary responsibility of setting its standards of practice and bringing clarity to the Controlled Act and the scope of practice, even though five other Colleges share the same Controlled Act.** Whatever the general and other benefits that may well result for the patient from interprofessional collaboration among all the health Colleges, and particularly those that share the same Controlled Act, it is imperative that the College of Psychotherapists be permitted the necessary time to first determine the competencies of their profession under the regulatory framework. Only then should the other professions be invited into dialogue.

CAPT Is a Recognized Stakeholder

CAPT is pleased to have been consulted by HPRAC for responses to the *Discussion Guide* on interprofessional collaboration, but we do feel that CAPT should have been consulted earlier on these matters, as others were prior to the development of the current *Discussion Guide* (see page 4 of *Discussion Guide (DG)*). CAPT is known to HPRAC from both our oral and written submissions in September and October 2005, and from our written responses in the summer of 2006 to the HPRAC *New Directions* report. Moreover, following CAPT's submission to the Standing Committee on Social Policy in April 2007, the Ministry of Health and Long-Term Care identified CAPT as one of only three psychotherapy stakeholders and the only representative of psychodynamic psychotherapy invited to an information session on the formation of the Transitional Council and new College of Psychotherapists, on October 31, 2007. **In light of the fact that CAPT is known and recognized by the Ministry, we wondered why we were not invited to the October 2007 consultations. Though our College is not yet established, as a recognized stakeholder in the psychotherapy regulation process, going forward CAPT requests participation in any future workshops and consultations.**

Thank you.

I. INTRODUCTION

In the spirit in which the *Discussion Guide* was developed and distributed and in which the consultations are being conducted, CAPT endorses a patient/client-centred approach to the delivery of health care in all its forms, including psychotherapy. It is CAPT's position that this fundamental principle should undergird all the recommendations to the Minister concerning interprofessionalism among health Colleges and professionals in the province. That fundamental principle of a patient/client-centred approach lies at the heart of all CAPT's responses to the *Discussion Guide*.

CAPT's approach, here, is to answer selected questions from among those posed by HPRAC in the *Discussion Guide* on interprofessional collaboration (see Section V). As well, we wish first to articulate, in broad strokes, some concerns and suggestions that have been evoked by this *Discussion Guide*, and which we respectfully request that HPRAC consider when making its recommendations to the Minister. Those broad strokes include the following central positions that CAPT takes in this submission:

1. CAPT supports the movement towards a more patient-centred, holistic approach to health care represented by the thrust toward interprofessional collaboration, specifically such collaboration at the College level that would involve a sharing of ideas and approaches with the objective of enhancing the care of the patient/client.
2. The requirement for absolute confidentiality in psychodynamic psychotherapy sets psychotherapy apart from the rest of the health care system and requires a different approach for psychotherapy at the clinical level than for the interprofessional collaboration generally practiced either within a single profession (College) or, for example, by family health teams. And it requires a different approach even at the College level for the complaints and discipline procedure.
3. While CAPT favours removing obstacles and rigidities in the regulatory system, we think that real change towards interprofessional collaboration should come first from the teaching and training institutions and then from voluntary initiatives at the clinical level. Looking to the long term, a revolution in health care is unlikely to come from oversight bodies and more regulation. Rather, we could expect to see collaboration between the Colleges and

between the professions at the clinical level if the teaching and training institutions themselves practice collaboration and promote appropriate models of interprofessional care for all the professions. The Colleges, of course, in their regulatory and educative role would be in dialogue about this with the teaching and training institutions.

We begin with our perspective on interprofessional collaboration, which includes our support for this initiative, some suggestions for its application, and some concerns.

II. NEW FOCUS ON INTERPROFESSIONAL COLLABORATION

Interprofessional care is the provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings. (DG 9)

In a general sense, CAPT understands that there is good philosophy behind the concept of interprofessionalism among health care providers. It seems that a more holistic and humanistic approach to health care is at the centre of the interprofessional thrust, challenging the conventional medical model in an important way by attempting to deal with the fragmentation of specializations which both presupposes a biochemical view of the human being and permits specialties to be separated off, without anyone taking into consideration the whole human being.

Psychodynamic psychotherapy is well poised in this regard because we are already rooted in a holistic approach. CAPT agrees that at all levels there has to be some kind of resistance to the fragmentation of the human being. **The movement towards interprofessional care is a humanistic move to ensure that we do not lose the human context.** We note that this is, in a way, a retrieval of an older view of medicine itself, before the explosion of scientific knowledge led to often-fragmented specialization and a confident materialistic reductionism—that so often missed the person while treating a disease. **CAPT welcomes the movement towards a more patient/client-centred, holistic approach to health care, which is consonant with psychodynamic psychotherapy's long tradition of care for the whole person.**

The centrality of the patient/client has an adjunct and complementary implication. There is a growing sense throughout the field of medical science itself that the patient is, in fact, the primary agent of his or her own healing, and medical doctors are coming to see

the practice of medicine as cooperation between doctor and patient for prevention of illness and as aid to the self-healing processes of the patient. This understanding that the client is the primary agent of his or her own healing is intrinsic to psychodynamic psychotherapy's understanding of psychotherapeutic healing. **Certainly, interprofessional collaboration at the College level could mean a sharing of ideas and approaches on this important comprehension of a truly patient-centred health care system.**

Psychodynamic psychotherapy has a long tradition of resisting the trend towards a fragmentation of the human being. It has always had a holistic and non-fragmented approach to the patient/client. Our profession has much to bring to the conversation, and much to contribute if we could envisage a renewal of health education across all the disciplines, a renaissance of thinking towards a more holistic, interconnected view of the patient/client and of the patient/client's agency in healing.

Moreover, many of the psychotherapy training schools in Ontario, already within that holistic tradition, have recent experience working collaboratively towards a shared educational goal. **CAPT, which had a role in helping to set up the Association of Psychotherapy Training Institutes (APTI), recommends to HPRAC APTI's work on a common curriculum (including modules for the different modalities) as a signal example of interprofessional collaboration among the psychotherapy training institutes.**

Professional sharing on this level among the health regulatory Colleges could be very informative and beneficial—a co-operative, collegial enterprise that would enhance a patient-centred view of health care, and which would encourage the Colleges and their members to work collaboratively, rather than competitively. CAPT supports this approach and welcomes the movement towards it.

Psychodynamic psychotherapy, however, has some dimensions that will fall outside of any practically imaginable holistic health system in Ontario, and it is these aspects that we wish to address. On a clinical level we perceive three major difficulties for the College of Psychotherapists in entering symmetrically into collaborative practice:

1. Psychotherapy is broader than its area of connection with the health system. *(Imagine a small circle, psychotherapy, which intersects with a larger circle, the health care system, so that the smaller circle remains partly outside the larger one).*

2. Though collaboration could sometimes be parallel and respectful, the intrinsic need for confidentiality in therapy sets this profession apart.
3. Psychotherapy requires a special form of complaints and discipline procedure.

Much of Our Work Is Outside the Health System

A significant proportion of the work of psychodynamic psychotherapy functions better independently of the health system. Use of the term “treatment” in the scope of practice and “treat” in the Controlled Act could be understood to indicate a passive acceptance by the client of something that is being done by the psychotherapist. This does not characterize the process of psychodynamic psychotherapy, which has always been understood as a cooperative work by two people. We do not see psychodynamic psychotherapy as a “treatment” in the ordinary sense of the word, but rather as a process by which the client gains a greater awareness of himself or herself, specifically about those thoughts and feelings and beliefs that are unconscious or only partly understood, and which may cause suffering in the client and impede health and psychological/emotional well-being and growth. A great many of the clients seeking psychodynamic psychotherapy are not dysfunctional or ill. The language of “mental health” and “mental illness” is not our preferred or dominant discourse. To characterize all users of therapy as dysfunctional or mentally ill would ignore a substantial proportion of our clientele.

Many clients of CAPT psychotherapists have never had any contact with the funded mental health system. They have never been prescribed drugs for a psychological condition and they have never discussed their psychological state or emotional concerns with a doctor. They often find a therapist through speaking with a friend, looking through the Yellow Pages or searching the Internet. They are self-referred and have no diagnosis. For the most part, they pay for their own therapy themselves. Many explicitly wish to avoid medication. They come with concerns about patterns that they see emerging in their lives or feelings of unhappiness or dissatisfaction. Although some clients enter therapy to address problems, others come primarily to explore their inner life and to access their creativity.

CAPT is concerned that these clients' search for meaning not be medicalized.

Some clients may have been prescribed medication for anxiety or depression by a family physician or psychiatrist or they may have a diagnosis of a psychiatric nature. They may then have sought out psychodynamic therapy on their own, or the physician may have given them the name of a referral service or a psychotherapist. The client may tell the

therapist of the diagnosis, if there is one, or the physician may provide a note stating the diagnosis. But often there is no contact between the referring physician and the psychotherapist, though we support the client's relationship with his/her physician or psychiatrist.

If the patient/client seeks out medical assistance as part of his or her search for greater equilibrium and mental well-being, that would be supported by the therapist as something the client chooses to do to help himself or herself. But it is not part of the therapy itself, which is quite different. We underscore the importance of preserving that difference. **The medicalization of the client's therapy is a particular risk if the psychotherapist is seen as just another member of an interprofessional, collaborative health team.**

We move now to the issue of confidentiality, which is the starting point for psychodynamic psychotherapy.

III. THE PRIMACY OF CONFIDENTIALITY

Generally there is no discussion about the patient/client between the medical doctor and the psychodynamic psychotherapist, even if the patient/client would like there to be that kind of discussion. It is typically not part of our professional practice to engage in interprofessional discussion at that level. There are express reasons for a great reluctance to do so, most notably the issue of confidentiality.

Confidentiality is the more concerning issue and the one with more serious implications for a person's therapy. **Though psychotherapists could, at times, be integrated into professional health teams, at least on a theoretical, intellectual, and educational level, the requirement for a confidentiality that goes beyond ordinary privacy rights sets psychotherapy apart from the rest of the health care system and requires psychodynamic therapists to keep a certain distance from the team, especially in terms of decision-making and the sharing of patient/client information.**

One of the cornerstones of psychodynamic therapy is the understanding that healing in therapy happens through relating—and the assurance of confidentiality is central to that relating. That understanding is at the heart of the scope of practice and the Controlled Act in the *Psychotherapy Act, 2007* (“...delivered through a therapeutic relationship....” Sections 3 and 4). It is imperative that that central idea be factored into any decisions

concerning the practice of psychotherapy in the province. We cannot emphasize this enough. **A therapy that rests on relating requires a different approach than one that is primarily directed at healing the body** (though CAPT acknowledges that relating in the delivery of physical health care should also be a concern, it is not as crucial to the provision of health care as it is with psychotherapy).

All psychodynamic modalities agree on these things especially:

- The agency of the client and the relational, cooperative nature of the therapy are of prime importance.
- Both client and therapist pay attention to the depth dimension of human life, within and under what is consciously known and said or what is observable as a symptom.

Much of the work in psychodynamic therapy involves an exploration of the unconscious through the interpretation of dreams, phantasies, and narrative. This exploration requires ongoing alertness to the enduring influences of childhood experiences, including psychological realities that antecede language and choice, and attention to the development and implications of both transference and countertransference in the therapeutic relationship. **Trust in the confidentiality of what occurs in the therapy session is imperative if the work is to proceed.**

The intrinsic need for confidentiality sets psychodynamic psychotherapists apart from other health care providers. Collaboration with a health team could sometimes be parallel and respectful. **But within that interprofessional team CAPT would insist on the primacy of the confidentiality of what is communicated by the client in the therapy sessions—indeed, the confidentiality of all that happens between the client and therapist in the sessions. Psychotherapist-client privilege must be protected, if the therapy is to be protected. Without that privilege as a guarantee, the psychotherapist in the psychodynamic modality is placed in a position of conflict of interest, and the trust of the patient/client is eroded.**

In *The New Informants: The Betrayal of Confidentiality in Psychoanalysis and Psychotherapy* (1995), authors Christopher Bollas (an eminent psychoanalyst) and David Sundelson (an appellate lawyer) explain the imperative for fundamental and absolute confidentiality in the therapeutic relationship, particularly in psychoanalytic/psychodynamic psychotherapy. **If the patient/client is to feel able to go to the most troubled parts of himself or herself, the places of the greatest shame and fear, then the patient/client must have the assurance of strict confidentiality.** If

a patient/client fears either consciously or unconsciously that what is said to his psychotherapist would be shared with his doctor or other members of his health team, the disclosure necessary for the client's therapy may never take place.

The contents of a psychoanalysis are strictly confidential and any and all disclosures by the psychoanalyst—such as discussing a patient with colleagues, arranging for a hospitalization, acting in the interests of a child patient—must be given in the understanding that confidentiality is maintained and that in all circumstances privilege is retained by the psychoanalyst. (Bollas and Sundelson 156)

Bollas and Sundelson argue that it is important for the psychoanalyst/therapist to be able to seek clinical supervision, but that this can be done without revealing the identity of the patient/client (156). **That presupposes that it is not from the patient's/client's interprofessional team of health care providers that supervision for the client is to be sought.**

In the light of this stricture it is CAPT's firmly held position that even in the case of the Controlled Act under the interpretation CAPT has offered (that the "serious disorder" referred to in the Controlled Act be understood to be such as requires custodial care of the individual) the patient/client-psychotherapist privilege must be absolutely maintained. It is imperative that the actual work between the client and therapist and any disclosures by the client remain confidential if the therapy is to have integrity. Nothing of what the client reveals to the psychotherapist should be communicated, except in a strictly supervisory context. Of course, the umbrella of confidentiality must cover the supervision as well.

Any communication to other health care workers about the therapy must be done by the clients themselves and not by their therapists. If the client envisions the therapy as open to other people, there are things the client will not do in therapy, even if he or she views the sharing as personally helpful (for example, if the client is using the therapy to prove disability). Communication from the therapist about a patient/client to other health care providers taints the therapy.

As a way to guard against even the suspicion that the therapist would share anything about the therapy with another member of an interprofessional team CAPT recommends the development and standardization of a form in which the client declares that he or she does not want anything from the therapy shared with

anyone else on the team. Psychotherapy requires an absolute containment. This is a matter of patient rights in a patient-centred therapy in which the patient/client is the agent of her own therapy, of his own healing.

CAPT defends, absolutely, the “right of any person...to speak in private about his or her mental life” (Bollas and Sundelson xiii). **Without real confidentiality, psychodynamic psychotherapy is impossible.**

IV. COMPLAINTS AND DISCIPLINE PROCEDURE

Complaints Procedure and Alternative Dispute Resolution

CAPT supports the principle of accountability, but the confidentiality and sensitive nature of psychotherapy raise special considerations for the development of a complaints, investigations, and discipline procedure.

CAPT strongly recommends that the College of Psychotherapists be given time and latitude to do the necessary work to establish a complaints and discipline procedure specific to the profession of psychotherapy. This should involve a study of alternative dispute resolution procedures that could accommodate hearing the client, addressing findings of misconduct, and providing a resolution that enhances rather than detracts from the therapeutic process. The College will need time to develop a viable complaints process that does not immediately leap to a judicial approach but provides considerable flexibility for dealing with these matters.

CAPT supports the development of a mechanism that holds the therapist accountable to a high standard of competence and ethical behaviour. Under regulation it is expected that there be a complaints process for the public so that the College can be seen to be protecting the client from harm. And whether or not harm has been done to a client, it is important that there be a venue for the client to be heard.

Charges of inadequate psychotherapy must be treated seriously, but they must be considered with the understanding that therapy is not simple and straight-forward. For example, a complaints procedure must be flexible enough to take the complexity of transference into account, while still providing a real hearing for the client so that actual offenses and incompetence on the part of the therapist, where they have occurred, can be addressed—and so that where they have not occurred the client can, nevertheless, be heard.

The College of Psychotherapists will face the challenge of developing a complaints, investigations, and discipline procedure that serves the client by allowing for the possibility of both misconduct on the part of the therapist and transference on the part of the client—and a host of gradations between the two. And in every instance, the psychotherapist should preserve confidentiality to the maximum that is practicable. Of course, if the client chooses an adversarial posture from the beginning and opens up the material of the therapy, there is not much the therapist can do to preserve the now shattered therapy. In any case, a complaints and discipline process for the College of Psychotherapists will require a different set of criteria than for other complaints procedures. We anticipate that this will be a delicate and complex process.

CAPT is aware of one professional association of psychotherapists that has grappled with the difficulty of a complaints process for 15 years. They found that the standard procedures used by other health professionals proved unsatisfactory when applied to psychotherapy. This organization is currently developing a protocol that focuses on restoring harmony in the therapeutic relationship, where that is possible.

We are cognizant that this kind of creative thinking will need to be applied to the complaints procedure for the College of Psychotherapists, in order to preserve the critically important elements that are the cornerstones of good psychotherapy: confidentiality; the primacy of the client's well-being; the preservation of the therapeutic relationship in all its complexity; and the maintenance of a high standard of competence and ethical behavior for all psychotherapists.

For all these reasons, the College of Psychotherapists must itself work out the specific needs of a complaints process particular to psychotherapy, and one that is not subsumed under a single complaints model for all the health Colleges.

V. RESPONSES TO HPRAC'S QUESTIONS

We have selected questions to respond to, from among the 43 posed by HPRAC. In some cases, we have grouped questions and responded jointly to them. You will notice that we have sometimes repeated material in the responses to the questions that was already articulated in our remarks above. This was done in case Section V (the questions portion) becomes separated from the paper as a whole during your analysis of our responses.

V.1. DEFINING INTERPROFESSIONAL COLLABORATION

HPRAC indicated that it had developed a statement of “interpretation of what the Minister’s question portends,” and that any initiatives be directed to finding ways to:

Assist health regulatory colleges and their members to work collaboratively, rather than competitively, and to learn from and about each other through a process of mutual respect and shared knowledge to:

- Improve patient care and facilitate better results for patients;
- Protect the public interest; and ensure the highest standards of professional conduct and patient safety;
- Regulate the health professions in a manner that maximizes collective resources effectively and efficiently, while protecting the public interest;
- Optimize the skills and competencies of diverse health care professionals to enhance access to high quality and safe services;
- Ensure access to high quality and safe services no matter which health profession is responsible for delivering care or treatment, and
- Enhance scopes of practice to ensure that all regulated health professionals work to their maximum competence and capability.

1. Please comment on the above statement that HPRAC has used to focus this discussion and initiatives. Are there elements that should be added or removed? If so, what are they?

CAPT’s Response to Question 1

The strange use of “portends” in this statement, “HPRAC has developed the following statement to convey its interpretation of what the Minister’s question portends” (DG 41), seems to indicate HPRAC’s uneasy intention of *going beyond* the Minister’s question. Otherwise HPRAC could say it “has developed the following statement to convey its interpretation of the Minister’s question.”

And indeed HPRAC does go beyond the Minister’s question. The Minister speaks of “interprofessional collaboration between health Colleges,” while HPRAC extends this to the issue of “interprofessional care” at the clinical level (DG 9). Further, in the text box it states, “Assist health regulatory colleges and *their members* to work collaboratively . . .” (DG 41, italics ours). **So a question about how health Colleges might better**

collaborate in their regulatory work becomes the vaster matter of interprofessional health care at all levels.

That the Minister's question concerns collaboration of the Colleges in their regulatory work is clear from where he asks HPRAC to begin: "beginning with the development of standards of practice and professional practice guidelines where regulated health professions share the same or similar controlled acts . . ." (DG 45). **Yet where the Minister asks HPRAC to begin is omitted from its interpretation of what his question "portends."**

HPRAC also omits from its interpretation of the Minister's question his reminder to respect the independence of the Colleges. This omission disturbs the balance of the Minister's question.

Summary of CAPT's response to Question 1:

- HPRAC extends the Minister's clear question concerning interprofessional collaboration between the health Colleges to the vaster matter of interprofessional health care at all levels, including the clinical level.
- HPRAC omits to begin where the Minister asked it to begin: "with the development of standards of practice and professional practice guidelines where regulated health professions share the same or similar controlled acts"
- HPRAC omits the Minister's balanced reminder of the independence of the health Colleges.

V.2. ELIMINATING THE BARRIERS TO COLLABORATION

2. Are there barriers in the *RHPA*, the health profession acts or their regulations that restrict or prevent collaboration among the Colleges? If so, what are they? Should they be eliminated? If so, how? (For example, do existing scopes of practice restrict or prevent collaboration among health professionals?)

CAPT's Response to Question 2

The scope of practice in the *Psychotherapy Act, 2007* combines two models of psychotherapy. In the first, psychotherapy is understood to be a treatment of disturbances by an expert; in the second it is understood as a work done by two agents in relational alliance. The *Psychotherapy Act, 2007* awkwardly combines them into

“treatment . . . of disturbances by psychotherapeutic means, delivered through a therapeutic relationship . . .” (Section 3).

This dual model may, at least initially, give rise to a problem with internal collaboration within the psychotherapy profession. Psychologists, medical doctors, and some mental health workers will likely prefer a treatment model—the “treatment by expert” model is already well-established in existing health Colleges. However, the majority of members of the College of Psychotherapists will likely favour the relational model. In order to prevent barriers to interprofessional collaboration we will need to find ways to accommodate both models. Though two different understandings of psychotherapy have been put together in the scope of practice, one need not override or exclude the other. As the scope includes both models, both should be acknowledged if we are to enter into real collaboration at the College level.

5. Are there professional cultural issues that act as barriers to collaboration among the Colleges? What steps should be taken to minimize these barriers? Who should provide the leadership to eliminate them? What role can health care associations, including associations whose members are regulated professionals, play in this process?

CAPT's Response to Question 5

With the *Psychotherapy Act, 2007*, psychotherapy comes in from the margins. Our profession has not always been treated with respect, because we generally have not followed a medicalized model. This has been a significant cultural impediment. CAPT anticipates that it will not be easy for psychotherapy to achieve respect among our fellow regulated health professions. That is another reason why it is imperative the College of Psychotherapists be permitted to independently determine the standards and competencies of the profession under the regulatory framework. Only then should the other five Colleges who share the Controlled Act and the other health professions be invited into dialogue.

7. Should all regulated health professionals be required to hold minimum professional liability insurance coverage?

8. If so, what would be the minimum expected terms and conditions for that insurance coverage?

CAPT's Response to Questions 7 and 8

All CAPT members are encouraged to hold professional liability insurance, and the majority do. We feel it is a responsibility that a psychodynamic therapist should embrace. The current minimum professional liability insurance policy available specifically to CAPT members, at a group rate, is \$1,000,000 for each claim with a limit of a \$2,000,000 aggregate claim in any one year, for the current annual premium of \$324 plus provincial tax. CAPT members would find it onerous if there were an imposed minimum greater than that amount. It would, for example, be devastating to the relative affordability and accessibility of psychotherapy if therapists were required to hold insurance anywhere close to what medical doctors need to carry.

V.3. DEVELOPING ENABLERS FOR COLLABORATION

9. What changes to the *RHPA*, the health profession acts or their regulations are needed to encourage, require, facilitate and enable collaboration among the Colleges?

CAPT's Response to Question 9

A question about changes to regulations should not be the first question. Rather, a question about educative measures, going forward, in all the health Colleges, makes more sense for the long-term. The real change concerning collaboration among the health Colleges will come first in the teaching and training institutions, and then at the clinical level—not through a series of new regulations. It is short-term thinking to attempt a revolution in health care through regulations from above.

Mary Lou Gignac, President of the Federation of Health Regulatory Colleges of Ontario, addressed the assembly of the four newly regulated professions at the Ministry of Health and Long-Term Care meeting of October 31, 2007 (“Regulation of Health Professions In Ontario: Regulatory Environment and Implications”). In commenting on “Regulatory Philosophies” (Slide 7) she suggested that although Colleges have both a policing and an educative role, the public is better served if the College emphasizes support and education of its members over policing.

11. What collaborative policy or program initiatives are needed to ensure support is provided to new Colleges as they are being established?

CAPT's Response to Question 11

CAPT recommends that the College of Psychotherapists be given the time and opportunity to interpret the Controlled Act of Psychotherapy and to interpret the scope of practice of the profession before the other established Colleges, which are given the Controlled Act of Psychotherapy, attempt to give authoritative interpretations of the Controlled Act or the scope of practice.

This is doubly important in the specific case of the College of Psychotherapists because:

- the Controlled Act as legislated has no clear empirical grounding.
- the scope of practice uneasily combines two models of psychotherapy that are not easily reconcilable.

These two issues are dealt with more fully in our responses to Questions 2 and 22-26.

On a positive note, CAPT would welcome from the Ministry and the Federation of Health Regulatory Colleges of Ontario (FHRCO) a "course" for new Transitional Councils on how to set up their regulatory frameworks.

12. Are there administrative responsibilities within Colleges that could be shared with related Colleges? What barriers exist to shared administration services?

CAPT's Response to Question 12

CAPT considers that Federation of Health Regulatory Colleges of Ontario (FHRCO) might provide the lead in shepherding some smaller Colleges into a shared management structure, if this proved to be a way of reducing costs. Some examples of shared administrative responsibilities might be financial machinery, records of membership registration, fees, and records of continuing education.

CAPT's concern about more broadly sharing administrative responsibilities is that the College of Psychotherapists will have some unique features:

- a) so much psychotherapy occurs outside the formal health system, and
- b) there is a special need to protect the confidentiality of psychotherapy beyond ordinary privacy rights.

For this reason, any required auditing of practices or research mandated by the Minister,

and, especially, anything connected to the complaints and discipline process should be managed solely by the College of Psychotherapists.

13. Should Ontario introduce a common framework, consisting of common structures and processes, for all regulated health professions to address complaints, investigations or disciplinary matters arising in an interprofessional care setting?

CAPT's Response to Question 13

As CAPT explained in the section on the "Primacy of Confidentiality" (Section III), psychotherapy at the clinical level must have a degree of insulation from collaboration in order to protect its essentially confidential structure. Therefore, in a collaborative or multidisciplinary setting, psychotherapy itself could function in parallel with other health professions, but, at the same time, would maintain a significant separation from them—for the same reason, the psychotherapist should have no role in team decisions about all the other health matters. Perhaps a single or combined complaints and discipline committee would make sense for the other professions if they are seamlessly united in team decision-making, but it surely makes no sense for the College of Psychotherapists.

If the complaint were about the psychotherapy specifically, it would be handled only by the College of Psychotherapists. In what follows we appeal for time to develop procedures appropriate to psychotherapy.

Charges of inadequate psychotherapy must be treated seriously, but, as we have already indicated earlier, in the "Complaints and Discipline Procedure" section (Section IV), such charges must be considered with the understanding that psychotherapy is not simple and straight-forward. For example, a complaints procedure must be flexible enough to take the complexity of transference in the therapeutic relationship into account, while still providing a real hearing for the client so that actual offenses and incompetence on the part of the therapist, where they have occurred, can be addressed—and so that where they have not occurred the client can, nevertheless, be heard.

The College of Psychotherapists will face the challenge of developing a complaints, investigations, and discipline procedure that serves the client by allowing for the possibility of both misconduct on the part of the therapist and transference on the part of the client—and a host of gradations between the two. And in every instance, the psychotherapist should preserve confidentiality to the maximum that is practicable. Of

course, if the client chooses an adversarial posture from the beginning and opens up the material of the therapy, there is not much the therapist can do to preserve the now shattered therapy. Creative thinking will be required in order to preserve the confidentiality of the therapy and, where possible, the therapeutic relationship in all its complexity, while maintaining a high standard of competence and ethical behavior for all psychotherapists. A complaints and discipline procedure for the College of Psychotherapists will require a different set of criteria than for other health Colleges' complaints procedures. We anticipate that this will be a delicate and complex process that will require considerable time and thought to work through.

Because of the special requirements of psychotherapy, the College of Psychotherapists (or the Transitional Council before that) must itself work out the specific needs of a complaints process particular to psychotherapy, and one that is not subsumed under a single complaints model for all the health Colleges.

CAPT strongly recommends that the College of Psychotherapists be given time and latitude to do the necessary, appropriate work to establish its own complaints and discipline procedure. This should involve a study of alternative dispute resolution procedures.

16. If so, what should and should not be addressed in an amendment to the statute?

For example, should the *RHPA* be amended to enable Colleges to establish joint committees to deal with complaints, investigations and discipline in respect of issues arising in an interprofessional care setting?

CAPT's Response to Question 16

For all the reasons outlined in Section IV and in CAPT's response to Question 13, we feel that this would be a very bad idea for the College of Psychotherapists.

17. Considering reforms in other jurisdictions, what would be the merits of a single complaints model in Ontario? How should such a 'model' be funded?

CAPT's Response to Question 17

As we have said in our response to Question 13, CAPT does not see any merit in a single complaints model, which would present irresolvable difficulties for psychotherapy.

18. Would the authority to conduct joint investigations following complaints or reports relating to professionals who work in a multidisciplinary setting or practice provide more efficient investigations of such cases?

CAPT's Response to Question 18

Whatever the merits for joint investigations for other Colleges, as we said in our response to Question 13, CAPT thinks that the College of Psychotherapists should not be included in such a joint complaints, investigations, and discipline procedure.

19. Should Colleges have further authority to collaborate in the disposition of complaints and reports relating to professionals in a multidisciplinary setting or practice?

CAPT's Response to Question 19

CAPT has already expressed concerns about a joint complaints process in the response to Question 13. Question 19 adds the reporting procedure, and we once again emphasize that the complaints procedure for psychotherapy will have to be carefully developed to ensure that the key principles that form the foundation of the practice of psychotherapy are preserved. Reporting of any kind will also have to respect the same parameters of confidentiality, in order for the College to maintain the integrity of the therapeutic relationship.

Responses to complaints and any reporting arising from the practice of psychotherapy in a multidisciplinary setting should not be subsumed under single complaints or reporting models for all the health Colleges.

22. Would a joint quality assurance program among relevant Colleges enable the Colleges to develop common standards of practice or professional practice guidelines where the same or similar Controlled Acts are shared?

23. Would a joint quality assurance program among Colleges whose members have similar scopes of practice, share the same or similar Controlled Acts, or provide closely related services often involving the same areas of the body, provide opportunities for enhanced continuing competence and exposure to best practices? If yes, how should program standards be jointly set and measured?

25. Should an independent arm's-length organization facilitate and support collaboration among the Colleges, particularly with a view to the development of common standards of practice and professional practice guidelines?

26. If so, what should its specific mandate include or not include? For example:

- Educate the Colleges, professions and the public on the regulatory model, the health professions and everyone's role within the regulatory system;
- Create common resource repositories (e.g., a data warehouse to track regulatory indicators, such as the level and nature of quality assurance activities, complaints and disciplinary actions and the cost of regulation);
- Research and develop standards of practice and professional practice guidelines, and disseminate best practices;
- Resolve disagreements among professions that share overlapping scopes of practice and the same or similar Controlled Acts;
- Address issues arising from conflicting legislation, and
- Have an oversight function over regulatory bodies, as in the United Kingdom.

CAPT's Response to Questions 22, 23, 25, 26

There are two particular problems for the College of Psychotherapists:

1. Controlled Act

The Controlled Act of Psychotherapy, which it shares with five other Colleges, urgently needs clarification and empirical anchoring. CAPT has outlined this problem and proposed a solution in its Brief to the Social Policy Committee on Bill 171 (the *Health System Improvements Act, 2007*). (Solution included following item 2 of this response.)

Every other Controlled Act is empirically anchored. In each case, a health practitioner without authority to do the Controlled Act will have complete clarity beforehand as to what he or she is not allowed to do. Twelve of the Controlled Acts have to do with bodily actions and the thirteenth, diagnosis, is empirically anchored by making the Controlled Act "communicating...a diagnosis." There is no such clarity for the Controlled Act of Psychotherapy.

Imagine a psychotherapist who is not certified to do the Controlled Act of Psychotherapy approaching a client and being required beforehand to know whether the individual has a “serious disorder . . . that “may seriously impair” (*Psychotherapy Act, 2007*, Section 4). Oftentimes such a serious disorder does not immediately show itself, but emerges only over time.

HPRAC argued, of course, in *New Directions* that a Controlled Act of Psychotherapy was impossible to set up. Nevertheless, the *Psychotherapy Act, 2007* gives us one. If there is to be a Controlled Act of Psychotherapy then it must be empirically identifiable as such.

CAPT understands that the Minister’s letter reminding HPRAC of the independence of the Colleges suggests that the as-yet-unformed College of Psychotherapists should have the right to clarify its own Controlled Act of Psychotherapy before a new “oversight body” or the older Colleges make any determinations. The nascent College of Psychotherapists needs protection and encouragement.

2. Scope of Practice

There arises a similar problem with regard to the scope of practice of psychotherapy. The scope of practice in the *Psychotherapy Act, 2007*, in the manner of HPRAC’s *New Directions*, combines two models of psychotherapy. In the first, psychotherapy is understood to be a treatment of disturbances by an expert; in the second, it is understood as a work done by two agents in relational alliance. The *Psychotherapy Act, 2007* awkwardly combines them into “treatment . . . of disturbances by psychotherapeutic means, delivered through a therapeutic relationship . . .” (Section 3).

Again, the College of Psychotherapists needs to have the primary responsibility of bringing clarity to the scope of practice before a new “oversight body” or the existing Colleges make any determinations. This is all the more crucial in that the vast majority of members of the future College of Psychotherapists will likely favour the relational model, whereas the “treatment by expert” model is already well-established in existing health Colleges.

As we indicated earlier, one of the cornerstones of psychodynamic psychotherapy is the understanding that healing in therapy happens through relating—that concept is central to both the scope of practice and the Controlled Act in the *Psychotherapy Act, 2007*.

(See also responses to Questions 2, 11, 22-26.)

**The Solution Posed by CAPT In Its Brief to the Social Policy Committee
on Bill 171, on How to Empirically Anchor the Controlled Act**

As it stands, the description of treating a "...serious disorder...that may seriously impair..." lacks simple clarity and easy determinability. We could anchor it empirically by adding:

*The "serious disorder" is understood to be such as requires
custodial care of the individual.*

It would then follow that the Controlled Act of Psychotherapy would always occur within an institution. This has the added advantage for harm reduction in that the psychotherapist within a custodial environment would always be functioning as a member of a team.

We cannot hang the Controlled Act merely on a formal diagnosis:

- 1) Because of the disappointing degree of unreliability in diagnostic practice (PDM Task Force [2006]. *Psychodynamic Diagnostic Manual*. Silver Spring, MD: Alliance of Psychoanalytic Organisations, 3)
- 2) Because diagnosis is even more unreliable as a predictor of *future* impairment
- 3) Because after the pharmacological intervention, for example, the individual may well be able to engage in psychotherapy in an ordinary way.

We would understand the grounds for custodial care to be one of the following:

- 1) Enduring and manifest danger of self-harm
- 2) Enduring and manifest danger of harm to others
- 3) Enduring and manifest psychological inability to care for the self.

27. Are there any existing bodies that could take on responsibilities in this area? If so, what are they?

CAPT's Response to Question 27

CAPT thinks that the Federation of Health Regulatory Colleges of Ontario (FHRCO) would be an obvious candidate, especially if collaboration was first thought of as a voluntary system for the Colleges. FHRCO has already created a precedent for voluntary collaboration. This approach would be a best initial step and would reduce the regulatory burden and its associated costs.

28. If not, should a new and independent oversight body be formed? If so, how should it be funded?

CAPT's Response to Question 28

CAPT considers that if an oversight body were to be formed and had a regulatory function over the self-regulating Colleges, it would have to be funded by the Ministry of Health and Long-Term Care, not by fees from the health professionals. As it is, psychotherapists in Ontario are going to find paying for their College quite onerous.

29. Should the Minister direct the Colleges, using his existing powers under the *RHPA*, to engage in specific collaborative initiatives (e.g., to develop instruments to support interprofessional care)? Why or why not?

CAPT's Response to Question 29

CAPT considers that the Minister could appropriately direct the health Colleges to consider interprofessional collaboration as part of their educative and supportive function. Above all, the Colleges could require the teaching and training institutions to teach according to a patient-centred, holistic, and collaborative model of health care.

The real change will come first in the teaching and training institutions and then at the clinical level—not through a series of new regulations. It would be short-term thinking to attempt a revolution in health care simply through regulations and other directives from above.

30. If so, should the Minister provide financial or other incentives to the Colleges to undertake these activities?

CAPT's Response to Question 30

CAPT considers that the Minister's interventions should be of a general kind, as stated above, in answer to Question 29, and therefore do not require special funding.

31. Should the Colleges be required to report to the Minister and/or the public on their collaborative activities on a regular basis? Why or why not?

CAPT's Response to Question 31

CAPT suggests that the Minister could ask that this matter be included in regular reports from the Colleges. The Colleges could make their reports available to the public on their respective Web sites.

32. Should minimum guidelines, standards and policies concerning matters such as conflict of interest, advertising, record keeping and the consent process be consistent across all Colleges? If yes, what guidelines, standards and policies could effectively be applied to all regulated health professions? If not, why not?

CAPT's Response to Question 32

CAPT considers that slight differences among the Colleges as to conflict of interest, advertising, record keeping, even ethics should cause no damage to the public. And it is a good thing that each College grapples with such issues itself. The public would be confused, however, if there were wide differences in the "consent process."

Anything, such as the consent process, which truly must be uniform across all the health Colleges, surely comes appropriately under the RHPA, its Procedural Code, or Ministry regulations under the RHPA.

If one of the Colleges was to a serious degree different in its guidelines, standards, and policies from the other Colleges, the Minister could intervene in favour of a higher degree of similarity—but this should happen only after the Colleges individually struggle to develop protocols appropriate to their own professions.

33. What kinds of structures and processes could facilitate collaboration among Colleges to address issues related to standards of practice and professional practice guidelines for those professions that deal with closely related activities (e.g. dental hygiene, dental technology, dentistry and denturism; or opticianry, optometry and ophthalmology)? (For example, joint colleges, collaborative Councils or independent bodies such as the Council for Healthcare Regulatory Excellence in the UK.)

CAPT's Response to Question 33

CAPT notes that the examples concerning dental professions and eye care professions are the easy ones, because dental science and eye science are each quite unified. There are no serious disagreements about the science within the dental professions—or about the science of eye care within the eye care profession. To reach agreement on standards of practice and professional guidelines in these professions should not be difficult. Only historical barriers of competition stand in the way.

But Ontario has embraced a group of health professions, for example medicine (Western), traditional Chinese medicine, homeopathy, and naturopathy, which all deal with the same body but see it in completely different ways.

The Government of Ontario has rightly decided not to ratify one of these over the other. As was stated in the Compendium for Bill 171,

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. (December, 6, 2006, 53)

In the same spirit, the government cannot ask for the standards of practice or professional practice guidelines to be the same for these professions, except in the most general sense—for example, that assessments be careful, that medications be monitored regularly, and so on.

A similar problem occurs in the internal regulation of psychotherapy across its own modalities (*Psychotherapy Act, 2007*). *New Directions* lists “the four basic psychotherapeutic orientations” and acknowledges that “Within each are various modalities” (208, Chapter 7, Section 3.2). It is clear also from the Ministry of Health and Long-Term Care's Fact Sheet concerning Bill 171 (December 12, 2006) that the

legislation embraces many modalities in the profession of psychotherapy, and has no intention of privileging one.

When *New Directions* suggested a list of elements common to all types of formal psychotherapy training, it was actually a list of skills needed by any health professional working one-on-one with patients/clients. Such requirements must be very general if we are to find common elements among the various psychotherapies.

Elements common to all types of formal psychotherapy training include the ability to: listen to and understand clients and patients and attend to nonverbal communication, develop and maintain a therapeutic alliance with patients and clients, understand the impact of the therapist's own feelings and behaviour so they do not interfere with treatment, and recognize and maintain appropriate therapeutic boundaries. (*New Directions* 210, Chapter 7, Section 3.5)

It is clear that the College of Psychotherapists will have within itself modalities as different from each other as Western medicine is different from homeopathy. Hence, the College of Psychotherapists has before it the considerable task of *internal* interprofessional collaboration.

CAPT, which had a role in helping to set up the Association of Psychotherapy Training Institutes (APTI), recommends to HPRAC APTI's work on a common curriculum (including modules for the different modalities) as a signal example of interprofessional collaboration among the teaching institutes.

The difficulties concerning psychotherapy are large enough internally for the new College. They increase mightily when we consider that five other Colleges also get the Controlled Act of Psychotherapy. No doubt these Colleges will wish to have their say about standards of practice.

CAPT wishes to speak up for the not-yet-formed College of Psychotherapists. In the name of the independence of the profession of psychotherapy and its College, we think the College of Psychotherapists must first be allowed to set its standards of practice and interpret its scope of practice and the Controlled Act of Psychotherapy. Only then should the other professions be invited into dialogue.

In general, CAPT recommends that since Ontario has embraced such diversity in its

health system, it should not lose heart and attempt to impose uniformity from above. **Rather, it should encourage a gradual interprofessional coming together by a similar transformation towards holistic health care in the education and training of all the health professions towards a holistic and collaborative patient-centred approach.**

34. Would the development of a *Collaboration Toolkit*, containing some or all of the elements suggested above, serve to facilitate and support collaboration among the Colleges?

CAPT's Response to Question 34

CAPT considers a *Collaboration Toolkit* as an **educative** tool for the Colleges to be an excellent idea.

35. If so, what should be included in a *Collaboration Toolkit* and who should be responsible for developing it?

CAPT's Response to Question 35

CAPT considers that among other things the *Collaboration Toolkit* might include

- a minimal/general code of ethics
- guidelines about the consent process
- examples of fruitful collaboration
- models of shared administrative structures.

Thinking of it as an educative tool and not a general regulatory protocol, we think the Federation of Health Regulatory Colleges of Ontario (FHRCO) would appropriately author it.

36. Should the standards of practice and professional practice guidelines that the Colleges adopt be legally enforceable? Why or why not?

CAPT's Response to Question 36

CAPT thinks the health Colleges should not increase their legal powers beyond what is already in place:

1. It is not necessary.
2. It would embroil the Colleges in the justice system. This would be a bureaucratic and financial nightmare.

CAPT is firmly opposed to increasing the legislative weight of the Colleges' function. That will lead inevitably to an increased emphasis on the policing role of Colleges, whereas the philosophic trend is towards the educative and supportive functions (see Gignac's presentation to the assembly at the Ministry meeting of October 31, 2007, Slide 7).

Increased legal powers will also invite increased litigation, with its paralyzing and expensive consequences. That will turn the focus of change away from the educational system and from what is needed if the various health disciplines, services, and trainings are to move to a holistic, integrated human focus that encourages collaboration.

37. If so, should the Colleges be given statutory rule-making powers (as in New Brunswick) allowing them to enforce the standards of practice and professional practice guidelines that they adopt? Why or why not?

CAPT's Response to Question 37

CAPT considers that the authority to register and de-register members is quite adequate. Besides, if given statutory rule-making powers, the Colleges could be pressured towards an expansion of their policing functions. Then the preferred educative function of the Colleges could be overwhelmed.

38. What kinds of enforceable rules should the Colleges be able to make without needing Ministerial or legislative approval?

CAPT's Response to Question 38

CAPT considers that the Colleges have all the powers they need. Our view is that the Colleges' ability to register or de-register members is sufficient regulatory power for securing the public good, which requires integrity, competence, and continuing education on the part of all the members.

CAPT envisages the Colleges together embracing a holistic, patient/client-centred health care. Their influence will be in two directions:

1. Towards an educative influence on the members of the College.
2. Towards collaboration with the teaching institutions so that training for the professions is consciously patient-centred, holistic, and collaborative.

We repeat that the change must be initiated at the level of the teaching institutions.

V.4. INTERPROFESSIONAL CARE AT THE CLINICAL LEVEL

40. How will greater collaboration among the Colleges serve to enhance interprofessional care at the clinical level?

CAPT's Response to Question 40

CAPT reiterates how important it is that the College of Psychotherapists be permitted the necessary time, first, to determine the competencies of the psychotherapy profession under the regulatory framework before the other Colleges are invited into dialogue.

However, once the College of Psychotherapists has had sufficient time to establish its standards of practice and professional guidelines, collaboration at the College level, including the College of Psychotherapists, could mean a sharing of ideas and approaches towards a truly patient-centred health care system that would include psychotherapy. The Minister could direct the health Colleges to consider interprofessional collaboration as part of their educative and supportive function. As well, the Colleges could request that the teaching and training institutions teach according to a patient-centred, holistic, and collaborative model of health care. This would encourage a gradual transformation in the education and training of all the health professions towards a holistic and collaborative patient-centred approach—which would enhance the care of the patient/client.

Many of the psychotherapy training schools in Ontario, already within that holistic tradition, have recent experience working collaboratively towards a shared educational goal. The Association of Psychotherapy Training Institutes (APTI) has created a common curriculum (including modules for the different modalities)—a signal example of interprofessional collaboration among the psychotherapy training institutes. Professional sharing among the health regulatory Colleges, of the sort demonstrated by APTI with a focus on education and training, could be very informative and beneficial—a co-operative, collegial enterprise that could increase respect at both the collegial and clinical levels among professionals, encouraging the Colleges and their members to

work collaboratively rather than competitively. The trickle-down effect would encourage and enhance interprofessional, collaborative care of the patient at the clinical level—and could also meet initiatives from those working at the clinical level.

We have already explained how psychotherapy has special requirements for a confidentiality that goes beyond ordinary privacy rights. (See particularly Sections III and IV, and responses to Questions 12, 13, and 22-26.) For this reason, collaboration with a health team including psychodynamic psychotherapists could at times be parallel, but the intrinsic requirement for confidentiality sets psychotherapy apart from other health care providers. Provisions for the requirement of confidentiality must be factored into any collaborative arrangement at the clinical level, in order to protect the patient's/client's rights and care.

Summary of CAPT's response to Question 40:

- Once the College of Psychotherapists has determined the competencies of the psychotherapy profession, collaboration at the College level could mean a sharing of ideas and approaches towards a truly patient-centred health care system.
- The Colleges could request that the teaching and training institutions teach according to a patient-centred, holistic, and collaborative model of health care.
- APTI provides a signal example of interprofessional collaboration among the psychotherapy training institutes that could be used as a model for educative collaboration among the health Colleges. This kind of co-operative, collegial enterprise could increase respect at both the collegial and clinical levels among professionals, ultimately encouraging interprofessional, collaborative care of the patient at the clinical level.
- Provisions for the requirement of confidentiality must be factored into any collaborative arrangement at the clinical level, in order to protect the patient's/client's rights and care.

41. Are any changes to the *RHPA*, the health profession acts or their regulations needed to encourage, require, facilitate and enable interprofessional care at the clinical level? If so, what are they?

CAPT's Response to Question 41

Where the Government could help enormously is by creating an alternative funding system that removes all entrepreneurial pressure from health care. Most medical doctors are currently in an entrepreneurial relation to public funding. There is high motivation to specialization and to multiply the exact service of the specialty. There is generally no reward for contextualized and interprofessional care.

This issue is softly treated in several places in your *Discussion Guide*. It is said that other financial models are being developed. CAPT understands that there are 150 teams of medical doctors, family health teams, already in collaborative salaried practice in Ontario. We generally support this approach, with the already noted requirement that psychotherapy be handled differently, as it has special requirements related to the issue of confidentiality—for the protection of the patient, as a matter of patient rights.

42. Should Ontario law have a requirement similar to the one in New Zealand?

CAPT's Response to Question 42

CAPT considers that to follow the New Zealand example would be to inject a spurious clarity and simplicity into the matter of interprofessional health care. Moreover, it could breed unnecessary litigation.

Again we emphasize that the first place for change and development is in the teaching and training institutions. Following from that, there should be dialogue between the College and the appropriate teaching institutions. Then there will emerge a core of health professionals educated in patient-centred, holistic, and collaborative care.

VI. SUMMARY

The College of Psychotherapists, as the primary College governing psychotherapy, needs to have the primary responsibility of setting its standards of practice and bringing clarity to the Controlled Act and the scope of practice, even though five other Colleges share the same Controlled Act. As the Minister's letter to HPRAC acknowledged, "individual health Colleges independently govern their professions and establish the competencies for their profession."

CAPT welcomes the movement towards a more patient/client-centered, holistic approach to health care, which is consonant with psychodynamic psychotherapy's long tradition of this. We support the thrust toward interprofessional collaboration, particularly at the College level, encouraging a sharing of ideas and approaches aimed at enhancing the care of the patient/client.

Interprofessional collaboration involving psychotherapy, either at the College level or at the clinical level, could at times be parallel and respectful. However, CAPT has some concerns with interprofessional collaboration at the clinical level:

- Psychotherapy clients' search for meaning should not be medicalized. The medicalization of the client's therapy is a particular risk if the psychotherapist is seen as just another member of an interprofessional, collaborative health team.
- The requirement for confidentiality in psychodynamic psychotherapy sets psychotherapy apart from the rest of the health care system and requires a different approach for psychotherapy at the clinical level than for the interprofessional collaboration generally practiced either within a single profession (College) or, for example, by family health teams. This requirement for confidentiality goes beyond ordinary privacy rights. Provisions for the requirement of confidentiality must be factored into any collaborative arrangement at the clinical level, in order to protect the patient's/client's rights and care.

As a way to guard against even the suspicion that the therapist would share anything about the therapy with another member of an interprofessional team, CAPT recommends the development and standardization of a form in which the client declares that he or she does not want anything from the therapy shared with anyone else on the team.

CAPT supports the principle of accountability, but the confidentiality and sensitive nature of psychotherapy raise special considerations for the development of a complaints, investigations, and discipline procedure. Psychotherapy needs a special kind of complaints and discipline procedure. CAPT strongly recommends that the College of Psychotherapists be given time and latitude to do the necessary work to establish a complaints procedure specific to the profession of psychotherapy. The College of Psychotherapists must itself work out the specific needs of a complaints process particular to psychotherapy, and one that is not subsumed under a single complaints model for all the health Colleges.

While CAPT favours removing obstacles and rigidities in the regulatory system, we think that real change towards interprofessional collaboration should come first from the teaching and training institutions and then from voluntary initiatives at the clinical level. Looking to the long term, a revolution in health care is unlikely to come from oversight bodies and more regulation. Rather, we could expect to see collaboration between the Colleges and between the professions at the clinical level if the teaching and training institutions themselves practice collaboration and promote appropriate models of interprofessional care for all the professions. The Colleges, of course, in their regulatory and educative role would be in dialogue about this with the teaching and training institutions.

VII. FINAL REMARKS

Thank you for inviting CAPT to participate in this conversation. Going forward, we hope to be invited to all future consultations that may have an impact on the College of Psychotherapists and the practice of psychotherapy in the Province of Ontario. CAPT looks forward to continued collaboration in this regard.

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