

**TASK GROUP FOR COUNSELLOR REGULATION
IN BRITISH COLUMBIA**

**COMMENTARY ON THE ISSUES RELATING TO THE
REGULATION OF PSYCHOTHERAPY AND PSYCHOTHERAPISTS
IN ONTARIO**

A submission to the Health Professions Regulatory Advisory Council of Ontario

October 28, 2005

TABLE OF CONTENTS

1) INTRODUCTION	2
2) ORIGINS OF THE TASK GROUP	2
3) WHY REGULATE HEALTH PROFESSIONALS?	3
3.1) The regulatory models.....	3
3.2) Risk of harm - the hub of the regulatory wheel.....	7
4) REGULATING PSYCHOTHERAPY IN BRITISH COLUMBIA.....	8
5) REGULATING COUNSELLING IN BRITISH COLUMBIA	10
5.1) Chronology of events (1993 to the present)	10
5.2) Reasons why counsellors should be designated under the HPA	11
6) COMMENTARY ON THE 22 QUESTIONS	13
6.1) Defining psychotherapy	13
6.2) Comments on the working definition.....	14
(a) Psychotherapy as a controlled act.....	14
(b) Psychotherapy as scope of practice definition.....	15
(c) Differentiating between psychotherapy and counselling	16
6.3) Psychotherapy risk of harm	16
(a) Harm resulting from incompetence.....	17
(b) Harm resulting from unethical practice.....	18
(c) Harm resulting from impaired practice	18
(d) Harm resulting from unprofessional practice.....	18
6.4) Decreasing risk of harm	19

6.5) Other factors for/against regulation	21
6.6) Meeting a public need by regulating psychotherapists?.....	22
6.7) Restricted title?	22
6.8) Regulating psychotherapists but not psychotherapy	23
6.9) Other issues re: regulating psychotherapists	23
6.10) Meeting a public need by regulating psychotherapy?.....	24
6.11) Regulating psychotherapy without regulating psychotherapists	24
6.12) Other issues re: regulating psychotherapy.....	24
6.13) Use of the RHPA.....	25
6.14) Psychotherapy as a controlled act	25
(a) Defining the controlled act through a risk of harm analysis	25
(b) Who should perform a psychotherapy controlled act?.....	25
6.15) Create a new college or join an existing one?	26
(a) Minimum number of registrants	27
(c) Significance of the entry requirements.....	27
(d) Joining a college of psychologists?	27
6.16) Other regulatory frameworks.....	28
6.17) Other regulatory models?	28
(a) The “no strings attached” title protection model	28
(b) Voluntary, non-statutory self-regulation.....	29
(c) Delegation and its short-comings.....	30
6.18) Exceptions?.....	31
6.19) Transitions?.....	32
6.20) Continued practice through a transition?.....	32
6.21) Grand-parenting?	32
(a) Grand-parenting existing practitioners.....	32
(b) Porting existing practitioners.....	33
(c) Limited registration.....	34
6.22) Entry standards?.....	34
(a) Who should set the entry standards?.....	34
(b) How should the entry standards be set?	34
(c) Why establish competency-based entry standards?	36
7) ADDITIONAL COMMENTS.....	38
7.1) Regulation by title protection now, and controlled acts later	38
7.2) Separation of functions.....	38
7.3) Psychological diagnosis as a reserved action	39

1) INTRODUCTION

The BC Task Group for Counsellor Regulation (“Task Group”) is submitting this Commentary to the Health Professions Regulatory Advisory Council of Ontario (“Ontario Council”) because the Group anticipates that the answers to the 22 questions posed by the Council and, in particular the conclusions the Council may draw from those answers in its final report to the Ontario Minister of Health and Long Term Care, may have an impact on the decisions of the BC government in relation to the regulation of counselling in this province. Indeed, the Group is providing the BC Ministry of Health with a copy of this submission at the same time that it is being presented to the Ontario Council.

In this Commentary, the Task Group will begin by explaining its understanding of the legal and social policy reasons for regulating health professionals, regardless of the type of profession being considered for regulation or which province is considering this question. In doing so, the Group will focus on the two basic models of professional regulation that can be derived from both BC’s and Ontario’s health professions legislation.

With this foundation, the Group will provide an overview of the situation in BC concerning the regulation of both psychotherapy and counselling.

The Group will then offer comments in response to the Ontario Council’s 22 questions; comments the Group hopes will contribute to the Council’s final report to the Minister.

In the last section, the Group will address some additional issues.

Before embarking on these topics, the origins and composition of the Group will be summarized.

2) ORIGINS OF THE TASK GROUP

The Task Group for Counsellor Regulation was formed in 1998. The year before, BC’s Health Professions Council (“BCHPC”) had recommended an alternative to designating counselling under BC’s *Health Professions Act* (“HPA”). In response to pointed criticisms of the Council’s faulty analysis and its mishandling of the counselling applications, the Ministry of Health hired a consultant to look at different models for regulating counsellors, including the option of designation under the HPA. In order to prepare a common submission on those issues and to communicate a united position to the Ministry on the best form for counsellor regulation in BC, a number of professional associations formed the Task Group.

The Task Group is currently comprised of the BC Association of Clinical Counsellors, the American Association of Pastoral Counsellors, the Association of Substance Abuse Programs of British Columbia, the Canadian Counselling Association (BC Chapter), the Music Therapy Association of BC, the BC Art Therapy Association, and the BC

Association for Marriage and Family Therapy. Collectively, these seven member organizations represent some 2,500 counsellors across BC.

3) WHY REGULATE HEALTH PROFESSIONALS?

It is useful to discuss the legal and social policy reasons why governments decide that a health profession (or any profession for that matter) should be regulated under provincial statute, and what informs government decisions about the form that such regulation should take.

The Task Group agrees with the Ontario Council and the Ontario Coalition of Mental Health Professionals (“Ontario Coalition”) that a decision to regulate any health profession or health service should be based on a risk of harm analysis. The Group undertook its own analysis in its 1998 submission to the BC Ministry of Health, and the information in this section is based on that submission.¹

Before making any decision on whether or not to regulate a profession, and the form that such regulation should take, it is important to consider the nature of the risks of harm to the public that can be reasonably associated with the services that are provided by that profession. Such an analysis is important, because the rationale to regulate any profession and the decision as to the particular form of regulation should both be based on a clear understanding of the risks of harm and the options that best reduce or eliminate those risks.

The focus of this section of the Task Group’s Commentary will be on the importance of undertaking a risk of harm analysis, and the usefulness of the information that such an analysis can provide. Later, in response to the Ontario Council’s question #3, the Task Group will identify the physical, psychological, emotional and financial harms that reasonably can be expected to occur if counselling services are provided by persons who are *not* sufficiently skilled, knowledgeable or experienced, as well as harms that may occur if counselling services are provided in an unethical or impaired fashion.

Before discussing a risk of harm analysis, however, it is useful to describe the legislative and social policy framework into which the results of such an analysis can be employed to create the most appropriate regulatory model.

3.1) The regulatory models

Articulating the risks of harm associated with the services commonly provided by a profession can help to identify the type regulatory model that government should employ which would most effectively address the identified harms at the lowest, reasonable cost to all concerned. But since the types of regulatory models government’s can employ are limited, it is useful to first look closely at the legislative options.

¹ *Joint Response to the Discussion Paper on the Regulation of Counselling*, a submission to the BC Ministry of Health, prepared by the Task Group (November 20, 1998).

In its 1994 report, *Regulating Professions and Occupations*, the Manitoba Law Reform Commission (“MLRC”) made a clear distinction between the sorts of risks of harm that should lead to a licensing model (in which “controlled acts” in Ontario or “reserved actions” in BC are granted to one or more professions) and those which indicate that a certification approach (i.e. in which only title protection is granted to a profession) would be more appropriate. The Commission’s observations were applied and elaborated on by BC’s Health Professions Council (“BCHPC”).

On pages 9 to 10 of its July 1998 report on the designation of traditional Chinese medicine under BC’s HPA, the BCHPC made an important observation about the social policy criteria for regulating a health profession under that statute. The Task Group believes these comments have a broader application and are relevant to the Ontario Council’s current project.

The Public Interest Criteria contained in s. 5(1) of the Regulation provide the context in which the Council will analyze the risk of harm in the applicants' practice. While the Council may also consider the s.5(2) criteria in making its designation decision, these criteria do not address risk of harm. If the Council decides that the profession should be designated, the Council will determine an appropriate scope of practice statement for the profession. The Council will then determine which aspects of the scope of practice have been shown to present a significant risk of harm. These will be defined as reserved acts, as directed in s.10(3)(b)(v) of the HPA and the Council's Terms of Reference. Any other aspects of the scope of practice of a health profession are considered to be capable of being shared with other health practitioners and the general public.

There is a distinction between analyzing risk of harm for the purposes of s.5(1) and for reserved acts. The s.5(1) analysis is broadly based and looks at the extent of the risk of physical, mental or emotional harm to the health, safety or well being of the public in the practice of the profession. This analysis looks generally at the services performed by practitioners, the technology used, the invasiveness of procedures or treatments and the degree of regulation or supervision of practitioners, as directed in s.5(1)(a), (b), (c) and (d). The Council will make its determination of whether the profession should be designated on the basis of this analysis together with the analysis of the criteria contained in s.5(2) of the Regulation.

After it is determined that the profession should be designated, a more narrowly focused risk of harm analysis is conducted to determine whether the health profession will be granted one or more reserved acts. The Council emphasizes that it is not necessary for a health profession to be granted any reserved acts in order to be designated. However, once the decision to designate is made, the Council will look at whether there are acts or activities within the profession's scope of practice which present such a significant risk of harm that they must be designated reserved

acts, as directed in s.10(3)(b)(v) of the HPA. In the Shared Scope of Practice Working Paper issued by the Council in January 1998, reserved acts have been restricted primarily to physical acts which carry a significant risk of harm.

It is clear from this extract that the BCHPC identified two distinct types or levels of harm that justify professional regulation.

The first or lower level of harm analysis considers whether it is in the public interest to designate a profession and grant it some form of title protection. Granting a profession only title protection is useful if no serious risks of harm can be reasonably associated with the provided services, but where instead it is necessary to help the public to distinguish or differentiate between those who are members of a professional regulatory body and thus accountable to their peers, and those who are not. As was also noted by the MLRC, professionals who are regulated under a title protection only model are known as “certified professionals”.

Usually, certified professionals must meet certain minimum qualifications, and agree to abide by a code of ethics. Their conduct can be investigated by their regulatory body, even if they quit the profession. Thus, the title protection model provides the public with some assurance that the professional who is using an exclusive title has basic competencies, must follow a code of conduct and is accountable to an authority for incompetent or unethical behaviour. Under this model, the public is free to purchase services from a certified professional or from anyone else who may also be providing those same services. This is because a practice monopoly is not granted to a profession under a title protection model. Anyone can provide the services in question.

The second or higher level of risk of harm analysis considers a different type of public interest the results of which can lead to the granting of an exclusive occupational title *and* some form of practice monopoly (e.g. a controlled act in Ontario or reserved actions in BC). If a profession is granted a controlled act, this has the effect of limiting public choice. Only that profession (and others who may also be granted that same controlled act or a similar one) would be allowed to provide those restricted services. Those who have not also been granted the controlled act could be subject to injunction or prosecution for contravention of the controlled act prohibition that is itself set out in the governing legislation. Usually, governments will not act to establish controlled acts unless the risks of harm of not so acting are sufficiently great as to warrant such a reduction in public choice. The greater the risk, the less choice will be allowed.

In its 1998 report, the BCHPC also noted that it is not necessary for a health profession to be granted a reserved action (controlled act in Ontario) in order to be designated under the HPA. Indeed, there are regulated professions in both Ontario and BC that have not been granted any practice monopolies, and yet there is a clear public interest in their continued regulation. For example, in Ontario, regulated massage therapists have not been granted any type of controlled act, and yet it is clearly important that massage therapists continue to be regulated by a College under the HPRA because they provide a

“hands on” therapy to nude or nearly nude members of the public, behind closed doors, and without supervision.

For governments to grant a profession a controlled act (as opposed to just title protection), a serious risk of demonstrable harm must be reasonably associated with the service or function in question. In particular, the harm should result if the service is provided by those who are not suitably trained so as to avoid or minimize the identified risks. To date, the primary focus has been on identifying the physical harms associated with health care services, and this has led to the creation of a list of very specific, and narrowly-defined controlled acts in Ontario and a similar list of reserved actions in BC.

Given the two different models for regulating health professionals, a number of important questions need to be addressed in the risk analysis before deciding which model would work best:

- What is the precise nature of the harms to the client/patient (if not also third parties) that can reasonably be associated with the services or function in question? Are the harms physical, psychological, emotional, financial, etc.?
- Do these harms have serious consequences, or do they result in relatively minor outcomes? Or can the outcomes vary, and if so, why?
- Is everyone likely to be effected in a similar way in terms of adverse outcomes? Or are there individual characteristics that need to be taken into consideration that can modify or reduce either the harm or its likelihood?
- If a particular harm is a frequent or common outcome, is it also a one that has nominal or minimum adverse consequences for the person so effected? Or is it a fairly uncommon result, but one that can very severe consequences for the person so affected?

Once the potential risks of harm have been thoroughly documented, the analysis would then turn to considering how those risks can be minimized or the harms reduced:

- What steps can be taken to reduce or eliminate the identified risks of harm?
- In what specific way would these steps reduce or eliminate the risks of harm?

Once the risks and harms have been identified, and the corresponding corrective measures have been developed, it is then necessary to consider if those measures provide a basis to define a controlled act that could be subject to a legislative prohibition. This further step in the policy analysis may lead to the conclusion that only a title protection model is needed. Or some other solution may be identified other than government regulation.

The Task Group will have more to say about what it believes would be the best model to regulate psychotherapy or psychotherapists later in this Commentary. Our point here is that the process of choosing the best model should be based on a clear understanding of the risks of harm to the public.

Determining whether the risks of harm associated with the provision of psychotherapy can be best reduced or eliminated by way of a title protection (certification) model, or by

reducing public choice and applying the controlled acts (licensing) model is the essence of the Ontario Council's task. But regardless of which model is eventually decided, a risk of harm analysis can also provide useful information when it comes time to later implement either model.

3.2) Risk of harm - the hub of the regulatory wheel

An accurate and meaningful description of the risks of harm associated with the services commonly provided by a profession can contribute toward defining and improving the effectiveness of a regulatory model itself, be this a certification (title protection) or licensing (controlled act) model. For example, meaningful descriptions of the risks of harm should lead to the following:

- An articulation of the sorts of competencies and ethical behaviour that persons who provide the service (either generally or in the form of a controlled act) should possess so as to reduce or eliminate the potential harms.
- The development by a college of examination questions or practical tests that can be used to ascertain whether or not an applicant to the profession has sufficient knowledge, skill, ability and judgment to safely and ethically provide the profession's services (either generally or in the form of a controlled act).
- The identification of the core elements of a set of professional practice standards and a code of professional ethics to guide the behaviour of the profession (when either carrying out the controlled act or providing services within the general scope) and, when necessary, to use those standards as a reference in assessing an individual's conduct during an investigation or a later disciplinary hearing.
- The development of appropriate continuing education programs so that members of the profession will continue to provide their services in a competent and ethical fashion.
- The setting of priorities for self-monitoring functions, annual performance or practice audits, case reviews or similar activities.

The Task Group has come to appreciate that a risk of harm analysis forms the center or the hub of the regulatory wheel. With a clear understanding of risks of harm, it is possible to move outward and develop each of the above program elements in a coherent and meaningful fashion (the "spokes" of the regulatory wheel), and to also help to define how each program would relate to the others (the "rim" of the regulatory wheel).

In turn, the success of the regulatory model and these various program elements can be measured by observed changes in reported incidents of actual harm caused to the public, be this caused by registrants or non-registrants. Such harms can be identified by monitoring public complaints to the regulatory body, law suits filed against members of the profession and others (and possibly claims dealt with by professional insurance companies), the laying of criminal charges, and employer initiated disciplinary proceedings.

For many of the health professions who are currently regulated across Canada, a comprehensive risk of harm analysis was not undertaken before they were regulated. For most health professions, the harms were perhaps fairly obvious, and it did not require

much imagination to understand why governments should pass legislation to regulate those professions.

The same, unfortunately, cannot be said of those helping professions whose services do not have a direct effect on the body of a client/patient. Thus, before governments move forward with regulating professions like counselling or psychotherapy, in particular in the current climate of “de-regulation”, it is necessary to devote some attention to a risk of harm analysis. Such an analysis should provide useful information in terms of helping decision-makers define both the scope of the problem and the best or most cost-effective solutions.

4) REGULATING PSYCHOTHERAPY IN BRITISH COLUMBIA

In the late 1990s, psychologists petitioned the BCHPC to recommend to government that psychotherapy become a “reserved act” under BC’s HPA, and – in turn – to grant to psychologists the proposed psychotherapy reserved act.

In rejecting both proposals, the BCHPC made a number of observations about regulating psychotherapy. These observations were set out in Part I – Vol. 2 “Post-Hearing Update of Preliminary Report – Psychologists”, a part of the BCHPC’s 2001 report, *Safe Choices*. The BCHPC’s comments are set out here in their entirety.

A. Psychotherapy: Proposed Reserved Act

The BC Psychological Association (Association) and others have submitted a number of post-hearing articles and letters which discuss the restrictions on psychotherapy which exist in Quebec and Alberta and forty-three states. The Association continues to assert that psychotherapy presents a significant risk of harm when used with patients who have a documented psychological diagnosis. This is the position being advocated in Ontario by the College of Psychologists of Ontario in response to the *Regulated Health Professions Act Five-Year Review*. For persons without a documented psychological diagnosis, the Association asserts that psychotherapy can be performed without significant risk. This would allow counselors and social workers to perform psychotherapy for clients who have not been diagnosed with a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life. This rationale is based upon the vulnerability of such patients and the belief that a substantial risk of harm can involve both physical and psychological, emotional or mental harm.

The Association cites the Montreux Clinic situation in Victoria as an example of psychotherapy which proved harmful when used with patients who had been diagnosed with such a disorder. Hypnotherapy was also cited as potentially harmful when used with a patient having a diagnosed psychological disorder.

The Association's argument is that psychotherapy requires the ability to diagnose. Inherent in diagnosis of mental or psychological disorders is the concept of treatment. Treatment requires knowledge of indications and contraindications for such treatment (psychotherapy). In the Association's submission, psychotherapy should require a prescription, if not performed by a practitioner with the ability to diagnose.

The Council has given careful consideration to the submissions made by the College of Psychologists of British Columbia (College) and the Association. The Council has not recommended that "psychotherapy" be made a reserved act for the following reasons:

- * The risk of harm proposed is contingent upon the presence of a contraindication. ... In the Council's view, activities which are harmful on contingency are not properly the subject of reserved acts.
- * Psychotherapy is difficult to define. The Council received submissions that over 400 types of interventions can be considered to be psychotherapy;
- * Restricting psychotherapy would inhibit the practice of other counsellors or therapists;
- * The reserved title "psychologist" provides protection to the public who are seeking psychotherapy; and
- * The Council has added the term "psychotherapy" to the scope of practice statement for psychologists.

On page 11 of its *Consultation Discussion Guide* (September 2005), the Ontario Council stated: "British Columbia has been reviewing the regulation of psychotherapy for many years."

The Task Group has received no indication from the BC Ministry of Health that it intends to depart from the BCHPC's 2001 recommendation that psychotherapy *not* become a reserved action under the HPA. Certainly, the Ministry has not proposed in any public document that psychotherapy will become a reserved action or even that it would be granted to psychologists or any other health professions under the HPA.

It may be that the Ontario Council's comment refers to the on-going review of the regulation of counselling in BC.

5) REGULATING COUNSELLING IN BRITISH COLUMBIA

The following is a chronology of the major events that have taken place in BC since the early 1990s, when the issue of regulating counselling was put on the table before the BCHPC.

5.1) Chronology of events (1993 to the present)

- *1993 to 1995:* Four counselling associations apply separately to the BCHPC to have their memberships designated under the HPA.² The BC Council unilaterally merges the applications with one other from a non-counselling profession, and did so without giving the applicants an opportunity to comment on that decision.
- *1997:* The BCHPC issues its final report, concluding that counselling was a health profession, and that there is a need to regulate the professions, but it did not recommend designation. The Council felt there was too much diversity in education, training and services among the counsellors from the merged applications and it was also concerned that an acceptable collective leadership might not emerge.
- *1998:* In response to the associations' criticisms of the Council's recommendations and its mishandling of their applications, the Ministry of Health³ hires a consultant to look at different regulatory models for regulating counsellors. The professional associations form the Task Group for Counsellor Regulation to communicate a united position to the Ministry on the best form of counsellor regulation.
- *November 1998:* The Task Group proposes a comprehensive model for regulating the profession under the HPA. In brief, the Group proposes a two-tiered registration mode (a generalist entry level with different classes for advanced competency registration in such areas as marriage and family therapy). The Group also adopts a competency-based approach to defining educational standards for registration in all classes.
- *1999:* The Ministry for Children and Families (MCF)⁴ issues a report on the need to regulate social service professionals, responding to the earlier recommendation of the Gove Commission that the MCF should revise the *Social Workers Act*. Instead of addressing that specific issue, however, the MCF recommends an umbrella statute, like the HPA, but with a super board that would oversee the regulation of all social service professionals. Without involving the Task Group, the MCF includes all counsellors in its ambitious model, even though very few counsellors provide services to MCF clients.
- *2001:* The Ministry of Health provides the Task Group with a copy of a confidential draft designation regulation. The Group provides its comments in May 2001, but has not heard back from the Ministry since. Because of its separate legislative initiative

² Health professions can be designated and new Colleges created by way of regulations approved by Cabinet under the HPA. The Legislature does not have to approve designation by way of a new statute.

³ Over the years, the Ministry of Health had been reorganized and renamed. For the purposes of this commentary, this original name will be used to refer to the Ministry that administers BC's HPA.

⁴ The Ministry for Children and Families has also undergone changes and been renamed. For the purposes of this commentary, the initials MCF will refer to this Ministry.

(see 1999 above), the MCF refuses to support the designation of counselling under the HPA.

- *2003*: After several meetings from 1999 to 2003, in October the MCF finally advises the Ministry of Health that it no longer objects to the designation of counselling under the HPA.
- *2003*: The Task Group initiates a process to identify competencies for counsellor registration that will also provide more details for an appropriate registration model.
- *May 2004*: After reviewing a list of general competencies and confirming the competency-based registration model it first proposed in 1998, the Group agrees to develop of a full set of specific competencies for counselling therapy registration.
- *September 2005*: After reviewing a draft of a full set of specific competencies for counsellors, the Task Group agrees to move forward with establishing the specific domains for each statement and validating the final profile.
- *November 2005*: Members of the Task Group will sponsor a national symposium in Vancouver to study the regulation of counselling across Canada.

5.2) Reasons why counsellors should be designated under the HPA

In a Ministerial Briefing Note the Task Group has presented to the Minister of Health, the Group set out a number of reasons why it believes that counselling should be regulated under BC's HPA and a new College of Counselling Therapists created to regulate this profession. The following reasons are based on that Note.

- While it did not recommend designation of counselling in 1997, the BCHPC did find that counsellors were a health profession as that term is defined under the HPA, and - because of the sensitive nature of the services they provide to the public, often done behind closed doors – there is a public interest in regulating counsellors (e.g. counsellors should have minimum competencies to be registered, follow a code of ethics and practice standards, and be accountable through a complaint investigation and resolution process established under legislation).
- Since 1998, the different counselling associations have demonstrated that they can work together collectively for the public benefit and – more importantly - that their members will continue that cooperation as registrants of a College of Counselling Therapists established under the HPA. The Task Group believes that it can develop a governance structure that will ensure continued goodwill amongst the different counselling professions.
- The members of the Task Group have spent or are committed to spending about \$80,000 to develop a comprehensive competency profile. This profile will provide about 500 detailed specifications which will, in turn, create a clear, measurable and defensible entry-level registration standard for counselling therapists in BC. (See the Attachment for details re: the validation of the draft set of competency statements.)
- In any form of regulation, it is critical that the public be able to readily differentiate between counsellors who are accountable to a professional body and those who are

not. Unlike HPA colleges and with three exceptions,⁵ the counselling organizations that make up the Task Group do not have legislative control over an occupational title. Designating counsellors under the HPA would include one or more occupational titles that only registrants of the new College could use, and this would in turn help the public make an informed choice.

- Designation of counselling under the HPA under a title protection model will not prevent non-registered counsellors from continuing to provide counselling services to the public;⁶ they would only be prevented from using one of the occupational titles granted to registrants of the new College.
- Counsellors who belong to the member organizations of the Task Group currently use titles that use adjectives like “registered” or “certified” in their titles to signify their membership in a professional association. If designation does not take place before the 2003 amendments to the HPA come into force those new provisions will limit use of these adjectives. As a result, many thousand of counsellor practitioners, ninety percent of whom are in private practice, would have to stop identifying themselves by the widely recognized titles that have become closely associated with a commitment to professional self-regulation, albeit voluntary and not supported by government legislation. This perhaps unintended effect of the 2003 amendments would not be in the public interest.⁷
- Every year, the different professional associations of the Task Group spend a total of about \$200,000 investigating and resolving public complaints against their members. Their memberships are prepared to transfer those resources to help support the work of a new College under the HPA. It is unrealistic for the government to expect the associations will continue to provide this service to the public without some movement toward designation under the Act.
- Despite investigating and resolving public complaints, the professional associations do not enjoy the legislative benefits that are given to colleges established under the HPA. For example, unlike HPA colleges, the associations cannot investigate or discipline former members who have resigned so as to avoid a complaint investigation. The associations also do not benefit from the protection from liability of exercising disciplinary powers that is given to HPA colleges under the *Disciplinary Authority Protection Act*. More importantly, the association’s inspection powers are restricted if a member refuses to cooperate, and their powers of persuasion to encourage a member to cooperate are very limited.

⁵ The BCATA holds occupational title protection under what is now Part 10 of BC’s *Society Act* for the title “Art Therapist, Registered”. The Canadian Association for Music Therapy holds the registered trademark of “Music Therapist Accredited” under the federal *Trade-marks Act*, and members of the provincial associations are entitled to use this title if they meet the requirements of the CAMT’s accreditation process. The Canadian Counselling Association holds a trademark for the title “Canadian Certified Counsellor”, also under the federal *Trade-marks Act*, which is used by its members in BC and across Canada.

⁶ An exception might be if psychologists are granted a reserved action of “psychological diagnosis”, in which counsellors may apply to be granted a similar reserved action. See section 7.3 under Additional Comments.

⁷ It is not clear what the effect of the HPA prohibition will be on the occupational titles that have already been granted or are used under the authority of BC’s *Society Act* or the federal *Trade-marks Act*.

- Unlike HPA colleges, members of the public are not appointed to the boards of the professional associations, and the associations are not accountable to either the Ombudsman or the Ministry of Health for the way that they investigate and resolve complaints. Designation would ensure public accountability.
- About 2,500 counsellors are members of the existing professional associations that form the Task Group. An estimated 2,000 other counsellors are not members of any association, so they are not accountable, even under the current, limited form of voluntary self-regulation.
- Designating counselling therapists under the HPA will not cost the government any money, because the estimated 4,500 counsellors who could become registrants will pay the cost of running the new College. The Task Group estimates that an annual fee of \$350 should be sufficient to have that number of counsellors fully fund the operations of the new College and help it meet its mandate under the HPA.

6) COMMENTARY ON THE 22 QUESTIONS

In this section, the Task Group will provide its comments in response to the Ontario Council's 22 questions as set out in the its *Consultation Discussion Guide* ("the Guide").

6.1) Defining psychotherapy

QUESTION: Is it necessary to define psychotherapy in order to effectively regulate it? If so, is broad agreement on a definition necessary?

In the Introduction of its Guide, the Ontario Council states that formulating a clear definition of psychotherapy is an important first step in addressing the question as to whether or not psychotherapy or those who provide this service to the public should be regulated.

The Task Group appreciates that it is necessary to define psychotherapy, if not also reach an agreement on a single definition, but this step is critical only so long as psychotherapy or some subset of this therapy is to become a controlled act under Ontario's health professions legislation. If psychotherapy is to become a controlled act, then a clear, precise and accurate definition is required. In particular, the defined controlled act of psychotherapy should be sufficiently narrow so that it does not embrace those aspects of professional practice or psychotherapy that do not constitute a risk of harm (or at least not a serious risk of harm) to the public.

On the other hand, if psychotherapy will *not* become a controlled act under Ontario's legislation, but instead if psychotherapy is to be regulated indirectly (by regulating those who provide psychotherapy) through a title protection model, then it would be necessary to define only the scope of practice of psychotherapists (and possibly also the practice of other health professions who may also provide psychotherapy). In other words, if psychotherapists are to be regulated without granting them a controlled act of psychotherapy, then the definition or scope of practice of a psychotherapist can be more broadly or generally stated than would be the case if it was necessary to describe psychotherapy as a controlled act.

In this respect, there is a relationship between defining what may become a controlled act under Ontario's legislation (e.g. "psychotherapy") and those who may provide psychotherapy (e.g. "psychotherapists"), whether or not psychotherapy becomes a controlled act. On the other hand, because there are two different legislative reasons for defining these terms, it is likely that the two definitions will be quite different from each other. And whether both or only one term needs to be defined will depend on what form or model of regulation will be applied.

6.2) Comments on the working definition

QUESTIONS: Please comment on the working definition. Are there elements that should be included or deleted?

In its *Consultation Discussion Guide*, the Ontario Council has proposed a working definition for psychotherapy:

Psychotherapy is the treatment of a person or persons (who have cognitive, emotional, behavioural or social dysfunctions) through psychological, psychosocial or interpersonal methods. The nature of psychotherapy is often probing and intensive, and a specific treatment plan guides the application of these procedures. The practice of psychotherapy can be distinguished from both counselling, where the focus is on the provision of information, advice-giving, encouragement and instruction, and from spiritual counselling, which is counselling based on religious or faith-based belief systems.

This proposed definition needs to be considered from the perspective of a controlled act on the one hand, and from the perspective of a scope of practice definition on the other.

(a) Psychotherapy as a controlled act

The Task Group would suggest that this definition is not one that would provide the public, the profession, a college or (ultimately) the courts with any meaningful guidance in terms of deciding if an unregulated person was providing services that fell within psychotherapy controlled act. This definition is far too broad and likely captures more "professional turf" than is necessary to protect the public from harm. It also stands in contrast to the way the other controlled acts have been formulated under Ontario's legislation.

At this point in time, the Task Group cannot offer wording for psychotherapy as a controlled act, but the Group suggests that the risks of harm analysis outlined above would provide the sort of information that could then be employed to draft such an act. The Group also suggests that the same sort of analysis that led the Council to proposed the controlled acts for Ontario's other health professions could be employed to help it

define psychotherapy as a controlled act, or to decide if it is possible to even define psychotherapy as a controlled act.⁸

(b) Psychotherapy as scope of practice definition

On the other hand, if the Ontario Council's proposed definition is to become a description of the scope of practice of psychotherapists (if not also the scope of others who provide psychotherapy), then what is being proposed may be entirely appropriate. But if this is the purpose behind the proposed definition, there are important the factors that should be applied when drafting a profession's scope of practice.

The BCHPC has provided a useful explanation of the reasons why it is necessary to properly define the scope of any profession's practice. The BC Council's comments are helpful in terms of considering the definition of psychotherapy proposed by the Ontario Council, at least if such a definition is to be used as the basis to define the broad scope of psychotherapy practice as opposed to defining psychotherapy as a controlled act.

A health profession's scope statement should: describe what the profession does; describe the methods it uses; describe the purposes for which the profession provides services; define the area of practice for which the governing body must establish registration requirements and standards of practice; define the parameters of the profession for members of the profession, employers, courts and educators; inform the public about the services practitioners are qualified to perform; be sufficiently descriptive so that other health professions and members of the public alike can understand what the particular health profession does. The scope statement should not grant an exclusive scope of practice or itemize every facet of a profession's scope of practice.

From this, the Task Group has identified four components that are necessary to address in framing or defining a profession's scope of practice:

- There should be ACTION verbs to describe what the profession does;
- The SUBJECT or the focus of those actions should be identified;
- The PURPOSE underlying the actions should be summarized;
- Finally, it should describe in general terms, without listing everything, the METHODS the profession generally employs.

Applying these factors, the Task Group developed a definition of the scope of practice for counselling therapists:⁹

The practice of Counselling Therapy assists people experiencing difficulties in relationships, or within themselves, and enhances their growth and well-being, by making use of relational, conversational,

⁸ The general "risk of harm" criteria set out in the Council's *Criteria for the Inclusion of a New Controlled Act in the RHPA* is a useful starting place, but more detailed analysis and careful drafting would be required so that a psychotherapy controlled act would be practical and legally meaningful.

⁹ Approved by the Task Group for Counsellor Regulation in British Columbia on September 13, 2005.

somatic, expressive, or educational methods and techniques informed by established counselling and psychotherapeutic theories, research, ethical standards, human diversity and the range of human traditions.

(c) Differentiating between psychotherapy and counselling

In the Introduction to its Guide and within the definition it is proposing, the Ontario Council is also suggesting that psychotherapy should be differentiated from counselling, and that such differentiation is important when deciding whether or not to regulate, and what the best form of regulation should be. To quote from the Council's proposed definition:

The practice of psychotherapy can be distinguished from both counselling, where the focus is on the provision of information, advice-giving, encouragement and instruction, and from spiritual counselling, which is counselling based on religious or faith-based belief systems.

With respect, the Task Group does not agree with the assumptions underlying the Council's suggestion. The Group believes that, rather than being different or distinct from counselling, psychotherapy is a part of, even a very important aspect of, the broader practice of counselling. A review of the many definitions of counselling, not just the Group's proposed definition, would support this observation.

As can be seen from the Task Group's definition of counselling, the Group views psychotherapy as being one form or way that counselling therapy can be provided to a client. It is one of a number of different methods or techniques that counsellors can use to help clients deal with their problems and continue to grow.

Finally, these comments notwithstanding, the Ontario Council's proposed definition for psychotherapy is so vague that it would be difficult if not impossible to use it to differentiate psychotherapy from other forms of counselling or personal therapy.

6.3) Psychotherapy risk of harm

QUESTIONS: Does the practice of psychotherapy pose a risk of harm to the public? If so, how?

These are fundamentally important questions. Having spent many years working on developing a regulatory model for counselling therapists in BC, the Task Group has had to struggle with these very questions, albeit focused more broadly on counselling rather than narrowly on psychotherapy.

The Task Group agrees with the Ontario Council's summary of the types of harms that can be associated with psychotherapy (see for example the Introduction on page 1 of the Guide). Indeed, as part of the Group's own analysis in 1998 of the risk of harm associated with counselling, much the same general types of harms were identified.

The Task Group does not intend to answer this question as it related to psychotherapy. Instead, the Group will offer its list of identified risks that relate to counselling or counselling therapy more generally. In doing so, the Group hopes that this list may assist the Council in addressing this question as it applies to psychotherapy. Or the Council may want to reframe its mandate from the Minister and consider the broader question of how best to regulate counselling, and whether or not psychotherapy should become a controlled act and, if it should be, whether it should then be made available to counselling therapists (generally or only those with more advanced credentials).

The following summarizes of the risks of harm that can arise if someone is not sufficiently educated or experienced as a counsellor, or if they act in an unethical or impaired fashion while providing counseling therapy. In many of these examples, the resulting harm cannot be readily quantified. Also, the harm may result in either a continuation of the original problem or a worsening of the situation, leading to continued or greater personal suffering. Further, a common result of many of these examples is usually going to be an expenditure of funds by the person harmed or others, in particular to correct the problem that resulted.

(a) Harm resulting from incompetence

- Failure to obtain sufficient background information from the client (e.g. medical problems, family history, previous therapies, etc.) or failure to undertake a complete assessment of the client's problem and situation, leading to incorrect or inappropriate treatments, which can compound the true problem or be ineffective, resulting in further trauma to the client.
- Failure to correctly administer or interpret an assessment instrument, resulting in an incorrect assessment of the client, resulting in harm to the client.
- Inadequate, inappropriate or incorrect assessment of a client's underlying problem, leading to a treatment or therapy that either compounds the problem or is totally ineffective, resulting in further trauma to the client.
- Failure to correctly apply an appropriate treatment or therapy, which can compound the identified problem or be ineffective, resulting in greater or continued trauma to the client.
- Inappropriate use of hypnosis or guided imagery, such as with a client who has been hospitalized for psychosis or major depression, resulting in trauma to that client.
- Inappropriately advising a couple or individual client to end their relationship (or, conversely, to remain together) resulting in trauma to the client and others, such as children.
- Failure to inform a client that mental images which could emerge during certain therapeutic modalities may not be memories of actual events, resulting in trauma to the client and others.
- Failure to provide an objective means of evaluating the client's progress, resulting in exploitation of the client.
- Failure to properly assess, prevent, and document the possibility and potential of the client being suicidal or homicidal, resulting in serious harm to or death of the client or others, or failure to take steps to inform the police or the potential victim of homicidal

threats, resulting in serious harm to or the death of the victim.

- Failure to report to the police or other authorities, information disclosed by a client of an apparent situation of child abuse or neglect, resulting in trauma to or death of a child.
- Failure to recognize the possibility that the client may be suffering from a serious mental disorder which may require hospitalization, medication, or other treatment that is beyond the counsellor's abilities, and the further failure to refer the client with such a disorder to a psychiatrist or psychologists, resulting in trauma to or death of the client.
- Recommending the client discontinue use of a prescribed medication, resulting in trauma to or death of the client.

(b) Harm resulting from unethical practice

- Failure to preserve the client's right to confidentiality (except when excused by law), resulting in public disclosure of sensitive or personal information that harms the client.
- Inappropriate touching of or communicating verbally with a client in a sexual or romantic way, resulting in a breach of trust and trauma to the client.
- Expressing personal anger or frustration to a client, resulting in trauma to the client.
- Introducing the therapist's religious beliefs into therapy without the client's consent, resulting in exploitation of the client.
- Becoming involved in a business relationship with a client (e.g. renting a basement suite to a client), resulting in exploitation of the client.

(c) Harm resulting from impaired practice

- Providing a service to a client while the counsellor is impaired by alcohol, drugs, a physical or mental illness or some other dysfunction, resulting in trauma to the client.

(d) Harm resulting from unprofessional practice

- Failure to ensure that the interview/therapy room or setting is located and arranged so as to ensure the client feels comfortable about meeting with the counsellor, resulting in discomfort or possible trauma to the client.
- Discriminating against a client based on sexual orientation, race, disability, etc., resulting in trauma to the client.
- Pressuring a client to remain in the counselling relationship against the client's expressed desire to terminate, resulting in trauma to and exploitation of the client.
- Making a record or signing or issuing a certificate, report, account or similar document that is false, misleading or otherwise improper, resulting in trauma to the client.
- Failure to submit a required report that adversely affects compensation claim, such as through a national fund for victims of sexual abuse at residential schools.
- Charging a fee that is excessive in relation to the services provided, charging for services that were not provided or providing an unnecessary service, resulting in exploitation of the client.
- Requiring payment of the fee for service prior to service being provided, resulting in exploitation of the client.

Space and time does not permit the Task Group to develop a list of risks of harm that can reasonably be associated with psychotherapy or the work of psychotherapists, even under the broad definition of that term proposed by the Ontario Council. However, the Group believes that many of the risks it has listed above would be included in a list of harms the Council could develop with respect to psychotherapy or the practice of psychotherapists.

6.4) Decreasing risk of harm

QUESTIONS: Would regulatory intervention decrease the risk of harm to patients/clients? If so, how?

Space and time also does not allow the Task Group to address in this Commentary the specific interventions (regulatory or otherwise) that would reduce the risks of harm that can be reasonably associated with psychotherapy. The following is based on what the Group said in its 1998 submission to the BC government in relation to dealing with some of the harms the Group could identify with respect to counselling therapy.

Perhaps the first or most obvious intervention that can be used to decrease possible harms is for a regulatory body to require persons who will either perform the controlled act of psychotherapy or who want to use the occupational title of Psychotherapist to meet minimum competencies for registration. (The Group will provide more details on the issue of entry-to-practice standards later in this Commentary.)

Under a competency-based approach to evaluating the suitability of applicants to the profession, the regulatory body should develop screening processes and instruments that would detect applicants who do not have the appropriate competency or attitudinal foundation for safe and ethical practice. Again, determining what would be “appropriate” would involve a thorough analysis of the identified risks of harm, along the lines the Task Group has discussed above.

The Task Group now offers some examples as to how a competency based approach to setting entry standards could deal with some of the risks that it identified in its 1998 submission.

EXAMPLE #1) Risk of harm due to incompetence:

- *Failure to correctly administer or interpret an assessment instrument, resulting in an incorrect assessment of the client, resulting in harm to the client.*
- *Inadequate, inappropriate or incorrect assessment of a client’s underlying problem, leading to a treatment or therapy that either compounds the problem or is totally ineffective, resulting in further trauma to the client.*

Counselling Service: Personal Counselling

Client Need: Improve interpersonal relationships at home, at school, or in the workplace.

Counselling service: An important part of the service is selecting, administering, and

scoring standardized tests and interpreting results. Given the wide selection of off-the-shelf published tests, counsellors who lack sufficient education in the selection and use of such tests put their clients at risk of receiving wrong information that can seriously affect their recovery. This risk is increased due to pressure from some publishing houses who allow persons to use their tests after taking only a one- or two-day workshop.

Competency-based screening process or instrument: An oral/practical examination that requests the candidate to explain the results of an assessment instrument to a “client”, who has been instructed to respond in a particular way to any candidate’s explanation of what should be an obvious result in that given assessment. Two clinical skills would be assessed: the ability of the candidate to identify the result from the assessment instrument, and the candidate’s ability to explain that result when the “client” reacts in the preordained negative way to that result.

EXAMPLE #2) Risk of harm resulting from unethical practice (i.e. boundary issues)

- *Introducing the therapist’s religious beliefs into therapy without the client’s consent, resulting in exploitation of the client.*

Counselling Service: Drug and Alcohol Abuse counselling

Client Need: Coping with emotional problems such as depression

Counselling service: A number of Alcohol and Drug Abuse clinics are available to the public. Some are under the auspices of a hospital, others are private businesses, and many are sponsored by not-for-profit societies. Clients include a whole cross-section of the public from street people to middle and upper class persons. As a rule these persons are especially vulnerable emotionally and would be easy prey to a counsellor who might stray beyond professional boundaries either from lack of awareness of legitimate boundaries or from a sense of personal mission to ‘save’ the client through a particular brand of religion or philosophy.

Competency-based screening process or instrument: Questions on boundary issues both on written exams and also during oral/practical exam.

EXAMPLE #3) Risk of harm resulting from unprofessional practice

- *Discriminating against a client based on sexual orientation, race, disability, etc. resulting in trauma to the client.*

Counselling Service: Family counselling.

Client Need: Improve interpersonal and intrapersonal relationships.

Counselling service: Obviously refusing to treat clients based on any of these reasons would be unprofessional and unethical. But, perhaps discrimination might also arise more subtly, and even without the counsellor being aware that he/she is indeed practicing discrimination. Once more, take the example of a counsellor with inadequate background in psychological measurement who reaches for one or more of the many published tests

that purport to assess personality, self-esteem, etc. If the counsellor cannot critique these tests on factors such as psychometric properties, age, gender, racial origin and geographic location of norming group, etc. he/she may administer a test that is inappropriate for the client and thus provide an interpretation of results that could actually be harmful.

Competency-based screening process or instrument: Develop exam questions that will determine whether the candidate has sufficient background in psychometrics to be safe to practice – i.e. understands how to select and use the various published assessment processes and instruments, and do so in such a manner that does not result in a form of discrimination.

Competency-based assessment allows a profession to define the knowledge, skills, aptitudes, and attitudes expected from its members. The concept of professionalism, including ethics and code of conduct comes from within that profession; it should not be imposed from an outside authority. It enables the profession to adapt to changing environment brought about by changes in client expectations, or by new techniques or areas of knowledge, or use of new technology, or by changes in economic conditions. Thus, the Task Group believes that counsellors can have some flexibility in adapting to change on an ongoing basis, while continuing to meet their responsibility as a regulated profession to provide safe, consistent, competent service to the public.

6.5) Other factors for/against regulation

QUESTION: Please identify any other factors that weigh for or against regulatory intervention.

As is the case in BC, the Task Group expects that the vast majority of psychotherapists or counsellors who practice in Ontario are doing so as self-employed professionals. Only a minority is likely to be employed by agencies, and even fewer will work within large, well-resourced facilities. For this reason, options such as relying on employers to supervise psychotherapists or counsellors probably have little relevance in Ontario. Employer oversight is certainly not a viable regulatory option for most of BC's counselling therapists.

In the Guide, the Ontario Council suggests that one disadvantage of regulatory intervention would be that public access to psychotherapy could be reduced. Reduced access would not be a problem if only a title protection model of regulation was used to regulate psychotherapists, if not also counsellors.

On the other hand, if the decision is made to create a psychotherapy controlled act in Ontario, then reduced public access to psychotherapy would be a factor that would have to be taken into consideration. Because controlled acts are designed if not intended to reduce public choice and access so that only licensed practitioners can perform the hazardous act, the impact of reducing public access to psychotherapy should be off-set by the benefits of increased public protection.

As for increased costs to the profession if not also the public as a result of regulation, if either a title protection or a controlled act model helps to improve the quality of counselling therapy provided to the public, then such an allocation of what are likely very marginally higher costs is likely to be acceptable to all concerned.

Finally, under either model, it will be the responsibility of the regulatory body concerned to inform the public about the new regulated health profession by promoting the title(s) given to that profession. It is the profession's responsibility to help to reduce public confusion that may flow from a new regulatory model for the profession.

6.6) Meeting a public need by regulating psychotherapists?

QUESTION: Would a significant public need be met by regulating psychotherapists?

An answer to this question should flow in part from the analysis of the risks of harm associated with psychotherapy, but there can also be other reasons why those who provide psychotherapy (be they “psychotherapists” or not) should be regulated. In other words, reducing or eliminating potential harm to the public is an important “public need”, but it is not necessarily the only one.

Another example of meeting a public need would be where health care insurance plans or third party payors pay for psychotherapy or counselling services on behalf of their beneficiaries, employees or clients. For many such organizations, they would have more comfort in knowing that the money they are paying-out on behalf of their subscribers, employees, or clients to those who provide psychotherapy or counselling is going to professionals who are members of a regulatory body established under government legislation. This is because these third party payors can rely on the screening and monitoring functions of the college without having to implement those sorts of quality controls themselves. Indeed, many insurance plans or third party payors do not, as a matter of corporate policy, cover the cost of counselling services that are provided by persons who are not currently members of a regulatory body established under government legislation.

6.7) Restricted title?

QUESTION: Should the title “psychotherapist” be restricted? If so, to whom?

As noted above, under either a title protection or a controlled act model of professional regulation, it will be necessary to specify within the applicable legislation the specific title or titles that registrants of the college would be entitled to use. Use of these titles will help to inform the public that those professionals are regulated, meet minimum competency standards, and are accountable.

In this respect, the title Psychotherapist could be the primary restricted title. But the Ontario Council may want to consider the use of other titles, especially if it decides that

there is no need for psychotherapy to be a controlled act and that counselling, rather than just psychotherapy, should be regulated under a title protection model. In this respect, it may be useful to designate a number of occupational titles for the health professionals who provide some form of psychotherapy or counselling so that as many of such professionals as possible will become registrants of the new college.

If the Task Group's proposed two-tiered registration model is accepted by the BC government, the generalist or entry level registrant for the new College would be able to use the generic title Counselling Therapist. For registrants with more advanced competencies who are registered within specific classes that reflect areas of specialized practice of the second tier of registration, the Group proposes that they would be able to refer to themselves by titles like Marriage and Family Therapist, Art Therapists, Drug or Alcohol Counsellor, Music Therapist, Career Counsellor, Pastoral Counsellor, Clinical Counsellor and also Psychotherapist. The Ontario Council may want to consider a similar approach to title protection in its report to the Minister.

6.8) Regulating psychotherapists but not psychotherapy

QUESTION: Should psychotherapists be regulated without regulating psychotherapy?

Psychotherapists can be regulated without also regulating psychotherapy under an title protection model of professional regulation. As such, another way to ask this question is: *Which model of professional regulation should be employed – a title protection model or a controlled acts model?*

The Task Group cannot answer this question, but it would point to the approach that could be taken to address this issue, as outline above.

It may be that the title protection model being developed in BC could be applied in Ontario, where the focus is on regulating counsellors, not trying to establish a controlled act (reserved action in BC) of counselling therapy. So long as the BC government does not depart from the BCHPC's recommendation *not* to create a psychotherapy reserved action, there would be no need to consider the implications of regulating psychotherapy under BC's HPA.

6.9) Other issues re: regulating psychotherapists

QUESTION: Are there any other issues relating to the regulation of psychotherapists, as distinct from psychotherapy, you would like to comment on?

On page 22 of its Guide, under the heading Psychotherapists, the Ontario Council has stated:

While this approach [regulating psychotherapists] may provide some assurance to the public through title protection and restrictions on "holding out," regulating only the title and not limiting who may provide

psychotherapeutic services may undermine regulation. People who do not qualify to call themselves psychotherapists might simply call themselves by another title and continue to provide psychotherapy outside the regulatory framework.

While it is true that under a title protection model, people who do not qualify to call themselves a Psychotherapist might simply use another title and continue to provide psychotherapy outside the regulatory framework, that is an expected if not intended outcome of the title protection model.

On the other hand, if the risks of harm analysis finds that there should be a controlled act of psychotherapy, then only that legislative decision can prevent non-registrants from providing psychotherapy. In this respect, the controlled act model would prohibit non-registrants from providing psychotherapy, regardless of what title they used.

6.10) Meeting a public need by regulating psychotherapy?

QUESTION: Would a significant public need be met by regulating psychotherapy?

The risk of harm analysis that would lead to decisions on the best form of professional regulation should, in turn, help to address this question. In brief, such an analysis should identify if there is a public need to help facilitate choice by using only a title protection model, or if there was a need to reduce public choice and force people to seek out the services of only licensed practitioners who would be legally permitted to provide psychotherapy as a controlled act.

6.11) Regulating psychotherapy without regulating psychotherapists

QUESTION: Can psychotherapy be regulated without regulating psychotherapists?

Psychotherapy cannot be regulated without also regulating psychotherapists as well as those who may not call themselves psychotherapists but who nonetheless also provide some form of psychotherapy. Again, in order to regulate psychotherapy, it would have to become a controlled act under Ontario's legislation. Regulating psychotherapists and other providers can be accomplished by controlling only occupational titles.

6.12) Other issues re: regulating psychotherapy

QUESTION: Are there any other issues relating to the regulation of psychotherapy you would like to comment on?

The Task Group has no comment on this issue, but will have some further comments to offer under section 7 "Additional Comments".

6.13) Use of the RHPA

QUESTION: Is the RHPA the most appropriate statutory framework to use to regulate psychotherapists and/or psychotherapy?

Because Ontario's *Regulated Health Professions Act* ("RHPA") can be used to establish either a title protection or a controlled act model of professional regulation, and because the Act arguable reflects all the important social policy decisions, and contains all the rules and guidelines for both operating a college and regulating a profession, the Task Group can see no reason why the answer to this question should not be "yes".

The Task Group would also suggest that creating a new legislative framework would duplicate all the social policy and legal principles that currently exist within the RHPA framework. So long as the service being regulated and those who provide it fall within the broad rubric of health or health care, there should be no need to create a new statutory framework in Ontario.

6.14) Psychotherapy as a controlled act

QUESTIONS: Should psychotherapy be a Controlled Act under the RHPA? If so, what professions should be authorized to perform the Controlled Act of psychotherapy?

These are two very important but separate issues.

(a) Defining the controlled act through a risk of harm analysis

An answer the first question requires a careful analysis of the sort of risks of harm that can be identified in relation to the provision of psychotherapy. This is a difficult task, because the types of harm that can be identified with respect to psychotherapy are not necessarily obvious.

Unlike the controlled acts that are currently regulated under Ontario's health professions legislation, the adverse consequences that flow from the incompetent or unethical provision of psychotherapy are unlikely to result in "pools of blood". This does not mean, however, that - unlike its "physical harm" cousins - it is not possible to describe a psychotherapy controlled act. As the Task Group has discussed above, what is needed is a meaningful harm analysis that considers what can happen if this form of therapy is provided incompetently or unethically, especially to persons who are already vulnerable and facing personal challenges. If the risks are substantial and the resulting harms are serious, then making psychotherapy a controlled act would be justified. However, if psychotherapy is to become a controlled act in Ontario, it should be drafted so that the resulting legal definition does not capture more professional turf than is necessary to reduce public choice in service providers to a safe level.

(b) Who should perform a psychotherapy controlled act?

An answer to the second questions is easier to suggest, even if only in the abstract.

If the risk of harm analysis for psychotherapy eventually results in an articulation of the minimum competencies that are necessary for a practitioner to hold so as to reduce or avoid the adverse effects of the incompetent or unethical provision of this therapy, then - so long as any profession can demonstrate that its members have those same or greater competencies - those professions should in turn be entitled to perform the psychotherapy controlled act. On this principle, it would not matter if physicians, nurses, psychologists, clinical social workers or counselling therapists wanted to provide psychotherapy. The legislation and their regulatory bodies should not allow them to do so unless and until each profession can demonstrate that it possesses the necessary competencies to provide psychotherapy in a safe and ethical fashion. So long as a profession can demonstrate that it has those competencies, it can share the controlled act of psychotherapy with the other, equally competent professions.

Things can become complicated if it is determined that not all registrants of a college have the necessary entry-level competencies to be able to safely and ethically provide psychotherapy. So, for example, it may be the case that psychotherapy would have to be regulated as an advanced competency that should be performed by only those members of the profession who have completed specialized education and training programs that give them those advanced skills. Yet for other professions, their entry-level education and training may provide them with sufficient competencies so that any person registered with that college would be capable of providing psychotherapy safely and ethically.

In BC, the Task Group has begun the process of articulating the minimum competencies that it believes will be necessary to have before an applicant may become a Counselling Therapist at the entry level of the profession. Eventually, the Group expects it will be necessary to develop a set of competency profiles for each of the areas of advanced or specialized counselling practice, such as psychotherapy. At this point in time, however, and only so long as the BC government does not reverse the BCHPC's earlier recommendation, it will not be necessary to develop a specific licensing program within the proposed College of Counselling Therapists that would then allow counsellors with advanced training in psychotherapy to provide that therapy as a reserved action. However, it would be possible for the new College to develop those regulatory mechanisms if the government moves to make psychotherapy a reserved action in BC.

6.15) Create a new college or join an existing one?

QUESTIONS: Should psychotherapists be regulated as a new profession under the RHPA? (a) Should psychotherapists be regulated as part of an existing health regulatory College or under a new, separate College? (b) Should psychotherapists be regulated as a class within an existing College?

Theoretically, either option should work. But which one would work best would depend on many factors. The Task Group can speak to those which it has addressed in the past.

(a) Minimum number of registrants

For a college to be financially viable and able to carry out its statutory mandate, it needs as a minimum about 1,000 registrants. It is difficult to fund and staff college committees with membership numbers less than this threshold. It is likely that there are more than enough practitioners in Ontario who would want to become registrants of the new college and those numbers should ensure that it would work from both a financial and a manpower perspective.

(b) Internal governance

Another important question has to do with the internal governance of the College, in particular its board of directors. Given the proportion of public representatives appointed by the government per elected professional members on a college board, those considering establishing a new college or modifying an existing one will have to consider the composition of the College Board. For example, if the Board is to represent every type of practitioner who provides psychotherapy, then the total number of directors could be very large, arguably making the Board ineffective or too expensive.

It is possible to establish checks and balances within the structure and operation of the college and its committees that are sensitive to or reflect the diversity of the different practitioners who are captured within its regulatory embrace. For example, if an issue that is specific to one area of specialized practice has to be decided, the college could adopt a weighted voting system to reflect the higher degree of expertise of those specialists within that area of practice. No doubt, there are other, creative ways to adjust a college governance structure to facilitate cooperation within a multi-disciplinary profession.

(c) Significance of the entry requirements

Another related problem has to do with what the entry requirements for registration are likely to be, as they can have a significant impact on both membership numbers and composition.

In BC, the Task Group is proposing a single college that would oversee the regulation of a number of different types of counsellors, or at least counsellors with different professional orientations or clients. As the competency profile for counsellors that the Group is developing will focus on the minimum standards for safe and ethical counselling practice, it is anticipated that the resulting regulatory model should be able to bring into the new College about 4,000 to 4,5000 counselling therapists of many different orientations. Given the Group's now lengthy history of cooperation and consensus, it has every expectation that it will be able to find persons who can ensure the new College will have a functional governance structure.

(d) Joining a college of psychologists?

While some psychologists also provide psychotherapy, simply because a College of Psychologists currently exists does not necessarily make it the best option to regulate Psychotherapists. At a minimum, there would have to be agreement amongst non-psychologist providers of psychotherapy that they should be regulated as part of the College of Psychologists. Also, it may be that the potential number of Psychotherapists

could easily out-number and may therefore over-whelm the Psychologists within their current regulatory body. Further discussions amongst those potentially involved in joining an existing college should obviously take place before that option was pursued.

6.16) Other regulatory frameworks

QUESTION: Should another regulatory framework (using a new or existing statute) be used to address all matters relating to the issue of regulating psychotherapy and/or psychotherapists?

As a general comment, it is useful to distinguish between regulatory models that are possible under Ontario's RHPA or BC's HPA, and regulatory frameworks. As the Task Group has described above, two basic regulatory models exist under these two statutes: a title protection (certification) model and a controlled act (licensing) model.

Under either of these two modes, it is possible to develop a wide variety of regulatory frameworks or what the Task Group describes as governance structures. Thus, it is possible to have a title protection model that is administered by either a single profession college or by a multiple profession college. It would even be possible to have one profession within a multiple profession college that is entitled to perform a controlled act that would not be available to other professions within that same college.

6.17) Other regulatory models?

QUESTION: Are there any other regulatory models that should be considered?

The Task Group will discuss three other regulatory models, and describe their various short-comings.

(a) The “no strings attached” title protection model

In its 1997 report on counselling, the BCHPC recommended that the BC government consider the way that Washington State and Nebraska regulate counsellors. The Council felt that the approaches taken by those two states would be a useful alternative to consider. The Task Group has studied this model and finds it lacking.

The legislation from Washington State and Nebraska employ a “no strings attached” form of title protection regulatory model. Any person who wants to use one of the occupational titles reserved in those states need only apply and would be granted automatic registration. Applicants do not have to meet any educational or supervision requirements, and they do not have to pass any sort of screening/registration examination. About the only way that an applicant would be rejected is if they have a criminal conviction for an offence that would make them unsuitable to be registered as counsellors.

Obviously, this model is an extreme version of the title protection model that is possible under both Ontario and BC legislation. Such an approach is not likely to be of any value

if a risk of harm analysis indicates that persons who provide psychotherapy, be it as a controlled act or not, need to have some minimum education and training.

Finally, this “no entry standards” model does not appear to be one that is under active consideration within the BC Ministry of Health, for counselling or any other health profession.

(b) Voluntary, non-statutory self-regulation

The Task Group understands that the option the existing professional associations continue to regulate their members has been proposed as an alternative model. A variation on this would be to create a super board that would oversee the regulation of all the members of the different professional associations (e.g. the model proposed by the British Confederation of Psychotherapists). For reasons the Group will now explain, neither of these voluntary, non-statutory forms of self-regulation are viable options, at least not in the long-term.

The first problem professional associations face is that, with one or two exceptions, they do not have the legal leverage to encourage their members to remain as members during the course of a complaint investigation or a later disciplinary hearing. Because it is no longer possible for professional associations to obtain title protection under the federal *Trade-Marks Act*,¹⁰ and because there is no provision in Ontario’s society legislation like that found in Part 10 of BC’s *Society Act*, the only option that gives a regulatory body some leverage over its members would be if a college is created and its registrants are granted some form of occupational title protection.

Title protection under the RHPA also is a way to encourage the many hundreds of persons who are not currently a member of a professional association to join the new college. Allowing the current voluntary self-regulation approach to continue, or modifying it under some sort of coordinating board, would do little to encourage those who are not members of these associations to join that voluntary effort.

Another major problem is that if one of their members quits a professional association to avoid a complaint investigation or a disciplinary hearing, the association loses

¹⁰ On March 27, 2003 the Supreme Court of Canada (SCC) dismissed an application for leave to appeal a decision of the Federal Court of Appeal (FCA): [2002] S.C.C.A. No. 316. By so doing, the SCC was in effect upholding the May 28, 2002 decision of the FCA in Ontario Assn. Of Architects v. Assn. Of Architectural Technologists of Ontario [2002] F.C.J. No. 813, 2002 FCA 218, (2002) 291 N.R. 61, (2002) 19 C.P.R. (4th) 417, (2002) 215 D.L.R. 94th) 550, [2003] 1 F.C. 331. About five months after the FCA handed down its decision, the Canadian Intellectual Property Office (CIPO) issued a notice that explained the Office’s new policy concerning the test that it would apply in adjudication applications for official marks under the *Trade-marks Act* by public authorities. The notice adopted the two-part test that the FCA had articulated in determining whether an applicant was a public authority. However, the Office went further and gave examples of criteria that it would consider in applying the first part of the new test. A major criteria is “government control”, and the examples given by the CIPO in its new policy are the same ones that are currently found in the *HPA* or will become part of the Act when the recent amendments are proclaimed into force. Therefore, only regulatory bodies established under and with mandates set out in legislation like the *HPA* are going to be able to obtain official marks in the future.

jurisdiction over that member. In contrast, a college under the RHPA does not lose jurisdiction over one of its members if that professional resigns from the registry for any reason.

Like their counterparts in BC, the Ontario associations also do not have the same powers of inspection as is given to colleges under the health professions legislation. Basically, the associations must rely on the goodwill of their members. This cooperation can be challenged in the face of serious allegations that may require significant interventions by the regulatory body into a professional's practice or a visit to his or her office.

The Ontario associations also do not have the legal capacity to require a member to undergo a medical, psychiatric or psychological assessments to determine if that member is suffering from a physical ailment or mental illness that could compromise his or her effectiveness or even result in harm to clients or others. These are the sorts of powers that are held by colleges under Ontario's and BC's professional governance legislation.

It is also unlikely that the Ontario associations would be willing to have members of the public appointed to their private boards, or be required to have the public sit on their various committees to ensure that the associations act in the public interest. Under the RHPA and the HPA, the government can appoint public representatives to play this important role. Also, governments do not pay the public representatives for their time on a college board. The college that they have been appointed to must cover their expenses and any per diems. It is unlikely that the members of the professional associations will want to shoulder these additional costs.

Finally, if it is determined that psychotherapy should become a controlled act under the RHPA, then the only way that such a decision could be implemented would be if those who provide psychotherapy became registrants of a RHPA college. None of the Ontario professional associations could or should hold the legal authority to regulate a controlled act.

(c) Delegation and its short-comings

In theory, it is possible to establish a mechanism that allows one profession to delegate to another the authority to perform all or part of a controlled act. But a great deal of cooperation must exist between the two professions generally, and between the professional who wants to delegate the act and the one who would like to perform it.

For example, it is necessary to reach agreements between colleges on what skills and abilities the profession to receive the controlled act must possess. There may also be a need to limit or put conditions on whether only a part of the controlled act can be either delegated or performed. The responsible for assessing the competency of the receiving practitioner needs to also be clarified. The scope and nature of supervision, if any, would also have to be worked out. If something went wrong, would both professionals be accountable to their separate colleges, or would just the delegating professional be accountable? And should it be permissible to delegate the performance of a controlled act to a practitioner who is not even a member of a college?

No doubt, there are many other issues that would need to be addressed before the Council could conclude that psychotherapy as a controlled act could be delegated from one profession to another. If the experience in BC is any indication, it is unlikely that practitioners in Ontario would accept being able to perform psychotherapy as a controlled act if that act was to be delegated to them by psychologists.

6.18) Exceptions?

QUESTIONS: If there is to be regulatory intervention, should exceptions be made? If so, for what professions and/ or services?

Establishing exceptions to a regulatory intervention makes sense, at least in theory, only if a controlled act model of regulation is to be employed under the RHPA. This is because the exceptions would likely be directed to exempting either certain types of persons from having to be regulated before they could perform the controlled act, or it would be directed at exempting certain types of services or activities that would otherwise fall within the controlled act, whether those exempted services or activities are performed by health professionals or not. See for example section 29 of the RHPA.

As a general rule, it is not necessary to establish exceptions if the form of regulation is only a title protection model. This is because that model does not itself prevent anyone from performing a particular service or function that is provided by the profession in question.

That said, if other professions in Ontario also commonly use an occupational title like Psychotherapist, then they should be granted the same title as would be granted to members of the new college. But if the government's intention is to allow the public to differentiate between regulated/accountable health care professionals, and persons who are not accountable to their peers, then the occupational title assigned to the profession should be unique and help, not hinder, the public's ability to identify that the psychotherapists they are seeing is a member of a professional regulatory body. This is why in BC, the Task Group has embraced the BC Ministry of Health suggestion to use the new title "Counselling Therapist".

The Task Group has no opinion as to what specific exceptions should be established in Ontario. Those which currently exist within Ontario's legislation may be sufficient. A final decision on this should be informed by the decision as to whether or not there needs to be a psychotherapy controlled act.

6.19) Transitions?

QUESTIONS: Should there be a transition period during which all practitioners must qualify? If so, how long should it be?

A transition period would be necessary only if the approach to regulating psychotherapists involves a controlled act (e.g. if psychotherapy as a controlled act was established under the RHPA). This is because there may be many persons who currently provide psychotherapy but who would not meet the registration criteria established by the (new) college to be able to perform that controlled act. So it may be necessary to give those persons a reasonable period of time to gain the necessary competencies to then meet the registration criteria and, in turn, be entitled to perform psychotherapy as a controlled act.

A transition period would not be as critical if the regulatory model involves only title protection. This is because no particular hardship should befall those who do not meet the registration criteria. They would only be prevented from using the exclusive title granted to the profession, such as Psychotherapist.

However, if there are currently many persons who provide psychotherapy and call themselves Psychotherapists, and if many of these practitioners are not likely to meet the college's entry requirements, they even under a title protection model there may need to be a grace period to allow those persons to obtain those competencies so that they could, in turn, use the occupational title that they used before the legislation came into effect.

6.20) Continued practice through a transition?

QUESTION: Should those currently practising psychotherapy be permitted to continue to practice throughout a transition period without meeting certain requirements?

Again, this would only be necessary to consider if the decision is made that psychotherapy should become a controlled act.

6.21) Grand-parenting?

QUESTIONS: Should some or all of those practising psychotherapy be "grandparented"? Should those seeking "grandparenting" be required to meet a different, less onerous set of minimum qualifications and standards than those likely to be required in a new regulatory environment?

(a) Grand-parenting existing practitioners

The Ontario Council has described "grand-parenting" as a situation where some applicants would not meet a college's entry standards, so applicants who have been providing psychotherapy or calling themselves Psychotherapist prior to the creation of the college would have to be given a period of time to become registered without having to prove that they hold the minimum competencies that are reflected in the entry standards.

Applying this definition, the option of grand-parenting existing but unregulated practitioners may be necessary. A number of factors would have to be taken into consideration in making that decision, such as:

- The total number of practitioners who currently provide psychotherapy but who are not, at the time of initial registration, regulated by a college.
- Should there be a minimum level of competency below which no one should be allowed to be grand-parented?
- What training or supervision requirements should there be that would allow anyone to provide psychotherapy safely and ethically?
- Should it be a requirement that someone seeking grand-parenting status not be subject to a current investigation? A law suit? Or a criminal investigation?
- Has the person been convicted for a criminal offence the nature of which would suggest they should not be allowed to be grand-parented?

The nature of the sort of issues that would need to be considered would be different if the grand-parenting option is to be employed in the context of a title protection model versus a controlled act model.

(b) Porting existing practitioners

The Task Group is proposing a different approach to grand-parenting.

While the first board of the new College of Counselling Therapists would have the legal authority to make the decision on grand-parenting, the Task Group is proposing that the new College “port” existing members of the organizations that make up the Group as well as any other counselling therapists but only so long as the professional associations can demonstrate that their members meet the college’s entry requirements. In turn, those requirements will be competency-based, as is mandated by the labour mobility provisions of the *Agreement on Internal Trade*.

Once the competency profile for a generalist counsellor has been verified and detailed, it should then be possible to compare those requirements to the certification model employed by the different organizations within the Group to see if there is sufficient match between them that would, in turn, allow for a one-time, time-limited porting of counsellors who are members of the Group organizations into the new College. Porting ensures that the membership criteria that are employed by an existing association are sufficiently similar to the entry-level competencies required by the College, thus allowing members in good standing of the current associations to apply for registration with the new College without having to take a registration examination. Porting would be possibly for only a limited period of time.

The same opportunity would be extended to counsellors who are not members of one of the existing Task Group organizations. Each such applicant would simply have to prove that the education and training they have obtained is substantially similar to the competency-based entry requirements set by the new College.

By this approach, the Task Group expects it will not be necessary for the new College in BC to consider “grand-parenting” any counsellor into the profession who does not meet the entry requirements. And given that those requirements will be focused on entry-level competencies and not advanced or specialized areas of counselling practice, the Group also expects the porting option will allow the maximum number of persons to become registrants of the new College while still maintaining a reasonable and defensible minimum entry requirement.

Porting may be an option in Ontario, if a new college is established or an existing one takes over the regulation of psychotherapy or psychotherapists.

(c) Limited registration

It is also possible to employ time-limited registration to allow those who do not meet the college’s entry standards to practice the profession subject to requirements that they upgrade their training within a specified time. They could also have limitations set so that they do not practice in certain areas (e.g. perform a controlled act) without supervision, if at all, either permanently or until they complete their upgrading.

Again, limited registration could take different forms, depending on the specific regulatory model being employed.

6.22) Entry standards?

QUESTION: How and by whom should minimum qualifications and standards be identified and set, including those for grandparenting?

(a) Who should set the entry standards?

Under the model proposed by the Task Group, and as is required by BC’s *Health Professions Act*, the entry requirements must be set out in the College’s bylaws. So, the answer to the “by whom” question in BC would be the College. However, under BC’s legislation, the provincial Cabinet must also approve those parts of the College’s bylaws which speak to entry requirements. So, both the board of the College and the Cabinet play a role in setting the minimum qualifications and standards for registration.

The approach in Ontario may be somewhat different than the approach employed under BC’s legislation. Regardless, the critical point here is that the regulatory body (with or without government oversight or involvement) should set the entry standards. External parties, such as educational institutions or professional associations, should not set these standards. These external organizations obviously play an important role in training and promoting the profession, but as a matter of social policy, they should not control the standards for membership in the profession.

(b) How should the entry standards be set?

There are many ways to identify and set the minimum qualifications and standards for registration, including both porting and grand-parenting. The approach taken in BC,

which the Task Group anticipates will be adopted and applied by the new College, has been to literally start from scratch.

One of the reasons the BCHPC did not recommend in 1997 that counselling be designated under the HPA was because the BC Council could not identify a core of education that was common to the different counsellors who had applied in the early 1990s for designation. Another concern raised by the Council was the potential to exclude counsellors who did not hold graduate degrees from being members of a new College. These two issues were given careful consideration by the Task Group and, in its November 1998 submission to the Ministry, the Group proposed a two-tiered or umbrella registration model (i.e. a generalist entry level with different classes for advanced competency registration). The Group also adopted a competency-based approach to defining the registration criteria. (As noted above, competency-based registration criteria are also mandated by the AIT.)

Since that time, the Task Group has been working on the details of its registration model, in particular to identify and define the core competencies for the entry-level or “generalist” counselling therapist.

The Task Group hired Dr. David Cane¹¹ to help the Group generate a detailed list of what is currently 228 specific competency statements, which in turn forms a working profile for counselling therapists at the entry level of practice. The Group is now engaged in a process of establishing the domains for each of specific statements and validating them through a consultation process involving a broad, representative sample of counsellors working in BC. (A copy of the draft being validated is attached to this Commentary.)

It is the Group’s expectation that the final version of the competency profile for counselling therapists will provide a clear, objective and defensible set of statements that the first board of the long-anticipated College could then use to establish the registration criteria for the generalist, entry-level counselling therapist. This competency profile could also be used by the College to develop a registration examination, if that was considered necessary. It could also be used to help the College identify the minimum competencies that would be necessary to facilitate the transfer of counsellors regulated in other provinces into BC (and vice versa) as required under the *Agreement on Internal Trade*. Finally, this document could also be used to help identify currently practicing counsellors who would be part of the first group of registrants to be ported into the new College from the member organizations of the Task Group, and others.

¹¹ Dr. David Cane is an educational consultant with over twenty-five years of employment and experience in education, management and leadership, including twelve years of employment at senior executive and chief executive levels of large institutions. He has broad experience in post-secondary education institutions (public and private), the health sector and aboriginal organizations. David’s background includes positions as college president, vice-president, dean of health sciences, department chair, faculty member and instructional skills / group facilitator. A full-time consultant since 1998, he is a partner in Catalysis Consulting of Kamloops, BC. His current work focuses on the development of employment and training standards: occupational analysis and profiling; professional certification, regulation and labour mobility issues; and training program accreditation.

The Task Group would be pleased to provide the Ontario Council with details of both the process that it is employing to develop the entry-level competency profile for counselling therapists, and the final profile itself when it is available.

(c) Why establish competency-based entry standards?

Approaching the setting of entry-level registration standards from the perspective of stating specific competency requirements is an almost universal practice for regulatory bodies in Canada, the United States and throughout the western industrialized world. There are many reasons for this, as summarized below from the perspective of the anticipated College of Counselling Therapists.

Competencies are measurable learning outcomes that can be objectively tested. Properly stated, competencies include knowledge, practical skill and attitudinal or behavioural components, thus providing a comprehensive description of the requirements for effective counselling practice. Because they focus on the *outcomes* of learning, competency statements are independent of the learning process, and recognize that different individuals may acquire learning in distinct ways. Therefore, competency statements may be used to compare the results of education programs or various combinations of education and clinical experience.

A clear articulation of the entry-level competencies for counselling practice in the form of a competency profile is of critical importance to a profession with a potentially very diverse membership. Developing competency statements that are fair and objective will help the College ensure safe and ethical counselling practice regardless of how the counsellor obtained those competencies. It will also help the College avoid lawsuits where applicants could claim that the registration standards were arbitrary or discriminatory.

An agreed set of entry-level competency statements will allow the first board of the new College to decide which members from the existing counselling organizations can automatically become members of the College without having to pass any sort of registration examination or similar process. (As noted above, this is described as “porting” of existing registrations with the professional associations.)

An entry-level competency profile will allow the first board of the new College to determine the combination(s) of education and clinical experience that will commonly be accepted as providing these competencies. In addition it will help the board identify other (less common) combinations of education and clinical experience that it may deem to be “substantially equivalent”. This will allow persons from other countries who have obtained their competencies as counsellors in different ways to be registered, on approval of the registration committee.

The first board could also use the entry-level competency statements to develop a registration examination process if it determines that this step is necessary. Registration examinations that are not developed from published, objective competency statements are often not legally defensible.

A document that properly describes the required practice competencies for registration as a counselling therapist will also guide the post-secondary education programs that train counsellors. Firstly, it will be important for all counselling education programs to integrate the required competencies into their programs so that graduates may qualify for registration. (In this context it is important to understand that the College's required practice competencies will *not limit* the scope of education programs; rather the entry-level competency profile will be a minimum standard for registration upon which programs may build according to their own specific goals and focus.)

Secondly, should the College want to establish an accreditation process for counselling education programs (either voluntary or mandatory), the competency profile would become an important part of the accreditation standards.¹² (Accreditation standards commonly include many other requirements, such as length of the program, faculty credentials, program financing, student fees and refunds, student discipline, etc.) To obtain and maintain accreditation with the new College, an education program would have to demonstrate that it provides graduates with the required competencies. This would apply under a single tier or a two-tiered registration model.

Finally, articulating the practice competencies for counselling will provide a basis for the College to be able to compare entry requirements in one jurisdiction with those from other provinces where counselling (or psychotherapy) may be regulated. Such a comparison – based explicitly on competencies - is required in order to comply with the *Agreement on Internal Trade*. Indeed, many professions have found it necessary to undertake such a task for the purposes of developing their labour mobility agreements under the AIT.

¹² As noted in the Canadian Counselling Association's 2003 *Accreditation Procedures and Standards*, it is important to distinguish between the accreditation of a counselling educational program and the certification and registration of graduates from these or other programs to become registrants of the new College. The CCA's procedures and standards are focused on the accreditation of programs and do not contain a set of competency profile statements, which would be the result of this proposed process.

7) ADDITIONAL COMMENTS

The Task Group has a few remaining, additional comments to offer the Ontario Council in this Commentary.

7.1) Regulation by title protection now, and controlled acts later

The Ontario Council may want to depart from the wording of the Minister's reference and consider the question as to whether counselling (including psychotherapy) should be regulated under a title protection model. If it is not clear to the Council that there are sufficiently serious risks of harm that can be reasonably associated with psychotherapy or, like in BC, it is not possible to define psychotherapy so that it could become a meaningful controlled act, then title protection under the RHPA may be a good, first step.

If it later becomes apparent that there is a need to regulate psychotherapy as a controlled act (and it is possible to define such an act), then the new College of Counsellors of Ontario (or some similar college) could then address the question as to whether or not its registrants should be granted the psychotherapy controlled act.

In brief, it may be possible if not desirable to regulate either psychotherapists or counsellors (or both) now, and then consider the need to establish a psychotherapy controlled act later; even if that is not for years from now.

7.2) Separation of functions

When a college is established under professional regulation, the role of the professional associations will or should change. If they played a role in setting educational standards as entry-to-practice criteria, approving codes of practice or professional practice standards, or investigating and resolving public complaints against their members, those functions would be taken over by the college as part of its statutory mandate. While the college would have to focus on promoting the public interest, the associations would be free of having to maintain their bifurcated mandates and could, instead, focus on promoting the interests of the profession and their members.

In some jurisdictions, notably Alberta, there has not been as clear a separation of functions between the colleges and the associations as there has been in BC, for example. In order for any regulatory model to work effectively and fairly, the various counselling and psychotherapy associations will need to ensure that they do not negatively impact on the college's mandate. In particular, they will not themselves "become" the college.

After designation, the professional associations can play an important role in support of professional regulation. For example, while the college may require its members maintain minimum annual continuing education, the associations can organize or sponsor the actual CE programs, charging their members a discounted rate for attendance.

Unlike the colleges, the associations will also be free to actively promote the services their profession provides to the public so as to secure sufficient financial remuneration

for their members. For example, they can work out payment plans with third parties, such as extended health care insurance plans, who would pay for the services provided by the new regulated health professionals to their beneficiaries.

The college can set a minimum level of professional insurance, but the associations can arrange for discounted professional liability insurance for the members.

7.3) Psychological diagnosis as a reserved action

In its *Preliminary Report on Psychologists Scope of Practice* (August 1999), the BCHPC recommended granting a diagnosis reserved act to psychologists that would read: “Making a diagnosis, identifying a mental or psychological disorder, dysfunction or condition as the cause of signs or symptoms of the individual.”

If the BC government acts on this recommendation, the implications of psychologists holding a psychological diagnosis reserved action under the HPA while counselling therapists do not should be self-evident. If counsellors and psychotherapists are not granted the same or substantially the same type of reserved action, they would be precluded by law from making or communicating a psychological diagnosis to their clients as a prelude to providing psychotherapy or any type of counselling.

This is obviously an issue the Task Group will be monitoring closely. But it is also an issue that should concern counsellors and psychotherapists if there is a possibility a similar controlled act could be granted to Ontario’s psychologists.