Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

Angela Verrier, RPN
President
Council of the College of Nurses of Ontario
101 Davenport Road
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November 19, 2014

Re: RNAO Recommendation to Rescind Requirement for Order to Perform Psychotherapy

Dear Angela,

Thank you for your response on October 14, 2014 to RNAO's letter dated September 3, 2014 expressing concern with the CNO Council's decision to require an order for a registered nurse (RN) to perform the controlled act of psychotherapy.

Upon further research, reflection, and consultation with our members who are experienced with psychotherapy as part of their nursing practice, we urge the Council to rescind this decision. Revisiting and amending this decision by establishing an initiation regulation for RNs (in addition to nurse practitioners) will: improve public safety; increase access to critical mental health nursing services; and strengthen consistency of approach to controlled acts thereby enhancing interprofessional collaboration.

Recognizing the potential for harm, RNAO has consistently supported the designation of psychotherapy as a controlled act.[1 2] Although psychotherapy may be the newest addition to the list of controlled acts in Ontario, there are CNO members who have practiced psychotherapy safely and effectively for decades. In the provincial context of too many Ontarians suffering harm due to unmet needs for mental health services,[3 4 5] the decision to require an order for psychotherapy works against the College's "duty to serve and protect the public interest."[6]

The rationale for the Council's decision to require an RN to have an order to initiate psychotherapy seems to be rooted in unease[7] with the *Regulated Health Professions Act*'s definition of the controlled act of psychotherapy:

> treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgment, insight, behaviour, communication or social functioning.[8]

This definition is more complex than what Health Professions Regulatory Advisory Council (HPRAC) originally proposed[9] and more disease-orientated than what RNAO recommended.[10] Although the merits and limitations of RHPA's definition may be debated, the CNO is missing its responsibility to the public interest by deferring action[11] and referring CNO members to the College of Psychotherapy.[12]

Improving Public Safety and Interest

There are compelling public interest reasons why the College of Nurses must reconsider its decision to require an order for an RN to perform psychotherapy. If an RN has the knowledge, skill, and judgment to perform psychotherapy as part of his or her practice, that same nurse must be competent and accountable to initiate psychotherapy or assess and refer the individual for more appropriate treatment and/or to another health care provider. It is always the responsibility of a regulated health professional to know the limits of one's abilities and to work collaboratively with other members of the interprofessional team to provide person-centred care.

In the October 14, 2014 letter to RNAO, the CNO justified the requirement for an order based on the RHPA definition and an arbitrarily decision to require CNO members to meet a different standard than other members of regulated professions who will have access to the controlled act of psychotherapy:

> When the proposed controlled act of psychotherapy becomes law, a client with such a serious health issue would also benefit from care provided by an NP or a physician. Either an NP or physician could provide an order in the context of the client's overall health management plan. The need for an order will ensure that a provider with the authority to diagnose supports the use of psychotherapy as the appropriate treatment.

Although physicians, NPs, and psychologists have access to the controlled act of communicating a diagnosis, occupational therapists, psychotherapists, and social workers do not.[13] [14] In fact, HPRAC recommended against linking diagnostic authority and psychotherapy: "Because clinical diagnosis is not a key component in the performance of psychotherapy and because training in psychotherapy does not extend to training in clinical diagnoses, HPRAC recommends that the controlled act of "Communicating a Diagnosis" is not required for psychotherapy."[15] The College of Occupational Therapists of Ontario, the Ontario College of Social Workers and Social Service Workers, and the Transitional Council, College of Registered Psychotherapists of Ontario have each respectively developed standards for psychotherapy,[16] practice guidelines for performing the controlled act of psychotherapy,[17] and professional practice standards for registered psychotherapists,[18] all without stipulating that their members obtain an order from an individual with diagnostic authority.

Instead of the biomedical model of diagnosis, HPRAC emphasized the need for assessment and the formation of a treatment plan. A treatment plan is based on "three elements: the patient's difficulties or treatment goals; articulation of the obstacles that stand in the way of achieving those goals; and the technique(s) or relationship(s) that can help the patient to learn how to address these obstacles."[19] In CNO's submissions to HPRAC, the College identified as a key element of psychotherapy, a requirement for "in-depth assessment of mental health status using a variety of tools and a diagnostic formulation such as a problem, problem list or pattern statement."[20] [21]

There is a growing understanding that trauma is a public health problem[22] that is prevalent, underestimated, and often neglected by health and human services systems and professionals.[23] [24] Immediate and delayed responses to trauma may manifest as emotional, physical, cognitive, behavioural, and/or existential reactions.[25] These are normal responses to the stressful experience of trauma, distressing to experience, but are not in themselves signs of mental illness or mental disorder.[26] Trauma may be a single event, numerous or repeated

events, or sustained/chronic trauma that wears down resilience. The additive and cumulative impacts of trauma may be especially damaging through biological embedding of adversities during critical development stages.[27] Early life stress[28] "triggers, aggravates, maintains and increases the recurrence" of adult psychiatric disorders.[29] A systematic review and meta-analysis found a causal relationship between childhood trauma and a range of mental disorders, substance use, suicide attempts, sexually transmitted infections, and risky sexual behaviour across the life course.[30]

As those who have experienced trauma "are at risk of being re-traumatized in every social service and health care setting,"[31] it is critical that providers, organizations, and systems become informed about and implement trauma-informed care.[32] [33] [34] Forcing a precipitous formal diagnosis as a precursor to ordering psychotherapy may cause more harm than good. Receiving a psychiatric diagnosis in itself can be devastating to the identity of those so diagnosed[35] [36] and "impose lifelong limitations through prophetic labeling."[37] An individual seeking services to address reactions to trauma may not fit a diagnostic criteria for mental illness and yet might still benefit from psychotherapy to ameliorate serious challenges impacting their health and well-being. Person-centred care would respect that individuals and families are best positioned to decide that they want help with stressful life events such as cancer, bereavement, and other life traumas[38] which may exacerbate underlying previous issues.

A fundamental ethical principle when treating clients who have been traumatized is that the utmost care must be taken "to ensure that interventions do no harm."[39] Requiring survivors of sexual abuse, many who experience health care services as triggers of past traumatic experiences,[40] to present to a physician or nurse practitioner to get an order may be particularly difficult for some. Not all Ontarians have access to a regular primary care provider and some that do are confronted with a "one-problem-per-visit"[41] rushed consultation that works against disclosure and safety. Sometimes the entry point to primary care for a person dealing with the impacts of trauma might be with the initial support of a psychotherapeutic relationship.
Even in the best of circumstances, requiring an order for this controlled act only by nurse psychotherapists will disrupt continuity of care and caregiver.

Increasing Access to Accountable and High Quality Mental Health Nursing Services

While it is critical to be mindful of potential harms that can occur as a result of the controlled act of psychotherapy, it is equally vital to be cognizant of actual harms that are occurring to Ontarians who are unable to access mental health services. Ontario's Select Committee on Mental Health and Addictions describe a crisis but one that is "suffered silently, as those who are experiencing a mental illness or addiction are ignored, stigmatized, and lack the social power to demand change."[42] Requiring a nurse psychotherapist to obtain an order works against public safety and the public interest in the following ways:

- it will potentially disrupt and threaten continuity of care of patients who are already in a psychotherapeutic relationship;[43]
- requiring an order will delay access to mental health services, especially in rural and remote communities that are experiencing shortages of NPs and physicians;
- as there is often not a bright line demarking counseling and psychotherapy, individual RNs may self-limit their nursing practice by retreating from appropriate counseling due to fear of stepping over the line into a controlled act requiring an order;

- by not enabling recognition of specialized educational credentials, competencies, and experience equivalent to other regulated professionals, nurses report feeling devalued, deskilled, and demoralized. This disappointment will drive nurses out of the profession of nursing, where psychotherapy is but one component of their nursing practice,[44] into regulatory oversight by the College of Registered Psychotherapists or even the College of Social Workers after seeking additional credentials. This represents not just a loss of individual talent but also has implications for recruitment and retention in the nursing professions as a whole.

Most importantly, once educational qualifications and standards for psychotherapy are established, the safest course of action is what the RHPA and *Nursing Act* have already outlined with respect to initiation of controlled acts:

> A nurse can initiate a procedure only when all of the following conditions are met:
> - the nurse has the knowledge, skill and judgment to perform the procedure safely, effectively and ethically;
> - the nurse has the knowledge, skill and judgment to determine whether the client's condition warrants performance of the procedure;
> - the nurse determines that the client's condition warrants performance of the procedure having considered:
>   - the known risks and benefits to the individual,
>   - the predictability of outcomes of performing the procedure,
>   - the safeguards and resources available in the circumstances to safely manage the outcomes of performing the procedure, and
>   - other relevant factors specific to the situation; and
> - the nurse accepts sole accountability for determining that the client's condition warrants performance of the procedure.[45]

Nurses who meet the above conditions for the controlled act of psychotherapy, as with others who have the authority to practice psychotherapy, are best situated to assess their own knowledge, skill, and judgment, a particular client's condition, appropriateness of intervention, and accept sole accountability for initiation. Consistent with the logic that the College argued with recommended changes made to the scope of practice for nurse practitioners, moving to autonomous legislative authority will more clearly establish direct accountability for safe practice.[46]

Enhancing Interprofessional Practice

In 2006 HPRAC reported that, in the course of its work, it heard and shared the concern that "existing Colleges have yet to establish specific educational qualifications and standards to adequately support the safe and effective practice of psychotherapy by their members."[47] Instead of abdicating responsibility of an element of nursing practice that a subset of nurses already have the competency to perform, the College should fulfill its RHPA object 4.1:

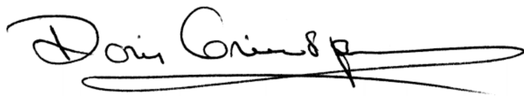
> To develop, in collaboration and consultation with other Colleges, standards of knowledge, skill and judgment relating to the performance of controlled acts common among health professions to enhance interprofessional collaboration, while respecting the unique character of individual health professions and their members.[48]

For these reasons, the RNAO urges the Council of the College of Nurses of Ontario to rescind its decision requiring an order for an RN to initiate psychotherapy. In order to strengthen

consistency of approach to controlled acts in the interests of public safety and enhancing interprofessional collaboration, the College must outline educational qualifications and standards for psychotherapy consistent with object 4.1 as soon as possible. As documented in the attached letter from the Mental Health Nursing Interest Group, RNAO members are willing to serve as resources to the CNO in establishing standards and regulations for the safe, competent, and autonomous practice of psychotherapy.

Thank you for considering these recommendations that will increase public safety, access to mental health services, and enhance interprofessional collaboration. We look forward to action on this important issue.

Warm regards,



Doris Grinspun, RN, MSN, PhD, LLD(hon), O.ONT.
Chief Executive Officer
Registered Nurses' Association of Ontario

Copy: Anne Coghlan, RN, MScN, Executive Director and CEO, College of Nurses of Ontario
Council of the College of Nurses of Ontario

Appendix A
Correspondence from the Mental Health Nurses Interest Group

Angela Verrier
President
Council of The College of Nurses of Ontario
101 Davenport Road
Toronto, ON M5R 3P1

November 19, 2014

Re: Nursing and the Controlled Act of Psychotherapy

Dear Angela,

Over the past several months many members of the Mental Health Nursing Interest Group (MHNIG) of Ontario have come forward to us to voice their concerns about the decision made regarding nurses requiring an order to perform the controlled act of psychotherapy.

Once proclaimed, the Ontario government has authorized physicians, nurses, occupational therapists, psychologists, social workers and members of the new College of Registered Psychotherapists of Ontario (CRPO) to perform the newly controlled act of psychotherapy. Each of the regulated Colleges listed is to govern their members' practice regarding psychotherapy. Unfortunately, the College of Nurses of Ontario has taken the position that "RNs and RPNs will require an order from a Nurse Practitioner (NP) or a physician to perform the controlled act of psychotherapy. NPs will have the authority to perform the controlled act of psychotherapy and will not need an order" (retrieved from CNO website: http://www.cno.org/learn-about-standards-guidelines/educational-tools/faq-practising-psychotherapy/). Our members believe that this statement restricts Registered Nurses (RNs) who have sufficient specialized education and experience to safely engage in psychotherapy. Furthermore, this barrier to practice marginalizes and devalues the role of the psychiatric/mental health nurse and RNs within Ontario.

RNs have had a long history of practicing psychotherapy, and many RNs currently practicing psychotherapy in Ontario have a great deal of experience and training. Our members have expressed concerns about receiving orders from physicians and NPs who may be untrained in psychotherapy. These restrictions may be viewed as creating a kind of de-skilling of the nursing profession. It is our understanding that NPs do not receive any further psychotherapy training in their entry-to-practice education than RNs, nor do physicians necessarily understand this area of expertise.

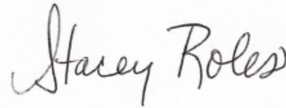
Further, requiring an order will undoubtedly increase delays in treatment times, particularly in rural and underserviced areas of Ontario, where the wait times for both Ministry funded and private therapy are already of significant length. This will also increase pressure on the primary care system and add an extra step for persons seeking mental health services when as a system we are trying to reduce barriers to receiving mental health care. In addition, there is concern that this barrier will disrupt the current and ongoing psychotherapy practice of RNs and their clients at this time. RNs are currently providing these services to a vastly underserviced and vulnerable health care community, and restrictions are not in the best interest of the public.

Rather than impose a restriction on the scope of practice of RNs by requiring an NP or physician order to perform psychotherapy, the MHNIG of the RNAO is requesting that the CNO grant RNs educated in psychotherapy access to the controlled act by establishing standards and regulations by which

competencies can be met in a similar way that the CRPO has outlined (see http://www.crpo.ca/home/the-regulations/). MHNIG members would be willing to work with the CNO in developing standards which would outline the knowledge, experience and skill a nurse would require through education and supervision to deem themselves competent to perform the act of psychotherapy.

Thank you for your consideration.

Sincerely,



Kamini Kalia, RN, MScN
President MHNIG, RNAO

Stacey Roles RN, BScN, MScN
Clinical Nurse Specialist
Advanced Practice Nurse Psychotherapist
Diplomate-Academy of Cognitive Therapy

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[7] "There was discussion about the subjectivity and lack of clarity of the definition of the controlled act of psychotherapy. The definition is in the *Regulated Health Professions Act*. It is a complex act to define and it was recognized that the definition poses challenges." College of Nurses of Ontario (2014). Council Minutes, March 6, 2014, 58. http://www.cno.org/Global/1-WhatIsCNO/council/meetings/2014/Council%20Minutes%20-%20March%202014.pdf
[8] *Regulated Health Professions Act*, 1991, c. 18, s. 27 (2).
[9] "HPRAC proposes the following description of psychotherapy form the scope of practice in the new regulatory framework: Psychotherapy is the provision of a psychological intervention or interventions delivered through a therapeutic relationship for the treatment of cognitive, emotional or behavioural disturbances." Health Professions Regulatory Advisory Council (2006). *Regulation of Health Professions in Ontario: New Directions.* Toronto: Author, 221. http://www.health.gov.on.ca/en/common/ministry/publications/reports/new_directions/new_directions.pdf
[10] RNAO's alternative description of psychotherapy submitted to HPRAC: "Psychotherapy is the provision of a psychological intervention or interventions, delivered through a therapeutic relationship, for the prevention and treatment of psychiatric illnesses, as well as to promote mental, behavioural or emotional health and address cognitive, emotional or behavioural disturbances."
Registered Nurses' Association of Ontario, 2006, 19.
[11] "It was noted that this is a high risk activity and a new controlled act. The College will monitor practice to determine if this is the right regulatory mechanism or if other options should be explored." College of Nurses of Ontario (2014). Council Minutes, March 6, 2014, 58.
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