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Mental Health Professionals' Views on the Regulation of Psychotherapy in Ontario
Les perspectives des professionnels de la santé mentale sur la réglementation de la psychothérapie en Ontario

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ABSTRACT
In Canada, mental health is regulated at the provincial level. In 2007, the Ontario government introduced the Psychotherapy Act (PA), which details the scope of practice as well as the controlled act of psychotherapy. The PA established the College of Registered Psychotherapists of Ontario (CRPO) to regulate its members in the service of protecting the public. Given the long history of contestation and ambiguity surrounding the definition of psychotherapy, the PA represents an important historic moment for practitioners in Ontario. However, little research has been conducted on psychotherapy practitioners' experiences and perspectives on professional regulation. This study qualitatively explored perspectives on and experiences with the PA among regulated mental health practitioners who have access to the act of psychotherapy in Ontario, including psychotherapists, nurses, physicians, occupational therapists, psychologists, and social workers. The study provides insights into the ways that these professional groups are impacted by the regulation of psychotherapy and has implications for the future implementation of statutory regulation.

RÉSUMÉ
Au Canada, la santé mentale est réglementée sur le plan provincial. En 2007, le gouvernement de l'Ontario a présenté la Loi sur les psychothérapeutes, qui décrit le champ d'exercice ainsi que l'acte autorisé de la psychothérapie. La Loi sur les psychothérapeutes a créé l'Ordre des psychothérapeutes autorisés de l'Ontario (OPAO) dans le but de protéger le public en réglementant ses membres. Étant donné la longue histoire de contestation et d'ambiguïté liée à la définition de la psychothérapie, la Loi représente un moment historique important pour les praticiens de l'Ontario.

Cependant, peu de recherche a été menée sur le vécu des praticiens de la psychothérapie et sur leur perspective sur la réglementation professionnelle. Cette étude qualitative analyse les perspectives sur la Loi sur les psychothérapeutes des praticiens de la santé mentale réglementés qui ont accès à l'acte de la psychothérapie en Ontario et leur vécu par rapport à celle-ci. Sont compris les psychothérapeutes, les infirmières, les médecins, les ergothérapeutes, les psychologues et les travailleurs sociaux. L'étude montre comment ces groupes professionnels sont touchés par la réglementation de la psychothérapie et a des implications pour la mise en oeuvre ultérieure du règlement d'application.

The definition of psychotherapy has been contested for decades worldwide and continues to be a source of tension. This is largely due to psychotherapy's broad and varied methodological and theoretical practices (Buchanan, 2003; Rosner, 2018). As of 2021, five provinces in Canada have legislation to protect psychotherapy professions. New Brunswick, Nova Scotia, and Alberta have legal protection over the title use of "psychotherapist," while Ontario and Quebec have the title and act of psychotherapy protected. British Columbia, Saskatchewan, Manitoba, Prince Edward Island, and Newfoundland and Labrador remain unregulated but are in the process of creating protective legislation (Canadian Counselling and Psychotherapy Association, 2020). In Ontario, the Psychotherapy Act (PA) was introduced in 2007 and proclaimed in 2015. This legislation amends the 1991 Regulated Health Professionals Act (RHPA), which established professional colleges that are responsible for protecting one or more protected acts as outlined in the RHPA. Protected acts are practices that are deemed unsafe to the public if used without formal training, such as communicating a diagnosis and dispensing, prescribing, selling, or compounding a drug (Government of Ontario, 1991). Only members of a respective college can practice the controlled act.

The College of Registered Psychotherapists of Ontario (CRPO) was established to protect the controlled act of psychotherapy. The CRPO's mission is "to develop standards and procedures to regulate psychotherapists in the public interest, striving to ensure competent and ethical practice within a professional accountability framework" (CRPO, n.d., Who We Are section). Under the RHPA, six colleges, including the CRPO, can legally practise psychotherapy—the College of Nurses of Ontario (CNO), College of Physicians and Surgeons of Ontario (CPSO), College of Occupational Therapists of Ontario (COTO), College of Psychologists of Ontario (CPO), and the Ontario College of Social Workers and Social Service Workers (OCSWSSW; Government of Ontario, 1991). The controlled act is defined by the PA as "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 judgement, insight, behaviour, communication or social functioning" (Government of Ontario, 2007, p. 1). Professionals practicing

psychotherapy were given a two-year transitionary period to become registered with a college that holds this controlled act and clarify questions regarding what practices this act includes and excludes. This period ended on December 31, 2019. After this time, only members of these six regulatory colleges can practice psychotherapy and legally use the title "psychotherapist" (Government of Ontario, 1991).

Given the long history of contestation and ambiguity surrounding the definition of psychotherapy, the PA represents an important historic moment for practitioners in Ontario. In addition to the PA's primary purpose of public protection from malpractice, it aids in defining and legitimizing professional boundaries by legally recognizing and unifying professionals through practices unique to them (Kreiner et al., 2006). The PA legally cements a specific definition of psychotherapy, which reinforces professional boundaries by granting some groups access to this practice. However, regulation can also have unforeseen negative impacts on various stakeholders. It can challenge professional autonomy by imposing external constraints on practice, impact the profession's identity, and influence professional and institutional relations and boundaries (Muzio & Kirkpatrick, 2011; Powell & Oberg, 2017).

This research gives voice to the struggles, gaps, and benefits health professionals experience as a result of the PA, which may not be recognized by policymakers and regulatory colleges. Shining light onto these experiences can help Ontario regulatory colleges and legislators become aware of and mitigate these challenges. Furthermore, this research can help guide other provinces and territories where psychotherapy is not yet regulated. They can draw from these insights to anticipate, prepare for, and be able to discuss the impacts of regulation on professional groups. It can also help those working with health professionals (e.g., employers, professional associations, insurance companies) better understand possible challenges regulated mental health professionals face, which can allow for more informed initiatives, policies, and systems to support them.

Furthermore, there is a gap in the literature on the impacts of legislative changes on Canadian health professional groups. Specifically, there is little literature that explores professional regulation from a perspective that accounts for intra-professional (within a professional group), inter-professional (between professional groups), and institutional influences on professional identity, boundaries, and legitimacy (Chreim et al., 2007). This is important because it can provide more wholistic insights into the ways that professional groups are impacted by regulation.

History of Psychotherapy in Canada and the United States

Although proposed in 2007, Ontario's Psychotherapy Act (PA) is a product of decades of professional turmoil surrounding the definition and claim to

psychotherapy (Government of Ontario, 2007). Entangled with this act is the history of a professional turf war around boundaries and identities that was born out of the growing popularity of psychology in Canada and the United States, which continues today (Buchanan, 2003).

The growth of psychotherapy was heavily dependent on being redefined from a spiritual practice to a scientific practice. Prior to the early 20th century, psychotherapy was not commonly recognized or known by the general public. While some psychiatrists were aware of the benefits of "talk therapy," many feared practicing psychotherapy would associate their profession with spirituality and pseudoscience. For psychiatrists, this association would conflict with their adherence to dominant positivist scientific knowledges that gained them legitimacy (Caplan, 1998). There were many historical moments that aided in aligning psychotherapy with scientific medical practices. There was the 1906 Emmanuel Movement, which aimed to combine spirituality and science to aid those with nervous disorders (Caplan, 1998). Secondly, Freud, who had a background in neurophysiology, opened the door for mental health to be discussed outside of physiology. While Freud was a firm believer that abnormalities in the physical brain produced "insanity," he also believed that the technology of his time was not sufficient to explore this connection. Thus, his theory did not focus on physical areas of the brain but on abstract psychological aspects of the mind. This helped decrease the ambivalence psychiatrists felt towards practices, language, and theories that focused on the "mind" (Bynum, 1964). Furthermore, David Shakow's introduction of the Boulder model of clinical psychology to the American Psychological Association in 1949 and Canadian Psychological Association in 1960 aided in consolidating tensions between psychology as a practice and psychology as scientific research (Albee, 2000; Fancher & Rutherford, 2017). The Boulder model adheres to a medical understanding of "mental disease" that is based on physiological brain and psychiatric diagnostic standards (Albee, 2000), while expecting practitioners to know how to interpret, use, and conduct scientific research (Bernhardt, 1960).

Aligning psychotherapy closer with scientific medical knowledge aided in increasing its legitimacy and demand, which led to a rush of professionals trying to (re)define their professions and lay claim to expertise of the mind (Caplan, 1998). As demand for psychotherapy continued to rise during WWI and II, psychiatrists were unable to keep up with requests for psychological services and other professionals, namely psychologists, were thrown into clinical positions (Albee, 2000). Without formal regulation or established training standards, individuals without adequate education began offering psychotherapy and related psychological services. This sparked public outcry as people were harmed by untrained practitioners and had no regulatory bodies to hold the individual accountable (Benjamin, 1986). Thus, professional groups for psychologists gathered to address training and practice standards and worked to define themselves

as a distinct professional group amongst others, such as clinical social workers, who were trying to lay claims to similar practices (Buchanan, 2003). A challenge these professional groups faced was trying to define the practice of psychotherapy given the breadth of theoretical orientations and practices their members adhered to, which is integral to gaining public recognition and legitimacy. For example, in Canada, social work was on the brink of not having access to the controlled act of psychotherapy despite having over half of its profession working in health care settings. Furthermore, a foundational principle of social work is social justice and attending to social aspects of health, which the Canadian Standing Senate Committee on Social Affairs named as integral to ensuring mental health (O'Brien & Calderwood, 2010). Social workers had to advocate to be regulated as health professionals, clarifying and (re)defining their professional boundaries to solidify their claim to psychotherapy (O'Brien & Calderwood, 2010).

Today, psychotherapy practice continues to grow and diversify. However, legislation, such as the PA, attempts to encapsulate the practice of psychotherapy and give it to certain professional groups to maintain public safety.

The RHPA and PA

In Canada, under the 1867 British North American Act, each province is responsible for the regulation and certification system of various professions (Dunbar, 1998). Provinces and territories are responsible for deciding which professions to regulate and how (Domene & Bedi, 2013; Lemmens & Ghimire, 2019). In the early 19th century, most health professions—including psychologists—were controlled by practitioners in the medical field, mainly medical doctors. Doctors had a monopoly overseeing "non-physician" professions and services, which reflected dominant Western scientific knowledges (O'Reilly, 2000). After the devastating impacts on medical service accessibility and affordability resulting from the Great Depression in the 1930s, the Canadian government began to introduce insurance for health services (Lemmens & Ghimire, 2019). In doing so, medical doctors lost some control of "non-physician" professions.

The health care regulation reform began in the '60s and '70s. This was sparked by a few factors, including the introduction of health insurance. There were intense conflicts and tensions between professions that fought to be independently recognized and legitimized by the public and government. Professions struggled to differentiate themselves from others and clearly define their identity and roles. Additionally, there was a growing concern for public safety as there were no regulation laws, which meant anyone could use professional titles or perform certain practices without legal consequences (Lemmens & Ghimire, 2019). While professionals may have been members of associations, the associations did not hold any legal bearing, and membership was not mandatory for practice (Markova et al., 2013). Prior to statutory regulation, professional associations composed of those

working in the field of psychology mainly guided the profession by providing professional standards of practice, helping establish a professional identity, and advocating for governmental regulation (Markova et al., 2013; Wand, 1993; for detailed historical accounts of psychotherapy in Canada, see Domene & Bedi, 2013; Dzinas, 2000; Martin et al., 2013). Furthermore, the need for governmental professional regulation was advocated by the Report of the Ontario Committee on the Healing Art in 1970 and by the Professional Organizations Committee in 1980. By 1982, the Ontario Health Professions Legislative Review was underway. Upon its completion in 1989, those participating in the provincial review drafted the RHPA (Lemmens & Ghimire, 2019). Throughout the revision of the RHPA from 1989 to 1991, many health professional groups fought to have their professions regulated (Lemmens & Ghimire, 2019) because becoming self-regulated cemented professional groups' distinctiveness and position in society (O'Reilly, 2000).

The RHPA was enacted in 1991 (Government of Ontario, 1991). This Act is meant to hold professionals openly accountable, improve service quality, and ensure public interest and safety (Lemmens & Ghimire, 2019). This Act outlines 28 health professions that are regulated under the Ontario Ministry of Health and Long-term Care and 26 regulatory colleges. Colleges are legal organizations that professionals must be members of to legally practice in their province and use a certain professional title (Government of Ontario, 1991). Colleges regulate professionals to ensure they are practicing within professional standards and their scope of practice to ensure the public has access to qualified and competent practitioners. The RHPA is an umbrella Act that covers 26 controlled acts, each establishing a regulatory college meant to guard an act. These controlled acts, such as communicating a diagnosis and psychotherapy, are deemed harmful to the public if used improperly or without sufficient training (Government of Ontario, 1991). Thus, only members of certain colleges have access to specific controlled acts. For example, the CRPO is responsible for regulating the controlled act of psychotherapy and is governed by the PA and the RHPA. Different professions can have access to multiple controlled acts. For example, registered psychologists can communicate a diagnosis and practice psychotherapy.

The RHPA's consequences and importance for establishing and legitimizing professional boundaries and identities are still felt today. The PA is the most recent Act to be included in the RHPA. This has repercussions for professionals who are permitted to practice psychotherapy and those who are no longer allowed to practice psychotherapy, such as counsellors. Amid these legislative changes, counsellors are struggling to reconstruct their professional identity (Gignac & Gazzola, 2016, 2018). There are also tensions and confusions around the language and practices professionals are legally allowed to use, which has implications for their legitimacy, identity, and boundaries. These tensions and confusions warrant further investigation. Before we discuss the current study aimed to address these

tensions, we briefly discuss the link between professional regulation and professional identity, boundaries, and legitimacy.

Professional Identities, Boundaries, and Legitimacy

Professional groups are groups of people who share a collective professional identity, which are the core beliefs, values, norms, goals, and practices that are unique to the profession (Chreim et al., 2007; Kreiner et al., 2006). *Professional identities* work to answer the question of "who are we?" However, individual professional identities also play a role in the larger collective as individuals formulate conceptions of the self in relation to their profession, answering the question of "who am I?" According to Kreiner et al. (2006), collective and individual identities are intertwined; changes in the identities of specific professionals may cumulatively result in changes in how the profession as a whole identifies itself. Likewise, changes in the collective professional identity may impact how specific members of the profession identify themselves. Regulation can impact professional identities in direct and indirect ways. Directly, regulation can explicitly outline expectations and exclusivity of professional practices, which can change how professionals understand their professional group and, thus, shape their professional practices (Chreim et al., 2007). Indirectly, regulation can shape how society (e.g., public, regulatory colleges, insurance companies) relates to the professional group in terms of their expectations of the profession (Chreim et al., 2007).

Professional groups need to have distinct collective identities to separate themselves from other professions. These distinctions between professional groups are called *professional boundaries*, which dictate who is included in a professional group (Fournier, 1999). The ongoing process of establishing and maintaining boundaries is called boundary work, which is a key aspect of the ongoing reproduction of professional groups (Fournier, 1999). Hence, professional boundaries encapsulate professional identities and help separate specific professional groups from others, ultimately aiming to create an "independent, autonomous, and self-contained area of knowledge" (Fournier, 1999, p. 69; Kreiner et al., 2006). Professional groups establish and maintain boundaries in many ways, including through legalization, credentialism, speech, and ways of relating with other professional groups (Fournier, 1999; Liberati et al., 2016). Professional boundaries are relational; they exist in relation to other professional groups and institutional and societal expectations and needs (Fournier, 1999; Powell & Oberg, 2017). Hierarchies of power can exist within professional settings, where some professionals' knowledge and practices are more legitimized and valued over others. In these hierarchies, one professional group may be seen as having more expertise on a topic than another group that holds similar knowledge and practices. Regulation can impact boundaries because it shapes ways of relating with other professional groups and institutions by legally cementing differences between

them, establishing expectations that are taken up by institutions, and offering legitimacy to professions (Fournier, 1999).

Legitimacy is central to the survival of a profession because it helps solidify professional identities and boundaries and defends the profession from pressures, doubts, and attacks outside of the professional body. Like professional identities and boundaries, legitimacy is a fluid process involving professions constantly changing on a spectrum of legitimacy (Deephouse et al., 2017). Groups are legitimized when they adhere to dominant societal norms, knowledges, systems, and structures (Deephouse et al., 2017). For example, psychiatry gained legitimacy by adhering to dominant scientific medical knowledge (Caplan, 1998). For professional groups to lay an uncontested claim to a particular expertise, they need to be publicly and legally recognized as a distinct group that is valuable to the greater society and competent within their claimed expertise (Deephouse et al., 2017). Legitimacy is important for professional groups because it helps ensure professional survival and access to resources, such as funding, insurance coverage, and public demand (Deephouse et al., 2017). Governmental regulation can help foster legitimacy as it legally cements professional identities and boundaries.

As psychotherapy historically held an ambiguous definition, multiple professional groups laid claim to it and fought for the legitimacy of their claim. Since the PA gives six colleges access to the controlled act, professional boundaries are (re)defined as the legitimacy of their claim to psychotherapy is solidified. However, since there are six colleges that can legally practice psychotherapy, this can lead to confusion around what differentiates these professional groups. Thus, this can blur professional identity and boundaries for the professional group, the public, and other stakeholders.

The Current Study

We explored perspectives on and experiences with the Psychotherapy Act (PA) among regulated mental health practitioners whose college has access to the controlled act of psychotherapy in Ontario, including the perceived effects of the PA on practitioners' professional identities, boundaries, and legitimacy. The study was guided by the following questions:

1. How do members of the six colleges who have access to the controlled act of psychotherapy understand the PA?
2. What are the implications of the PA on the professional boundaries of the six colleges that have access to the controlled act of psychotherapy?
3. What effect does the PA have between colleges and third-party players?

Responses were gathered through an open-ended online survey and analyzed using thematic analysis (Braun & Clarke, 2006, 2020). The study was informed by Powell and Oberg's (2017) theory of networks and institutions. Networks of relationships between actors (e.g., professional groups) do not exist only on one

level of scale (horizontally), such as inter-professionally or intra-professionally, but also work across various levels (vertically) through interactions between professional individuals, professional groups, and institutions. This multi-level approach recognizes power imbalances that may exist on various levels, which shape relationships on other levels. For example, a professional's relationship with a third-party payer may impact the professional's relationship with clients. If insurance companies do not provide coverage for a professional group's services, it could limit clients' access to those services. This multi-level approach also recognizes the variety of relationships and actors involved in the (re)production of identities, offering a more situated and dynamic understanding of professional entities (Powell & Oberg, 2017). Dynamics between relationships, identities, boundaries, and legitimacy were used as a general framework in the data analysis.

Method

Recruitment and Data Collection

Prior to recruitment, ethics approval was granted by the Research Ethics Board of the University of Guelph. Only actively practicing members of CRPO, CNO, COTO, CPO, CPSO, and OCSWSSW were included in the study. There were no restrictions related to participants' place of work, time in the field, or status with the college (i.e., qualifying, supervised, independent practice). Participants were recruited in one of three ways. The first author Google searched psychotherapy services in various Ontario municipalities, using a map as a guide to ensure professionals from all parts of the province were given a chance to participate. From these searches, participants were contacted individually via the email addresses provided on their company websites. Additionally, private and public clinics, hospitals, and organizations in Ontario found via this search were contacted and asked if they could distribute the survey and invitation to interview their staff. Lastly, various associations (provincial and national) linked to these professional bodies were contacted and asked to send the survey and invitation to interview via their listserv. An online survey was used (Qualtrics; https://www.qualtrics.com). Of the 22 survey questions, 6 were multiple choice questions addressing the respondent's professional demographic characteristics. Personal demographic information (e.g., age, gender, cultural background) was not collected. Next, 16 open-ended questions were used to elicit detailed accounts from participants. Participants were asked a variety of questions about their membership in a college, understanding of the PA, impact of the PA, among others.

Participants

There were a total of 74 survey participants (see Table 1). Of these, there were 31 CRPO members, 11 CPO members, 18 OCSWSSW members, 9 COTO members, 3 CNO members, and 2 CPSO members. Generally, most participants

worked in either private practice or community organizations, and a few worked in schools, hospitals, or multiple settings. Most were independent practitioners, with only a few qualifying (not full) members. While all participants were active members of their colleges, some did not specialize or offer psychotherapy (i.e., all CPSO, CNO, and a few OCSWSSW participants). As such, this was a limited sample, where none of the participating nurses and physicians actively practiced psychotherapy.

Data Analysis

Survey data from Qualtrics were analyzed using thematic analysis (TA; Braun & Clarke, 2006, 2020). TA is used to identify patterns of meaning (themes) in the data. The data were analyzed within and between colleges (see Figure 1). The first author conducted the data analysis. Braun and Clarke (2020) described six stages of data analysis: (a) getting familiar with the data, (b) generating codes, (c) constructing themes, (d) reviewing potential themes, (e) defining and naming themes, and (f) producing the report. The first author began by familiarizing herself with the data by reviewing responses throughout the collection period and after all responses were collected. She then engaged in line-by-line coding, staying close to the text and words of the participants. Afterward, the codes were further analyzed to identify patterns or themes in participants' responses. Relationships between the themes were explored, giving rise to broader themes. The final stages of the analysis involved defining in more precise terms the identified themes and producing the report. The themes were discussed and reviewed with other authors during theme development. They also aided in ensuring rigour and in the production of the final report.

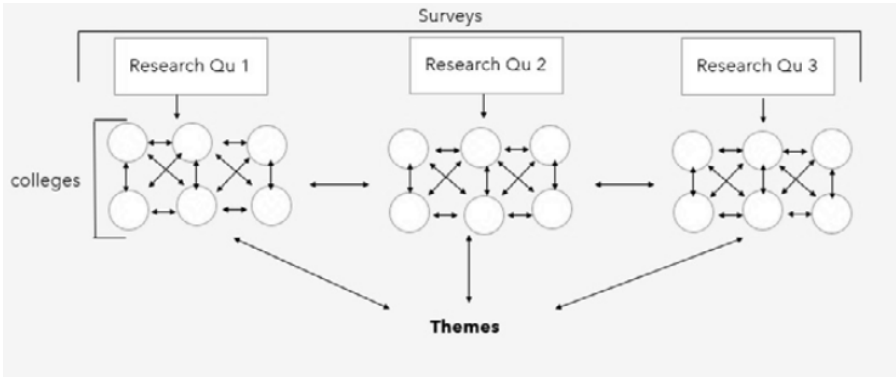
Four rigour criteria were used in the study (Lincoln & Guba, 1985). *Credibility* of the results was established through the first author's prolonged engagement with the data through multiple reviews of the data at various times with different constellations of research team members. *Credibility* was also achieved through reflexivity by being mindful of which participant responses we were drawn to, thinking through what drew us to them and speaking with other team members to discern if a particular idea or noticing was aligned with and helpful to the study. *Transferability*, or the extent to which the results can be transferred to other settings, was established through details regarding the sample and the "thick description" of the results. *Dependability*, or the study's integrity, was established through an audit trail, where the first author continuously memoed research decisions. This audit trail was collaborative, as the first author discussed decisions with other team members before proceeding. Additionally, in moments where decisions were made individually, they were reviewed by the other authors afterward. Finally, *confirmability*, or the extent to which the conclusions are seen as grounded in the observed data, was established by providing verbatim quotes alongside the conclusions.

Table 1
Summary of Participant Demographics

College	College Status	Years of Practice	Workplace
CRPO Total – 31	Independent practice – 25 Qualifying – 6	0-5 – 11 6-10 – 11 11-16 – 2 16-20 – 3 21+ – 4	Private practice – 15 Community organization – 14 School – 1 Hospital – 1
CPO Total – 11	Independent practice – 11	0-5 – 0 6-10 – 4 11-16 – 3 16-20 – 1 21+ – 3	Private practice – 8 Community organization – 1 School and private practice – 1 University – 1
OCSWSSW Total – 18	Independent practice – 18	0-5 – 6 6-10 – 1 11-16 – 2 16-20 – 2 21+ – 7	Private practice – 3 Community organization – 13 Hospital – 1 Private practice, community organization, and hospital – 1
COTO Total – 9	Independent practice – 9	0-5 – 3 21+ – 3	Private practice – 3
CNO Total – 3	Independent practice – 3	0-5 – 1 6-10 – 0 11-16 – 1 16-20 – 1 21+ – 0	Community organization – 1 Hospital – 2
CPSO Total – 2	Independent practice – 2	0-5 – 2 6-10 – 0 11-16 – 0 16-20 – 0 21+ – 0	Private practice – 1 Community organization – 1

Note. Summary of participant demographics by college, college status, years of practice, and workplace.

Figure 1
Data Analysis Process



Researcher Positionality

We are a team of psychotherapy educators, researchers, and practitioners, and we are members of the CPO and CRPO. We are white, educated, cisgender men and women residing in Ontario who have each been impacted by the PA in some way. The third author (NG) is a psychologist in Quebec and a professor in counselling psychology at the University of Ottawa. OS and JB are associate professors at the University of Guelph, while the primary data analyst (LV) was a graduate student in couple and family therapy at the University of Guelph at the time. JB is a member of the CRPO, and OS is a member of the CPO. At the time of this research, LV was seeking membership into the CRPO and already held an MA in social anthropology, which further sensitized her to systemic beliefs that assumed a dialectic relationship between macro, meso, and micro systems and post-modernist beliefs that understand knowledge as situated and co-constructed. These beliefs guided the research questions and data analysis as we were sensitized to the interactions between the systems involved in co-constructing the meaning of psychotherapy and professional identity.

Results

The following six themes were developed: Varied Knowledge of the PA; Varied Impacts on Professional Identity and Boundaries; College Gatekeeping Challenges and Complications; Increased Accountability; Heightened Interprofessional Tensions and Competition; and Enhanced Interprofessional, Institutional, and Public Recognition.

Varied Knowledge of the PA

Professionals covered under the PA disclosed having various levels of knowledge about the PA, ranging from no or little knowledge of the Act, to confusion, to complete understanding. Responses varied between and within professional groups. All doctors and two social workers had little to no knowledge of the PA. We wonder if this lack of knowledge stems from psychotherapy not being the main practice of their profession. For example, physicians' controlled acts center around procedures directly working with the physical body (Government of Ontario, 1991). Members need to pursue additional education to ensure they are competent in performing psychotherapy. Compared to the CRPO, whose only controlled act is psychotherapy, members of colleges such as the CPSO do not need to have full knowledge of the Act unless they choose to practice psychotherapy.

Alternatively, there were participants across all colleges (except medical doctors) who seemed to have a clear understanding of the PA. They cited the PA as restricting and defining psychotherapy, establishing the CRPO, and ensuring quality professional practices and competencies to protect the public. For example, an OCSWSSW member defined psychotherapy as "the assessment and treatment of cognitive, emotional, or behavioural disturbances by psychotherapeutic means, delivered through a therapeutic relationship based primarily on verbal or nonverbal communication." This definition closely aligns with the PA's definition of psychotherapy. The large number of participants who expressed a clear understanding of the PA indicates that many psychotherapy professionals are aware of the PA and how it impacts their practice.

Some described knowing the PA and understanding its legal implications but having some confusion about how this translates practically, specifically with regards to what it means to practice psychotherapy (versus a similar practice, like counselling). Psychotherapists, social workers, and nurses expressed confusion about the legal definition of psychotherapy as described by the PA. One member of the CRPO wondered how psychotherapy is practically different from counselling. They explained, "psychotherapy is different from counselling in theory; however, in practical life, it overlaps, and it is really difficult to keep both things separate."

Varied Impacts on Professional Identity and Boundaries

Some participants, notably psychotherapists, social workers, and occupational therapists, said the PA left them and others uncertain and confused about their professional role and identity and what this means for professional boundaries. One CRPO member explained they are confused if they "should belong to college of social work or the college of psychotherapists in Ontario and what are the benefits of each of them." A social worker explained that their workplace "continues to struggle to find the line between what is considered and not considered

psychotherapy." They mentioned this leaves people "feeling undervalued," and "anxious about crossing the line." Others (occupational therapists, nurses, doctors, and psychologists) noted that the PA had no impact on their professional boundaries. Nurses and physicians noted no change because psychotherapy is not something they perform. Social workers and occupational therapists described it as not changing their practices other than being more mindful of adhering to the PA. As one occupational therapist put it, "It [the PA] is more bureaucratic, with more regulatory red tape. It has not changed my clinical practice." Psychologists similarly cited no difference and noted that their identity as a psychologist is separate from the PA. A psychotherapist echoed these views and noted that his practice of psychotherapy is somewhat different from the controlled act of psychotherapy. He explained that his years of experience in the field gave him an understanding of what psychotherapy is and the practice he does. While the PA attempts to define this act, it remains vague and does not fully capture the complexity and diversity of psychotherapy. Hence, he noted a separation between the controlled act of psychotherapy and his professional practice, "It [the PA] basically doesn't change anything from my point of view—doesn't change my practice, doesn't change what I do or what I understand about it." For psychologists and psychotherapists, the experience of the PA having minimal impact on their professional identity could be due to the centrality psychotherapy played prior to the Act. Since their main practice was psychotherapy, they had already developed a professional identity that encompasses this practice.

For some occupational therapists, psychotherapists, and social workers, the PA helped make professional boundaries clearer. They named having a better understanding of what their scope of practice is and how they are different from other professionals. A CRPO member explained, "previously, my work fell in the cracks among OT, PT, SLP, psychologists, etc. This is a designation that appropriately supports the work I do rather than falling between the cracks of other colleges." Another participant similarly mentioned the PA "has given definition to part of the role of a social worker." These participants' experiences of having the PA's clear professional boundaries could be due to their legally recognized inclusion in a practice that was once on the periphery of their profession.

College Gatekeeping Challenges and Complications

During the transitionary period of the PA, the CRPO provided an opportunity for professionals already practicing psychotherapy to gain admission into the college based on alternative criteria. This is commonly referred to as being "grandparented." Social workers and psychotherapists noted that while this process was meant to keep experienced professionals working, there was minimal support and inconsistencies in the transition, which left some professionals excluded from the college. One social worker explained that the PA "caused significant anxiety for those staff affected, and there were inconsistencies as to who was accepted and not

accepted into CRPO during the grandparenting phase." Many psychotherapists and social workers also expressed frustrations with the difficulty of registering with the CRPO after the transitionary period of the PA. A CRPO participant expressed frustration over the lack of recognition for immigrants who "struggled to demonstrate their experience since the college requested considerable amount of documents." Another CRPO member shared this frustration with the recognition that the government did not adequately support the transition of experienced professionals and focused mostly on private practice practitioners, ignoring professional practice in other contexts, such as community agencies. According to one participant, "[regulation of psychotherapy] has brought forth 'credentialism' in many workplaces and has impacted morale. The government did not do a good job of supporting seasoned workers in this transition. They seemed solely focused on private practice practitioners."

Participants also commented on the difficulties surrounding the supervision of those from other colleges outside or inside the PA. One participant (social worker) discussed the impact supervision restrictions place on their ability to supervise those who do not have access to psychotherapy. Due to restrictions enforced by the PA, this participant shared that they must rework their approach to supervision to ensure that supervisees are working within their scope of practice (i.e., can no longer practice cognitive-behavioural therapy). As a consequence, there is less training and support for supervisees whose practice is restricted or who cannot fully utilize supervision. Many participants also noted that they needed to find new supervisors due to the PA, which can be difficult. One CRPO member noted they had to get a new job because their previous employer was unable to supervise them. A CPO member explained that since they can no longer supervise qualifying RPs, they are unable to hire RPs unless they are fully registered with the CRPO.

Increased Accountability

The PA seems to impact professional accountability in terms of who can practice psychotherapy and how they can practice it. Participants discussed greater scrutiny of their own and others' professional practice following the PA. Some participants (mostly social workers, occupational therapists, and psychotherapists) discussed the importance of ensuring clients' safety and wellbeing. While many practitioners noted that this accountability existed prior to the Act, the PA made it more pronounced through legal validation. One occupational therapist explained that the Act allowed for "increased protection for clients as therapists now have more consistent expectations regarding psychotherapy practice." A social worker elaborated on this accountability by voicing their appreciation for systems that allow the public to file complaints and launch investigations. Many members also mentioned that after the PA was enforced, they would not recommend clients to see unregulated professionals. One CRPO member explained this is because

"there is no recourse for clients in those cases where they have been abused or the non-regulated person engaged in misconduct." Overall, professionals expressed that inclusion in the PA heightened their sense of accountability to clients.

In addition to the PA creating a greater sense of accountability to clients, participants mentioned upholding the accountability of the profession through "policing" others. Members of the CRPO and OCSWSSW explained the impact the Act has on their behaviour towards other professionals within and outside of their college. Specifically, members explained that they are more inclined to scrutinize others and hold them accountable to the PA. One CRPO member explained that the Act "helps me see my role as a peer to ensure that they follow the standards of practice." To help ensure professionals are working within their scope of practice, one social worker explained that in their role as a clinical program supervisor, the PA offers a tool for educating supervisees about their professional obligations. Other participants, in particular psychotherapists, occupational therapists, and social workers, mentioned that they hold themselves accountable for adhering to the restrictions and guidelines of the PA. A CRPO member mentioned that the PA offered "a means to demonstrate my integrity in the profession." For some, the PA and associated standards of practice are "internalized" and are used to routinely guide and assess their professional practice. In other words, the PA helps hold professionals accountable in the eyes of their peers.

Given the increased scrutiny and restrictions that followed the PA, some practitioners voiced fear of accidentally violating the Act's guidelines. One CRPO member noticed their colleagues are "weary of their interventions, fearing repercussions." They went on to explain that the "added responsibilities of reporting any mistakes/breaches/etc., not only to our organisation but also to our college, which was new to them, has made them jaded and negative." This participant mentioned that this fear changed the atmosphere at work. This is echoed by a nurse who explained that the PA has "discouraged me from attempting to participate in therapy-type services as I don't want to inadvertently engage in the controlled act." A social worker explained that they were originally second-guessing their scope of practice despite years of experience. They went on to question the Act, acknowledging that while it is meant to protect the public, it "seems penalizing." This fear is not only for being reported for breaching practice guidelines, but name and title use as well. One occupational therapist shared stress over saying they practice psychotherapy due to the Act's confusing and ambiguous wording.

Heightened Interprofessional Tensions and Competition

Participants shared increased tensions between professions stemming from the PA. One participant (CRPO member) referred to these tensions as professional "turf wars." Psychotherapists, psychologists, and social workers expressed concerns about the competencies of professionals allowed to practice psychotherapy (e.g., doctors, nurses, psychotherapists) and inconsistent training practices and

expectations across colleges. These concerns did not appear to be directed at one college but at colleges outside participants' own colleges. A psychotherapist expressed concern over the competencies of nurses and physicians "who are allowed to perform the act of psychotherapy but most of who don't actually have training." This participant went on to name concerns that social workers' training does not "offer a wide range of psychotherapy specific courses." Counter to competency concerns due to inconsistent education, a psychologist explained that, to some extent, the differences in education could help with diversifying the field of mental health, facilitate more collaboration, and better meet the needs of the client. For this participant, differing training practices for each college promotes collaboration between mental health professionals, as they have different specializations and knowledges that complement each other and best meet the client's needs.

Competency concerns exasperate competition for resources as some practitioners believe that others should not receive certain benefits due to their lack of education or experience. This expands beyond the six colleges. One social worker shared a story of being hired at an agency that made them believe they were getting "a top wage for that position," later to find out that their pay was comparable to someone who was unregulated and had less education. Some psychologists worried that the PA 'diluted' the profession and other colleges posed a threat to their access to clients. As one psychologist explained, "The tricky part is that if a client can see someone literally half the price, they might think it's in their best benefit to see someone cheaper." Another psychologist explained that while other regulated mental health professionals may pose a risk to their work, "insurers still see psychologists as the gold standard." Some named their professional distinction of also having access to the controlled act of communicating a diagnosis as a shield from the "ever looming" threat of others encroaching on their work.

Concerns over competition were not shared by all. One social worker voiced that "it [the PA] created a divide amongst the different colleges. I always report, there is no reason to be divided, as there is enough client work for all disciplines."

Enhanced Interprofessional, Institutional, and Public Recognition

Participants belonging to five colleges (excluding doctors) mentioned that the PA helped enhance their professional credibility and legitimacy. A CRPO member voiced, "I find it's given me more credibility with the psychiatrist and psychologists I work with, as well as when others ask me what I do." This was echoed by an occupational therapist who said, "[the PA] gives OTs more credentials to perform psychotherapy and reminds others that OTs are capable to perform the psychotherapy, as long as they meet the criteria with training." Although participants generally shared an increased sense of being recognized by other professionals, some suggested that other colleges, included and excluded from the PA, may not know specific professions (e.g., psychotherapists) exist or have

little knowledge of their practices. A CRPO member expressed that a challenge they face in interacting with other professional colleges is that they do not know what an RP is. Another member explained members of other colleges think that the "PA only applies to members of the CRPO."

The public and institutions, particularly third-party payers, recognize colleges covered under the PA to various extents. Practitioners explained that clients typically have little education about the PA, which impacts clients' recognition of professionals. One social worker succinctly explained this, "[I] do not think that the public or clients understand or even know or care about the PA." A psychologist mentioned that while the PA "gives clients more choices," they may not know the "difference between professions." For third-party payers, participants explained there are varying levels of recognition of the profession, with some noting difficulty being covered to others noticing they are slowly being recognized more. The concern of lack of recognition was mainly expressed by CRPO members, which makes sense given the college was recently established. As one participant explained, "I can say for certain that it isn't easy to find insurance companies that'll accept psychotherapy from an RP, let alone a Qualifying member (a category which infuriatingly few institutions recognize)." This struggle for recognition is also shared by occupational therapists, one of whom shared, "it is difficult for my clients to claim insurance as psychotherapy by an OT is not in many insurance plans." Psychologists, psychotherapists, social workers, and occupational therapists discussed the need for advocating for public and institutional recognition in various ways.

Discussion

This study explored perspectives on and experiences with the PA among professionals whose regulatory college has access to the controlled act of psychotherapy in Ontario. There were differences among the perceived effects of the PA for the six colleges. Participants named varying effects and impacts of these effects intraprofessionally, interprofessionally, and institutionally. CPSO and CNO were institutionally embedded in the medical system prior to the PA. Not surprisingly, doctors and nurses noted little to no intraprofessional, interprofessional, or institutional changes due to the PA. Additionally, the controlled act of psychotherapy is peripheral to their primary professional identity, from which their professional legitimacy and power come. Since the CNO and CPSO are already institutionally embedded in strong networks of relationships, a new regulation, such as the PA, did little to shake the institutional relationships established (e.g., with third-party payers) and have little impact on professional boundaries, legitimacy, and professional identity intraprofessionally and interprofessionally. Similarly, the CPO is a long-established college that has recognized ties to psychotherapy prior to the Act. Psychologists developed a strong professional identity as specializing

in mental health through their historical ties to medicine and scientific research, which also solidified their public, legal, and institutional recognition (Benjamin, 1986). While the CPO draws from the medical knowledge core to the medical institution, their focus on the mind weakens their alignment with this institution, which has implications for the power and influence they hold. Prior to the PA, the CPO held the most claim and legitimacy of performing psychotherapy. However, the introduction of the PA legitimized the use of psychotherapy by members of the CRPO, COTO, and OCSWSSW, thus aligning these professions closer with the medical institution. In the present research, CPO members experienced little impact intraprofessionally and institutionally but voiced many interprofessional concerns. Participants were confident in their professional identity and noted no changes in their relationships with other institutions (e.g., insurance companies). However, they did voice concerns about their relationship with the other colleges (i.e., interprofessionally). As the PA further legitimized the inclusion of other professional groups into the medical institution on similar grounds as CPO members (i.e., expertise of the mind), some CPO members were nervous about competition for resources and brought about competency concerns of members of other colleges.

For professional groups that are newly created or do not fit with a dominant institution, regulation can bring the groups into an institution by aligning their knowledge closer to them (Powell & Oberg, 2017). Aligning a profession closer to an institution has implications for professional identity, which must be (re) negotiated based on the expectations of altered relationships (Powell & Oberg, 2017). This is in line with this study, where it was observed that social workers, occupational therapists, and psychotherapists perceived more intraprofessional, interprofessional, and institutional changes overall. Before the Act, members of the COTO and OCSWSSW provided counselling services that were unregulated. After the PA was established, members needed to redefine their practices in accordance with the new legislation. Similarly, the establishment of the CRPO brought together a diverse group of people who had different professional relationships and experiences. The PA (which uses a medicalized understanding of psychotherapy) brings members of these colleges closer to the dominant knowledge held by the medical institution, which may not fit for some of these practitioners, as seen in their various understandings of the PA and perceived impacts of the PA on professional identity. Hence, the PA impacted them intraprofessionally as there were inconsistencies and uncertainties around professional identity. Adapting to a new closeness with the medical institution also had implications for their interprofessional network of relationships as they need to work with others to (re) negotiate expectations and professional boundaries. This immense change and the loose alignment to the medical institution places COTO, OCSWSSW, and CRPO members in positions of less power as they have less recognition from other institutions and parties, such as insurance companies. Hence, unlike CNO and

CPSO members, they named the importance of advocating for their profession to obtain more institutional and collegial recognition.

Overall, this study supports the literature that speaks to a dynamic, multi-level, relational understanding of professions by exploring the perceived impacts of regulation on professional groups with different relationships to the broader medical institution. Those members who are institutionally cemented via existing legislation and align closely with the principal knowledges of the institution experience less relational changes overall from legislation that is not directly related to them. Those practitioners who are most aligned with an institution experience more interprofessional relational changes when they are implicated in legislation. Those who are loosely aligned with an institution experience more changes intraprofessionally, interprofessionally, and institutionally when regulation works to bring them closer to the institution. Hence, the further away a profession exists in relation to a dominant institution, the less legitimization and power they hold and the more institutional, intra- and interprofessional changes they face.

Implications

This research has implications for those creating and appraising policies around psychotherapy. In identifying the perceived challenges and benefits members of the six colleges faced, legislators, regulatory colleges, and professional associations can become aware of the implications of the PA and find ways to better support them. For example, the PA brings restrictions around supervision, particularly around which colleges can offer supervision to each other and the requirements for doing so. Participants noted that this made it more difficult to find a supervisor and can limit job opportunities (e.g., a clinical supervisor of an agency can be restricted from supervising certain college members), which can negatively impact client care. In recognizing this, regulatory colleges can collaboratively work together to ensure their standards for being a supervisor are similar or can offer a database of eligible supervisors for college members.

Furthermore, this research offers insights for provinces and territories that are in the process of regulating psychotherapy. This insight can help legislators, professional colleges, associations, and individual practitioners prepare, anticipate, and mitigate challenges they may face with this transition. Additionally, by considering the implications of regulating psychotherapy from a multi-level relational perspective, policymakers can better anticipate the effects of legislation on professional groups' identities, professional boundaries, and interactions with other institutions. This can be helpful for producing and introducing policies in ways that support professionals in this transition. For example, participants noted a rocky transition into the PA, describing anxiety over job loss and difficulties registering (especially for experienced therapists in agency settings and Canadian immigrants). Provinces and territories can mitigate this by collaborating more with agencies that provide psychotherapy by offering brochures, providing live

information sessions, or assembling a team to support the transition of employees. Regulatory colleges can also offer more alternatives or support for Canadian immigrants who have extensive experience practicing psychotherapy.

Lastly, this research offers professionals within these colleges insights into how their peers are responding to the PA. This can help professional groups feel more connected to and understanding of each other's experiences, which can impact how they relate to their peers.

Limitations and Future Research

As recruitment began at the beginning of the COVID-19 pandemic, recruitment was difficult and there were a limited number of respondents. As a result, our purposeful sample was suboptimal. Specifically, although we stratified the sample by college, some colleges were better represented in the sample than other colleges. For example, there were 31 CRPO members who participated and only 2 CPSO members. Thus, the experiences of some colleges' members were more well represented, developed, or nuanced than others. Furthermore, some settings were better represented in the sample than other settings. Most participants worked in private practice or community organizations. Those working in community organizations (especially in Northern Ontario) discussed how the transition into the PA made it more difficult for agencies to hire therapists. We wonder if the increased public demand for community resources due to COVID and the frustration of an understaffed system encouraged more individuals from agencies to participate. Furthermore, COVID placed more pressure on those working in hospital settings, which could account for the low number of respondents who worked in this space. This especially applied to CNO and CPSO members who noted they are extremely busy with adapting to emergency regulations and working within the precarity of the pandemic.

Additionally, this study included participants who were registered with the college but did not hold competencies to practice psychotherapy. In particular, this research did not include the experiences of CNO or CPSO participants who were practicing psychotherapy. While this is useful for understanding the impacts of the PA on general members of these colleges, it does not capture the experiences of those who have a closer relationship with the PA. Given these limitations, we were unable to reach saturation. Thus, the study is preliminary or exploratory, and future research could explore more in-depth the impacts of the PA, particularly on CNO and CPSO members practicing psychotherapy. Given the limited data, we were unable to fully address research questions two and three, which could be further investigated in future studies. Future research could also explore how third-party payers, the public, or community agencies understand the PA and how the Act changed their relationships with the six professional colleges and their practices.

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