Responses of Mental Health Professionals to the Regulation of Psychotherapy in Ontario

by

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ABSTRACT
RESPONSES OF MENTAL HEALTH PROFESSIONALS TO THE REGULATION OF
PSYCHOTHERAPY IN ONTARIO

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The 2007 Psychotherapy Act (PA) established psychotherapy as a controlled act in
Ontario that six professional colleges have access to, the College of Psychologists of Ontario,
College of Occupational Therapists of Ontario, College of Nurses of Ontario, College of
Physicians and Surgeons of Ontario, College of Social Work and Social Service Workers of
Ontario, and the newly created College of Registered Psychotherapists of Ontario
(Psychotherapy Act, 2007). The transitionary period ended in January 2020 at which time the PA
was fully enforced. Through an open-ended online survey and semi-structured interviews, this
research explores the experiences and perceived impacts of the PA on members of the six
colleges who have access to psychotherapy. Drawing from Powell and Oberg’s (2017)
conceptualization of multi-level relational networks, the study aims to explore perceived effects
of the PA on professional identities, boundaries, and legitimacy through the lens of intra-
professional, inter-professional, and institutional (e.g. third-party payers) relationships. Six
themes were produced through thematic analysis as outlined by Terry and colleagues (2017) and
were later unpacked using critical theory. Implications and limitations of this study are explored.
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1 Introduction

The definition of psychotherapy has been contested for decades worldwide and continues to be a source of tension. This is largely in part due to psychotherapy’s broad and varied methodological and theoretical practices (Buchanan, 2003; Rosner, 2018). As of 2021 five provinces 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 (RHPA, 1991). Only members of a respective college can practice the controlled acts protected by that college.

The College of Registered Psychotherapists (CRPO) was established to protect the controlled act of psychotherapy. Under the RHPA, six colleges, including the CRPO, can legally practice psychotherapy – 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) (RHPA, 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” (Psychotherapy Act, 2007). 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 December 31, 2019. After this time, only members of these six regulatory colleges can legally practice psychotherapy and legally use the title of psychotherapist in their professional name (RHPA, 1991).

Given the long history of contestation and ambiguity surrounding the definition of psychotherapy, the PA is 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).

1.1 Research aims

There is a gap in the literature on the impacts of legislative changes on Canadian health professional groups. Specifically, there is a little literature that explores professional regulation from a dynamic perspective that accounts for intra-professional (i.e. within a professional group), inter-professional (i.e. between professional groups), and institutional influences on
professional identity, boundaries, and legitimacy (Chreim et al., 2007). This is important because it can provide insights into the dynamic ways that professional groups are implicated by regulation. This can be helpful because it gives voice to health professionals’ experiences and struggles that may not be publicly acknowledged. This can help policy makers better understand implications of legislation and make more informed decisions. It can also help those working directly with health professionals’ (e.g. employers, professional associations, regulatory colleges) better understand possible challenges they face, which can allow for more informed initiatives, policies, and systems to support them. This study qualitatively explored perspectives on and experiences with the Psychotherapy Act (PA) among regulated mental health practitioners who have access to the act of psychotherapy in Ontario. These include psychotherapists, nurses, physicians, occupational therapists, psychologists, and social workers. The PA offers a unique opportunity to explore the effects of regulation on various professional relationships due to a multitude of reasons. Firstly, the PA reforms professional practices for six colleges, most of which have a long professional history. Hence, the study will not only look at the implications of establishing a new regulated profession (registered psychotherapists) but also at the effects of legislative changes on already established colleges and professions. It can provide insights on how new and old professions (re)orient themselves to new legislation, and its effects on their relationships to other institutions. Secondly, there are six colleges who have access to psychotherapy. This research can give insights on how colleges negotiate and understand their relationships to the other colleges who share the same act. Thirdly, given this Act became fully enforced in January 2020, there is an opportunity to explore professionals’ initial challenges, concerns, benefits, and perceptions of this change. Thus, the study is timely. Lastly, this research can illuminate professionals’ perception of how the Psychotherapy Act is
impacting the public’s access to psychotherapy, including barriers and safety concerns the PA may create, reproduce, alleviate, or resolve. Hence, this research can offer insight on how legislation, specifically the PA, impacts client welfare.

Specifically, the study unpacks the perceived impacts of the PA on intra-professional relationships, inter-professional relationships, and relationships with institutions. It also explores the perceived effects of the PA on practitioners’ professional identity, boundaries, and legitimacy. This research explored the following questions:

1. How do members of the six colleges who have access to the controlled act of psychotherapy understand the PA and the definition of the practice of psychotherapy?
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 effects does the PA have between colleges and between the college and institutions?

Responses were gathered through open-ended surveys and semi-structured interviews and analyzed using thematic analysis (Terry et al., 2017).

2 Literature Review

There are two main components that need to be considered when situating the impact of the PA on regulated health professionals. Firstly, since the PA established a new college and allowed 6 colleges access to the controlled act of psychotherapy (RHPA, 1991), it is important to unpack the literature that looks at the connections between regulation and professional identities, boundaries and legitimacy. Secondly, since this research focuses on a specific legislation that defines psychotherapy (Psychotherapy Act, 2007), it is important to briefly explore the history of psychotherapy and the PA.
2.1 Professional identities, boundaries and legitimacy

The main purpose of professional regulation is to protect the public from malpractice and unethical professional behaviours. However, it also has many consequences for professional groups. Regulation can shape professional identity, boundaries, and legitimacy because it legally recognizes specific professional groups as having expertise over a particular practice and holds the profession accountable to practice expectations (Chreim et al., 2007). Legally cementing practices influences professional’s understanding of what they do and expectations of themselves, thus shaping their professional identity (Chreim et al., 2007). Regulation also impacts the distinctions between the professional group and other groups, legally enforcing boundaries between them (Fournier, 1999). Furthermore, legal recognition can help legitimize the profession to other professional groups and institutions, which can gain the profession more access to resources such as clientele and funding (Deephouse et al., 2017). Hence, regulation impacts professionals intra-professionally (i.e. professionals’ relationships to themselves as professionals), inter-professionally (i.e. professionals’ relationship to other professional groups), and their relationship with other institutions (e.g. third-party payers). These levels of impact interact in dynamic ways as professions must negotiate between various understandings and expectations of professional identity, boundaries, and legitimacy (Powell & Oberg, 2017).

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 and colleagues (2006), collective
and individual identities are mutually shaping. Changes in 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. Kreiner et al. (2006) go on to argue that professional identities are best understood as fluid and situated, rather than static and universal. Individual and collective professional identities are developed and modified due to changing personal, institutional, and socio-historical circumstances. 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, shaping their professional practices (Chreim et al., 2007). Indirectly, regulation can shape how society (e.g., public, regulatory colleges, insurance companies) relate to the professional group in terms of their expectations of the profession. This shift in relating impacts the responses of the professional group, which can shape their overall professional identity (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 dictates what and who is and is not included in a professional group (Fournier, 1999). The ongoing process of establishing and maintaining boundaries is called boundary work, which is a key aspect to the ongoing (re)production of professional groups (Fournier, 1999). According to Fournier (1999), boundary work is done via professionals’ actively (re)producing a distinct professional identity which they base their authority on, and through the labour of division that aims to separate the profession from other professional groups. 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). Professional groups must constantly negotiate where one profession ends and the other begins. This can be difficult in collaborative care settings where professionals from various professional groups are working together for the benefit of the client. 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 professional group who holds similar knowledges and practices. Hence, in collaborative care settings where various professional groups are working closely together, power imbalances between professional groups can be heightened (Liberati et al., 2016). Therefore, professional boundaries are (re)produced by their relationship to different professional groups and each professional field shapes other professions surrounding them (Chreim et al., 2007; Fournier, 1999). Thus, professional boundaries and identities are changing inter-professionally (Powell & Oberg, 2017). Given the fluidity of professional identity, boundaries are also constantly changing. Regulation can impact professional boundaries because it impacts professional identities (as described above), which helps maintain and establish professional boundaries (Fournier, 1999). However, regulation also impacts boundaries because it shapes ways of relating with other professional groups and institutions by legally cementing differences between professional groups and
establishing expectations that are taken up by institutions (Fournier, 1999). Regulation also offers legitimacy to professional boundaries and identity.

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, professional legitimacy is a fluid process that is 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 knowledges that value empiricism (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). Professional legitimacy can be gained through various levels of interaction, all of which are dynamically related. Governmental regulation can help foster professional legitimacy as it legally cements professional identities and boundaries. Regulating a profession is a form of gatekeeping, as it impacts who can be a member of the professional collective (McGivern et al., 2015; Muzio & Kirkpatrick, 2011). This exclusivity and its entry standards protect the profession from other groups with similar identities or practices by ensuring only those who obtain certain training can become an active member of that profession. Thus, regulation can bolster legitimacy inter-professionally. This not only helps with preserving the profession’s boundaries, but aids in establishing standards and expectations for service quality (Muzio & Kirkpatrick, 2011). Legitimacy exists on a spectrum,
with some professional groups having more or less legitimacy than others. Professional groups can gain and maintain legitimacy through assessment by an evaluator such as a regulatory body who monitors professional bodies to ensure individuals are living up to their professional standards (Deephouse et al., 2017). Regular assessments bolster professional legitimacy because it reassures the public and other stakeholders, such as third-party payers, of the profession’s ongoing usefulness and professional rigour in their social context. Legitimacy through regulatory assessment also protects client welfare as the public can access services from professionals who maintain professional standards and are held accountable for their practices. In turn, quality service can bolster public faith in a profession, further legitimizing the professional group (Deephouse et al., 2017). This professional recognition can put the profession into contact with institutions (i.e. third-party payers) that bolster their resources and presence in the public. This strengthens their professional legitimacy as their professional identity becomes more institutionally embedded. Thus, regulation can help with “collective mobility” as it helps facilitate the profession’s interactions with other professional groups, institutions, and the public, which can help the profession becomes further socially legitimized, entrenched, and defined (Muzio & Kirkpatrick, 2011, p. 393).

An example of this is with clinical psychologists in Ontario who are regulated by the College of Psychologists of Ontario (CPO). Under this regulation they are given access to the controlled act of communicating a diagnosis. This helped psychologists gain access to independent insurance funding from third party payers who regularly use psychodiagnosis for insurance claims. Hence, being regulated enforces psychologists’ professional boundaries and presents them as a credible group of professionals. Regulation further establishes social expectations of the profession (communicating a psychodiagnosis), which allows other
institutions to approach them for their services. As more groups use their services, clinical psychologists become more institutionally embedded, which further legitimizes their profession and gives them access to more resources (Vesely, 2019).

However, regulation can also restrict professional autonomy via institutional and bureaucratic limitations (Buchanan, 2003). Professional groups are relatively autonomous, with the capacity to define and regulate their own professional identities. Governmental regulation works to govern, control, and discipline, professionals to ensure public safety (McGivern et al., 2015; Noordegraaf, 2011). Those imposing regulations from outside the profession are predominantly seen as “carriers of managerialism,” enforcing standardization and measurement techniques on professions to ensure quality assurance (McGivern et al., 2015; Noordegraaf, 2011, p. 1352). However, these “carriers” are not always members of the professional group and may impose restrictions or expectations that professionals do not agree with. Therefore, there can be tensions between professions advocating for complete autonomy, and regulations imposed by those outside the profession that aim for standardization.

Hence, professional groups have a distinct professional identity, which helps establish professional boundaries between themselves and other professional groups (Fournier, 1999). These professional identities and boundaries can be legitimized in various ways, including through regulation. Regulation helps legally recognize professional groups, which can shape a profession’s relationship with other institutions (i.e., third-party payers), professions, and between people within that professional group (McGivern et al., 2015; Muzio & Kirkpatrick, 2011). Thus, regulation can increase professional legitimacy through various levels of interaction, institutionally, inter-professionally and intra-professionally. These levels of interaction can be sites of negotiation, tension, and transformation as the professional group’s
relationships within and between professional groups, and with institutions change based on shifting social and political contexts (Kreiner et al., 2006). Tensions can arise when regulation imposes standards that challenge or limit the profession’s identity. When this happens, professionals can find themselves struggling to reclaim their professional autonomy within the constraints of regulatory expectations (Muzio & Kirkpatrick, 2011).

2.2 History of psychotherapy in North America

Although proposed in 2007, the Psychotherapy Act (PA) is a product of decades of professional turmoil surrounding the definition and claim to psychotherapy. Entangled with this act is the history of a “turf war” of professional psychology boundaries and identities that continue today (Buchanan, 2003). Thus, to fully comprehend the consequences of the PA, this history of conflict and ambiguity must be unpacked. It must be noted that the history of psychotherapy is not neatly contained. There are many possible points of entry and branches to explore (Rosner, 2018). This is mostly due to the diversity of the practice, which fueled past and present contestation of what psychotherapy is. Furthermore, many psychotherapeutic practices and theories that arose throughout history were taken up by a multitude of professions in different ways (Rosner, 2018). The history becomes even more diverse if we consider the international context of psychotherapy by moving away from North America and Europe, and examining other geographic areas (Rosner, 2018).

Given this complexity, this section briefly discusses the history of psychotherapy in Canada and the United States, which will help contextualize the establishment of the Psychotherapy Act in Canada. This history will briefly trace how psychotherapy began to gain legitimacy, starting with psychiatry and moving to psychology, and what sparked the need for regulation. It is also important to note that American and Canadian psychotherapy history and
professionalization (the process of creating a defined group of individuals with common knowledges, skills and identities that are socially recognized as distinct) are intimately linked. For decades, American associations have covered both Canadian and American professionals and academics, and remain tightly linked today (Wand, 1993).

Prior to the early 20th century, psychotherapy was not commonly recognized or known by the general American public. While some psychiatrists were aware of the benefits of “talk therapy” and the limitations of their medical model to understanding mental health, many feared practicing psychotherapy would associate their profession with spirituality and pseudoscience. For psychiatrists, this association would conflict with their adherence to dominant positivistic scientific knowledges that gained them legitimacy (Caplan, 1998). Due to this, psychiatrists were wary of using psychotherapy and were subjected to scrutiny and criticism if they advocated for it (Caplan, 1998).

Historical movements, such as the Emmanuel Movement, set the stage for abstract conceptualizations of the mind that favoured psychotherapy to be brought to the public’s attention. The 1906 Emmanuel Movement aimed to combine spirituality and science to aid those with nervous disorders. For example, members of the clergy worked with people with neurasthenia, which in the 19th century was a physical condition caused by being overworked. The term is no longer used but the condition is now understood as a psychological issue caused by emotional distress (Caplan, 1998). This movement was successful and spread quickly as it addressed a public demand for psychological services that were not being met. Upon realizing the rapid success of psychotherapy, medical professions—including psychiatrists—began arguing that they exclusively should be practicing psychotherapy, given their distinct professional training. Medical doctors fought to have control and claim expertise to
psychotherapy, noting it is in the public’s best interest that only medical professionals engage in these practices (Caplan, 1998).

The flurry of public and professional interest around the Emmanuel Movement and psychotherapy set the stage for Freud’s visit to America in 1909 to discuss psychoanalysis (Caplan, 1998). In addition to being timely, Freud’s theories helped decrease the ambivalence psychiatrists felt towards practices that focused on the “mind.” 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 does not focus on physical areas of the brain but on abstract psychological aspects of the mind. Keeping with public interest and demand, psychiatry took up Freud’s knowledges. This helped maintain psychiatry’s continued connection to medicine but also allowed them to focus their expertise on the “mind” instead of the physical brain (Bynum, 1964).

Public demand for psychotherapy continued to rise during WWI and II, a demand that could not be met by psychiatrists. Thus, other professionals, namely psychologists, were thrown in clinical positions (Albee, 2000). Without formal regulation or established training standards, individuals began claiming to be psychotherapists and practice without adequate education. This sparked public outcry as individuals were harmed by untrained practitioners and had no one to turn to hold the individual accountable (Benjamin, 1986). In light of these demands and issues, professional groups, such as psychologists, gathered to address training and practice standards, and define themselves as a distinct professional group amongst others who were trying to lay claims to similar practices. Specifically, there was a challenge in defining psychotherapy due to its diversity.
Today, psychological practice—the key component of which is psychological “treatment” or psychotherapy—continues to grow and diversify. However, legislation, such as the PA, attempts to encapsulate this act and give it to certain professional groups to maintain public safety and ensure the past does not repeat itself. This concern for public safety is one of main factors that gave rise to the Regulated Health Professionals Act (RHPA) and subsequently, the Psychotherapy Act (PA).

2.3 The RHPA and PA

While fairly new, the 1991 RHPA and 2007 PA is the result of a long history of changing knowledges, public demands, and professional group identities and practices. Exploring the contestation around psychotherapy and unpacking the nuances and complexities of regulation and professional groups offers a critical lens into how the RHPA and PA became established. In this section, the history of the RHPA and PA is outlined.

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 (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 of their grip on controlling “non-physician” professions.
The beginning of 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 who 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 growing concern for public interest as there were no regulation laws, which meant anyone could use professional titles or perform certain practices without legal consequence (Lemmes & Ghimire, 2019). While professionals may have been members of professional associations, did not hold any legal bearing and membership was not mandatory for practice (Markova et al., 2013). Associations helped advocate for the profession, provided professional resources, networking opportunities, and helped establish a professional identity (Markova et al., 2013). 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 (Lemmes & Ghimire, 2019).

Throughout the revision and finalization of the RHPA from 1989 to 1991, many health professional groups fought to have their professions regulated (Lemmens & Ghimire, 2019). Being included in the RHPA was a massive step towards professional legitimization as their professional boundaries, identities and roles would become legally protected, preventing other professions from encroaching on their professional “territory.” Becoming self-regulated cements their position in society (O’Reilly, 2000). This was an opportunity for professions to “maintain old embedded interpretations, strengthen marginalized interpretations, or introduce new propositions into the organizational blueprints under consideration by the policy designers and
decision makers” (O’Reilly, 2000, p. 5). Additionally, these self-regulating professions can also act as “institutional entrepreneurs,” changing their legitimacy status through their direct influence on institution and policy (Deephouse et al., 2017).

The RHPA was enacted in 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 (i.e., psychologist, nurse, psychiatrist) (RHPA, 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 (RHPA, 1991). The RHPA provides an overview of require professional collegial sections, such as the registration and quality assurance committees (RHPA, 1991). However, the RHPA also positions these professions as “self-regulating.” This means that while the provincial government provides organizational parameters, each college is responsible for creating and implementing their professional standards, and generally overseeing college operations and committees (Lemmens & Ghimire, 2019).

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 (RHPA, 1991). Thus, only members of certain colleges have access to specific controlled acts. For example, the College of Registered Psychotherapists (CRPO) is responsible for regulating the controlled act of psychotherapy and is governed by the Psychotherapy Act and
the RHPA. Furthermore, these controlled acts include an outline of the collegial standards and expectations (Lemmens & Ghimire, 2019). However, 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 Psychotherapy Act (PA) is the most recent Act to be included in the RHPA. This has repercussions for professionals who once identified with practicing psychotherapy, such as counsellors. Amid these legislative changes, counsellors are struggling to reconstruct their professional identity (Gignac & Gazzola, 2018). There are tensions and confusions around the language and practices they are legally allowed to use, which has implications for their professional and institutional relationships. This ambiguity has varied effects on counsellors. Some seriously consider leaving the field. Others perform little acts of resistance and defend their identity. While some may be apprehensive but are optimistic, holding hope that it will lead to positive changes (Gignac & Gazzola, 2018). The present study was initiated to explore these tensions and impacts.

3 Theoretical Framework

Powell and Oberg (2017) proposed a relational network understanding of institutions that considers the positionality of various actors involved in a relationship and the implications of this on ways of being and relating. Each actor enters a relationship with their own knowledges, practices, and goals, which shape how and why they interact with the other. Hence, relationships dialectically shape the ways of being of both parties involved so that their knowledges, practices, and identities are constantly in-the-making with one another. Relationships can also form between broader actors, such as professional groups, where the type of relationship developed
between individuals is shaped by their inclusion in a broader identity. For example, two people part of the same profession may not know each other, but when they meet, they are united by their professional identity and use this generally established relationship as a guideline for their interaction. Hence, actors create meanings for their relationships and identities, but are also shaped by the meanings created through interaction (Powell & Oberg, 2017).

Powell and Oberg (2017) recognize that networks are not comprised of two actors but are comprised of relationships between multiple actors that are constantly being co-created with one another and negotiating meaning. These networks of relations are do not only work on one level (i.e. horizontally), such as inter-professionally or intra-professionally, but work across various levels (i.e. vertically) through interactions between professional individuals, professional groups, and institutions. This multi-level approach recognizes power imbalances and 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 ways of being (Powell & Oberg, 2017).
Taking a multi-level relational approach to understanding professional groups, boundaries and legitimacy is helpful because it highlights professional connections to a variety of actors, which illuminates tensions and alliances that are (re)produced (Powell & Oberg, 2017). Specifically, Powell and Oberg’s (2017) multi-level relational understanding is helpful for unpacking the effects of the PA on members of professional colleges for two reasons. The relational aspect recognizes that professionals’ experience and understanding of their profession shapes and is shaped by various actors. Therefore, it helps attend to ways the professionals’ experience is co-created through relationships. Furthermore, taking a multi-level approach is helpful because it takes a more wholistic understanding by attending to various actors that are influencing professionals’ experience and acknowledging more possible areas of impact. Powell and Oberg’s (2017) theory informed this research as the research questions, which informed
survey and interview questions, explore the impacts of the PA on participants’ intra-
professional, inter-professional, and institutional relationships. Dynamics between relationships,
identities, boundaries, and legitimacy were also used as a general framework throughout data
analysis, trying to develop themes that took a more integrated approach to understanding
practitioners’ experience and acknowledged power dynamics within these networks that
influence experience.

4 Methods

4.1 Recruitment

Prior to recruitment, ethics approval was granted from the University of Guelph
(Appendix A). Only actively practicing members of CRPO, CNO, COTO, CPO, CPSO, and
OCSWSSW could participate. 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. They were contacted individually via email.
Private and public clinics, hospitals, and organizations in Ontario were contacted and asked if
they can distribute the survey and invitation to interview to 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.

4.2 Participants

There was a total of 74 survey participants. Of these, there were 31 CRPO members, 11
CPO members, 18 OCSWSSW members, 9 COTO members, 3 CNO members, and 2 CPSO
members. While all participants were active members of their college, some did not specialize or
offer psychotherapy (i.e., all CPSO, CNO, and a few OCSWSSW participants). Generally, most participants worked in either private practice or community organizations, and a few worked in schools, hospitals, or multiple settings. Most practitioners were independent practitioners, with only a few qualifying members (i.e., members of colleges that have not yet met the requirements to be a full member of the college). Please refer to Appendix B for a detailed summary of the survey participants. Two people were interviewed, one was an independent member of the CRPO, has been in the field for 15 years, and at the time of the interview was in private practice. The other interviewee was an independent member of the CPO and has been practicing for 26 years.

4.3 Data collection

The research questions outlined above were explored using a survey conducted via Qualtrics. Of the 22 survey questions, 6 were multiple choice demographic questions and 16 were open-ended questions used to elicit detailed accounts from participants (Appendix C). The survey questions were developed in light of the research questions: survey questions 1-2 addressed research question 1, questions 3-11 addressed research question 2, and questions 12-15 addressed the research question 3. Question 16 offered an opportunity offer information on the topic not captured with existing questions. Participants were not required to answer all short open-ended questions and could share as much or as little information as they wanted. No identifying information was requested, and responses were anonymized. Due to low participation rates halfway through the collection period, prospective participants were offered the opportunity to participate via the online survey or a semi-structured interview. Since there were few survey responses initially and many responses were short and vague, interviews were meant to provide another source of data that could offer more depth and richness to the research.
to get a more wholesome perspective of professionals’ experience of the PA. Two participants were interviewed. Interviews were conducted over MS Teams and were audio and video recorded. Once the interviews were manually transcribed by the researcher, the recordings were deleted. Interview questions mirrored the survey and lasted roughly an hour.

4.4 Data analysis

Survey data from Qualtrics were exported to Excel and interviews were transcribed in Word. The data were manually analyzed using thematic analysis (TA) as outlined by Terry and colleagues (2017) and informed by critical theory. TA identifies patterns of meaning (themes) in the data, which were later analyzed through a critical lens – situating them in relation to broader societal dynamics of power and privilege. The application of critical theory offers the opportunity to focus to the dynamics of various systems instead of reinforcing divides between organization, institution, and profession.

Generally, the data was analyzed within and between colleges. After exporting the survey data and transcribing the interviews, all responses were read, and curiosities and items of interest were noted in a researcher log. Next, the survey data were separated based on research questions and further divided into colleges. The data for each question were coded line by line. I identified relatively short, self-contained parts of text or units of meaning, attending to meaning recurrence and forcefulness (Terry et al., 2017; Lawless & Chen, 2018). Recurrence speaks to how many times certain meanings comes up in the text. Forcefulness focuses on how much importance or stress the individual places on certain meanings evident in inflection, volume, or phrasing (Lawless & Chen, 2018). In this step, coding stayed close to the text and words of the participants (Terry et al., 2017). Afterward, the codes for each question were further analyzed to develop themes for each college’s response to a research question. Relationships between the
colleges’ themes were explored, giving rise to broader themes that more fully addressed the research question. Next, the major themes developed from the research questions were compared to produce more encompassing themes. Interviews were also analyzed via thematic analysis, following a similar procedure of coding close to the text, and then developing themes. Since these interviews were semi-structured, they were not coded based on research questions. However, the questions were tentatively held during the analysis. Interview and survey themes were analyzed together and consolidated into the final themes noted in this research. The development of these broader themes was a recursive process that involved moving between types of data (i.e. survey and interview) and scales of inquiry (i.e., college’s response to a question, a college’s response to collection of questions meant to address a research question, and between research questions). Memos were kept throughout the analysis, tracking the researcher’s curiosities, and connecting codes and themes to the literature.

4.5 Rigour

While quantitative research often relies on validation via various reliability measurements (such as interrater reliability), reliability is not the goal of qualitative research (Morse, 2018). Instead of “hard” quantifiable data that implies a static phenomenon, qualitative research focuses on processes and subjectivities (Morse, 2018; Tracy, 2010). Echoing qualitative research’s focus on exploring dynamics of experience, the main goal of this research was to explore participants’ varied experiences and perspectives of the PA. Hence, it does not assume experiences of the PA to be a unidimensional phenomenon and takes time to unpack the complexities and variability of practitioners’ experiences. Transparency is important for enhancing the rigour of the study because it situates the context the research was produced in, including the author’s positionality in relation to the research and the author’s approach to the
research process. As a researcher, it is important to be reflexive because it brings awareness of how their subjectivity influences their research project, and the possible limitations and insights that arise from this (Berger, 2015). As a current student in the Couple and Family Therapy program at the University of Guelph, the author acknowledges she is working towards becoming a member of the CRPO. This career path fuels her interest in the legislation surrounding psychotherapy, which she will one day be governed by. The author used audit trails to track her thinking, decisions, and conceptualizations (Morse, 2018). This was documented in a notebook and in memos during data analysis. Transparency was also demonstrated in the use of thick description in this paper, which shows readers concrete data so they can come to their own interpretations rather than telling readers what to think (Tracy, 2010). While the full data set is not included in this paper, direct quotes are used to offer transparency.

5 Results

Six major themes were developed through analysis. The first theme reflects the various understandings of the legislation held by professionals covered under the PA. This variation spans from little to no knowledge of the PA, to knowledge of the PA but confusion around meaning, and full comprehension. The second theme focuses on participants’ perceptions of professional boundaries, which draw on understandings of professional identity. This spectrum includes the PA blurring boundaries, having no impact, and clarifying boundaries. The third theme is college gatekeeping, which leads to struggles transitioning into the College of Registered Psychotherapists of Ontario (CRPO), challenges registering with the CRPO, and supervision restrictions. The fourth theme unpacks practitioners’ accountability to who can practice and how. This theme outlines practitioners’ holding themselves accountable to clients, fearing prosecution by the college, and policing themselves and others. The fifth theme is
professional recognition from the public and third-party payers, which explores lack of public
education of professional boundaries established by the PA, varying degrees of recognition from
third-party payers, and advocating for recognition. The last theme explores professional
recognition from colleges included and excluded from the PA. This includes lack of knowledge
of their profession from other colleges, more collaboration, competency concerns, and
competition for resources.

5.1 Understandings of the PA

Professionals covered under the PA have various levels of understanding the guidelines
outlined in the PA. Understanding ranges from little to no knowledge of the Act, to confusion
(specifically around the given definition of psychotherapy), to full understanding.

5.1.1 Little to no knowledge of PA

Some professionals from colleges within the Act were unaware or had little knowledge of
the PA. They were specifically members from colleges whose main purpose is not centered on
practicing psychotherapy (i.e., social workers, doctors, nurses, occupational therapists). The
main function of these colleges lie outside psychotherapy and this practice is a specialization that
requires further training. For example, the College of Surgeons and Physicians of Ontario
(CPSO) main controlled acts center around procedures directly working with the physical body
(e.g. “Performing a procedure on tissue below the dermis”) and communicating a diagnosis
(RHPA, 1991). Members do not automatically have access to the controlled act of
psychotherapy. They 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.
5.1.2 Knowledgeable of the PA but confused

Participants described knowing the PA and understanding its legal implications but had some confusion about how this translates practically, specifically with regards to what it means to practice psychotherapy (versus a similar practice, like counselling). Members of the CRPO, Ontario College of Social Workers and Social Service Workers (OCSWSSW), and College of Nurses of Ontario (CNO) 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.” Participants explained the confusion in multiple ways. An OCSWSSW member understood the confusion through a historic legislative lens, tying it to legislative changes in professional titles. For this participant, the project of regulating psychotherapy in Ontario was confusing from the start, as evident from the government’s initial intent to regulate not only “psychotherapists” but also “mental health therapists” will less education and training in psychotherapy:

The definition that is being used to define psychotherapy, in my opinion, has always been controversial, and it has been difficult to find the ‘boundary’ between what is considered psychotherapy and non psychotherapy (counselling??). This challenge goes back to the HPRAC document that preceded the creation of the College of Psychotherapy. Initially, there were to be two classifications: Psychotherapist and Mental Health Therapist. However, the government removed the Mental Health Therapist classification.

Another member of the CRPO explained their confusion as grounded in the highly subjective or interpretive nature of the definition, which is different from more clear-cut, unambiguous definitions of other controlled acts (e.g., communicating a diagnosis, making an incision). For example, he questioned the phrases “serious disorder” and “seriously impair,” explaining that
different professionals would have different understandings of what constitutes “serious.” He asked, “How much does it have to impair your life so that you know that it’s serious? … What is the defining line of seriously impaired? What makes it serious versus not seriously impaired?”

For this participant, confusion of the definition of psychotherapy comes from the vagueness of the definition, which allows for multiple interpretations, blurring the lines between practicing psychotherapy and other related professional activities.

### 5.1.3 Clear understanding of the PA

There were members of all colleges (except CPSO) that had a clear understanding of the PA. Many professionals cited the PA as restricting and defining psychotherapy, establishing the CRPO, and ensuring quality professional practices and competencies to protect the public. Many professionals offered definitions of the PA in their own words, such as an OCSWSSW member who explained psychotherapy as “the practice of psychotherapy is the assessment and treatment of cognitive, emotional, or behavioural disturbances by psychotherapeutic means, delivered through a therapeutic relationship based primarily on verbal or non-verbal communication.” These definitions closely align with the PA’s definition of psychotherapy, which indicates many professionals who practice psychotherapy know the PA and understand the scope of their practice through this legislation.

### 5.2 Impacts on inter-professional boundaries

The PA impacted individual’s understandings of their professional boundaries between colleges. As explained before, professional boundaries are socially constructed separations of labour where individuals within a professional group are socially recognized as distinct. Boundaries between professional groups are distinguished based on differences between professions’ collective professional identity, which are the values, beliefs and practices that are
unique to them (Kreiner et al., 2006). For some, the PA blurred professional boundaries and created confusion around their professional identity. Others saw legislation as separate from their profession and reported no impact of the PA on their professional identity. Furthermore, some identified the PA as helpful for clarifying professional identities.

5.2.1 Blurring boundaries

Members of CRPO, OCSWSSW, and College of Occupational Therapists of Ontario (COTO) said the PA left them and others 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 psychotherapist in Ontario and what are the benefits of each of them.” Another member wondered if the PA made OCSWSSW members more confused about the meaning of being a social (service) worker. Since professional boundaries are based on having distinct professional identities, which include clear demarcations of practice, confusion surrounding the PA’s definition of the psychotherapy resulted in uncertainty of professional identity and thus, differences between their profession and others. An OCSWSSW participant explained that their workplace “continues to struggle to ‘find the line’ between what is considered/not considered psychotherapy.” They mentioned this leaves people “feeling undervalued,” and “anxious about ‘crossing the line.’” Confusions surrounding scope of practice leaves some anxious about their competency and unappreciated, which can rock their professional identity. This demonstrates blurred professional boundaries because uncertainty of practice leaves one wondering if they or someone else would be better suited to performing psychotherapy. Participants’ experiences of the PA blurring boundaries could be due to their newfound legal recognition of practicing psychotherapy, which may not have been
central to their professional identity prior. This practice inclusion means professionals’ need to reconceptualize and negotiate their professional boundaries between colleges.

5.2.2 No impact on boundaries

Members of COTO, OCSWSSW, CNO, CPSO and College of Psychologists of Ontario (CPO), noted that the PA had no impact on their professional boundaries. Members of the CNO and CPSO noted no change because psychotherapy is not something they perform. COTO and OCSWSSW members described it not changing their practices other than being more mindful of adhering to the PA. As one COTO member put it, “It [the PA] is more bureaucratic, with more regulatory red tape. It has not changed my clinical practice.”

CPO members cited no difference and noted that their identity as a psychologist is separate from the PA. One CPO member voiced:

I’ve been a psychologist for many, many years and in practice for years with a group of psychologists that I grew from 1 (myself) to over 20 psychologists. Very strong self-identity, and very strong ‘brand’ in our community and across Canada. Not sure how the development of the College of Psychotherapists could impact those things?!

A CRPO member echoed these feelings in an interview, noting 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 to complexity and diversity of psychotherapy. Hence, he notes 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 some CRPO members, 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 already developed a professional identity that encompasses this practice.

5.2.3 Clearer professional boundaries

CRPO, COTO, and OCSWSSW members described that the PA helped make professional boundaries clearer for them. Many 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.” A COTO member echoed these feelings by noting they have a “stronger sense of what we as a profession are able to do and bring to the table,” while an OCSWSSW participant mentioned the PA “has given definition to part of the role of a social worker.” These participants’ experiences of having the PA clear professional boundaries could be due to their legally recognized inclusion in a practice that was once in the periphery of their profession. The Act helped name and give legitimacy to a practice that was once minimally recognized.

As professional boundaries are strengthened with more distinct professional identities, for some participants, the PA provided an opportunity for participants to feel more connected and aware of their professional community. COTO members explained it allows them to “have deeper conversations” with their peers and gives them “increased shared common language.” A CNO participant described that the PA helped them recognize psychotherapy as a possible specialty within their field, which further highlights the “different ways nurses are able to work.” A CRPO member explained, “Being a member of the CPRPO has made it easier to relate to other members of the CRPO and professionals from other colleges.” Hence, more connection to peers
within their professional college helped solidify professional boundaries as their collective professional identity strengthened.

Members of CRPO and OCSWSSW also described feeling prideful of their profession given the clear boundaries the PA creates and validates. An OCSWSSW participant voiced that “belonging to a College has raised the self-esteem and sense of professionalism for some staff.” A CRPO member expressed, “I was seen as ‘just’ a mental health worker before, a ‘counsellor’, now I can proudly proclaim myself as a therapist, and others are doing this too.”

5.3 College gatekeeping

Regulatory colleges are responsible for ensuring qualified individuals enter the college through a rigorous registration process. However, for some (specifically those applying to the CRPO) this process has been cumbersome and left professionals, including those that may be qualified to effectively practice psychotherapy, without registration. Additionally, the PA poses difficulties with supervision in terms of the kind of students’ professionals can supervise, which has implications for students’ accessibility to supervision and diversity of training.

5.3.1 Difficulty grandparenting into the CRPO

During the transitional 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 “grandfathered” or “grandparented.” Participants’ from OCSWSSW and CRPO 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 OCSWSSW participant explained that the PA “caused significant anxiety for those staff affected, and there were inconsistencies as to who was accepted/not accepted into CRPO during the grandparenting
phase.” As will be explained later, those who were not grandparented into the CRPO continued to face difficulty in gaining entrance after the transitionary period.

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:

It [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. For example, one of the requirements of membership in CRPO is that you have a 2-year entail in your liability insurance (in case you wrap up your practice and then someone makes a complaint to the college). At agencies, liability insurance is a ‘given’ and done on a yearly renewal basis. For those employers who mandated membership for defined staff, this required them contacting insurance companies to change the language. This as well did not cover situations where a person may be granted membership into CPRO, but later might leave an agency and move to one that did not have this ‘caveat’ in place. In CRPO guidelines, one has to advise of these kind of situations—what happens if a ‘new’ employer is not willing to make this change in practice?

As this participant noted, the transitionary period was not sufficient in supporting experienced practitioners who worked in settings outside of private practice. Inconsistent transitional support has implications on professionals’ job prospects and feelings towards their workplace and college.

5.3.2 Difficulty registering with CRPO

Many CRPO and OCSWSSW 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 “struggle to demonstrate their
experience since the college requested considerable amount of documents.” The frustration over the required documentation was echoed by an OCSWSSW member who stated,

Given the delays, applying for the RP designation required ridiculous and unnecessary hoop jumping especially when it came to using the title—psychotherapist—it was frustrating to have to hold off due to fear of getting penalized for having the title on offices, cards etc... until approval came through.

Professionals who were unable to join the CRPO during the transitionary phase also shared having to go through this “hoop jumping”. Those who were not grandfathered in during the transitionary phase of the PA were later denied entry or had to provide further documentation. This left many experienced professionals who missed the window to be grandfathered into the CRPO unable to practice psychotherapy legally. One CRPO member shared their and their peers’ experience of getting into the college:

I was grandfathered. Many of my colleagues were hired after the grandfathering date and are now in limbo. Their scope of practice is limited to almost nothing until they have answers. They’ve been given a date that if they are not registered by, they lose their job. Few people in our small community are qualified to be registered under the new constraints and are actually registered. We are facing the next few years of providing our services with 2 to 6 staff until we find new staff coming out of school, as opposed to experienced clinicians unable to qualify under the new criteria. That puts an enormous amount of pressure back on unqualified RPs who are taking on all the complicated cases and are having a higher than usual caseloads. We are burned out and it’s just starting.

As described in this account, the delays and tough restrictions not only impact the livelihood of the unregulated professional, but also has negative impacts on regulated professionals who must take on more to accommodate for demand. This has repercussions for the mental health of professionals as they have less support. Higher rates of burnout and fewer experienced professionals greatly impact the quality of their services and client accessibility. This sentiment
was echoed by another CRPO member who explained client accessibility is lowering because there are less registered professionals available for hire and those who are part of the agency are still awaiting approval. They explained:

CRPO is a very difficult College to be part of and follow. CRPO doesn’t have another category of members (i.e. registered mental health therapists). It’s made it more difficult due to retention and recruitment difficulties to have enough clinicians to help clients.

Another CRPO member explained that difficulty with registration makes it even harder for clients in Northern Ontario, where there are already few mental health workers.

5.3.3 Supervision restrictions

Participants also commented on the difficulties surrounding supervision of those from other colleges outside or inside the PA. One OCSWSSW member explained the impact supervision restrictions places on their ability to supervise those who do not have access to psychotherapy:

In private practice, I would like to provide students a place of learning who are training to become clinicians. However, due to the new regulations, it has been difficult to support students because my practice is using psychotherapy modalities, such as CBT. It is difficult for students to participate if they are not allowed to use them. Previous to this Act, students could train in CBT and DBT and learn to use with clients. From my understanding CBT and DBT are now considered psychotherapy and restricted to registered psychotherapists. However, students can use mindfulness, relaxation techniques, metapsychology approaches and solution focused strategies. The impact is that there is less support, training, and assistance for social work students which can benefit clients’ accessibility to services.

As described, this participant named difficulty supervising those who do not have access to psychotherapy because their work involves psychotherapeutic techniques. Due to restrictions enforced by the PA, this participant must rework their approach to supervision to ensure that
supervisees are working within their scope of practice. The implications of this is less training and support for supervisees who cannot fully practice or utilize the knowledges of the supervisor. Less training and support for supervisees impacts clients as they cannot access additional services through the intern, which is within the scope of practice for the supervisor, that may be helpful.

Many participants also noted that they needed to find new supervisors due to the PA, which can be difficult. One CRPO member noting 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. This impact was also expressed during an interview with a CPO member, who explained that prior to the enforcement of the PA, psychologists could supervise any mental health worker and their client work would be included under their psychology licensure. During this time, psychologists would oversee many practitioners, who would have large case loads. When the transitionary period began, psychologists were concerned because there were so many people under their supervision. If these professionals did not become registered, then their cases would land on the psychologist. It is unrealistic for them to take on the caseloads of their supervisees along with their own, hence clients would have to be dropped or large numbers of clients would have to be transferred to other regulated mental health professionals who may or may not be available to accept these clients. The cause of this anxiety was the interpretation of the RHPA’s supervision guidelines after the PA was developed, as conveyed by one of the participants who was trained to join the CRPO:

RHPA only references to supervision in the context of training. So, what it says is nobody can perform the controlled act. Here are the exceptions. One, if you’re a member of a college with access to that act. Two, if you are a person in the process of becoming a member of a health profession and you are under the
supervision of a member of the profession. That “the” is important. To this day that “the” means that psychologists can’t take an RP as a student. But to be fair, that is not CPO’s fault. That is nothing more than a wrinkle that erupted because there was no such controlled act at the time when that was written.

He went on to explain a sense of loss over the collaborative and diverse supervision that existed prior to the Act,

It wasn’t unusual for mental health students to receive supervision by any number of other professions. You get that cross semination. I’ve received supervision from social workers in my training. I’ve worked with nurses. I think its great. I think it is a part of the richness of my experience and I think it’s a real loss. That’s due to the RHPA and its not an intentional thing, its simply the way the legislation was written before the controlled act of psychotherapy came.

The PA had unforeseen consequences on the execution of the RHPA, which was in existence years prior. As this participant noted, the word “the” in the RHPA’s outline of supervision was later interpreted with the enactment of the PA to mean supervisors can only supervise students working towards being members of their college. For him, this unforeseen implication results in less collaborative training that can be useful in increasing the richness of experience as supervisees can explore and integrate diverse ways of understanding and relating with clients. Hence, supervision restrictions do not only pose challenges for students’ accessibility to supervision, but also has implications for the richness of training.

5.4 Accountability

The PA impacts professional’s accountability to upholding the guidelines of the PA in terms of who can practice and how to practice. Professionals named being accountable to clients’ wellbeing, policing themselves and others, and voiced being fearful of violating PA guidelines.
5.4.1 Accountability to clients

Members of COTO, CRPO, and OCSWSSW drew from the PA’s intentions of ensuring client safety to highlight their responsibility to their client’s wellbeing. While many practitioners noted that this accountability existed for them and their field prior to the Act, the PA made it more pronounced through legal validation. One COTO member explained that the Act allowed for an “increased protection for clients as therapists now have more consistent expectations regarding psychotherapy practice.” A participant from the OCSWSSW 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 do 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 because they want to uphold the Act’s purpose is for public protection.

5.4.2 Policing others

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.” An OCSWSSW member stated:
I think having regulations ensures that people need to meet certain standards to provide this very important services. I would hope that this means that all parties are accountable for their practises and that disciplinary action can result in poor quality service.

Another member mentioned that they “have become aware that those not registered with a college have been challenged on their practices to ensure clients are protected.” To help ensure professionals are working within their scope of practice, one OCSWSSW member explained that in their role as a clinical program supervisor, the PA offers a tool of educating supervisees about their professional obligations.

5.4.3 Policing self

Participants who were registered with the CRPO, COTO, and OCSWSSW mentioned that they hold themselves accountable for adhering to the restrictions and guidelines of the PA. An OCSWSSW participant explained that the PA “add[ed] another layer of accountability…as a professional.” This is echoed by a CRPO member who mentioned that along with rising their “sense of accountability,” it is also “a visible means to demonstrate my integrity in the profession.” In other words, the PA works to encourage this participant to hold themselves accountable and is also a tool to show peers their integrity to the profession. For some, these guidelines are internalized, acting to continuously assess the work they are doing. This is evident in the voice of a COTO member who explained that their collegial guidelines are always in their mind while doing work with clients.

5.4.4 Fear of violating PA guidelines

Given the increased scrutiny and restrictions that followed the PA, some practitioners voiced fear of accidently violating the Act’s guidelines. One CRPO member noticed their colleagues are “weary of their interventions/suggestions, 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 has changed the atmosphere at work. This is echoed by a member of the CNO 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.” They also described not understanding the purpose of the Act since many colleges who have access to psychotherapy were regulated before.

This fear is not only for being reported for breaching practice guidelines, but name and title use as well. A COTO member shared stress over saying they practice psychotherapy due to the Act’s confusing and ambiguous wording. Additionally, a CPO member explained that their fear of violating PA supervision guidelines discourages them from supervising psychotherapists. While they acknowledge they might supervise RPs in the future, they remain uncertain.

5.5 Recognition from Peers of Colleges

Professionals from colleges who have access to the PA are professionally recognized to various extents by their peers from other colleges who practice and do not practice psychotherapy. Major subthemes include a general lack of knowledge of their profession, feeling a higher sense of credibility, more competency concerns, and a heightened sense of competition.

5.5.1 Lack of knowledge

While professionals may have a clear understanding of their professional boundaries, other colleges included and excluded from the PA may not know these professions exist or have
little knowledge of their practices. Hence, professionals may not fully recognize their profession due to lack of knowledge. 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.” An OCSWSSW member mentioned that speaking with those outside their college “sometimes forces [them] to speak to the profession,” which suggests those they speak to do have minimal knowledge of what they do. The minimal understanding from professionals from other colleges can result in confusion over the professionals’ competencies and practices. If professionals from other colleges do not know what practices certain professions can do, it can difficult to collaborate.

5.5.2 More credibility with other professionals

Participants belonging to five colleges (excluding CPSO) mentioned that having the PA established helped with credibility and fostered more collaboration between colleges. A CRPO member voiced, “I find it’s given me more credibility with the psychologists and psychiatrists I work with, as well as when other ask me what I do.” This was echoed by a COTO participant 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.” A CNO registrant expressed, “in general there is a more even power dynamic between physicians and nurses as time progresses.” Inclusion in the PA is a way to bolster credibility to other professionals and even power dynamics in the field of mental health. Increased credibility allows for more collaboration as professionals are recognized as competent. This was described by a CRPO participant who stated they felt like their recommendations were being taken more seriously after becoming a member of a regulated college.
5.5.3 Competency concerns

Participants from CRPO, CPO, and OCSWSSW expressed multiple competency concerns of other colleges included in the PA, mostly voicing worry about inconsistent training practices and expectations across colleges. These concerns did not appear to be directed at one college, but at colleges outside theirs. One CPO member noted:

I think I would just convey that [RPs] don’t necessary have the nuances that would have been learned by going to an intense clinical program (e.g., being ok with silence when a client isn’t talking in the session—how to wait it out, formulation skills, etc.). These types of skills really require training and aren’t formulaic like CBT. In the end, none of it really matters [RPs] are here to stay and will continue to find loopholes in the system.

A CRPO member 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 concern of social workers whose training does not “offer a wide range of psychotherapy specific courses.”

Concerns about their collegial peers’ competency to practice psychotherapy brings forth concerns about the services clients receive. One OCSWSSW participant explained generally:

I also wondered about the training that was made available for accreditation within each of the colleges and whether this was sufficient to safely engage with clients. There is a significant need for mental health care in out society and the solution is not just more providers, but more highly trained providers. The impact of poorly trained providers could serve to exasperate, not ameliorate, mental wellbeing.

Counter to competency concerns due to inconsistent education, a CPO interviewee explained that to some extent, the differences in education can help with diversifying the field of mental health, facilitate more collaboration, and better meet the needs of the client. They expressed it like this:
I don’t think we should be going into a model where its exactly the same training… I think there’s room for diversity, within limits….It would be great if we could get the needs of the client matched to the professional…I want them to be doing something that is not going to look identical to what I would be doing. I work a lot with OTs today where I’m the guy sitting in the office nose to nose with the client. The OT’s the one out in the community performing CBT… I’m in the office. I’m working on the trauma. I’m working on the deeper issues in a sense and laying the groundwork for what the OT is going to be doing in the community.

For this participant, differing training practices for each college promotes collaboration between mental health professionals as they have different specialities and knowledges that compliment each other and best meet the clients’ needs.

5.5.4 Competition

Participants from CPO, CRPO, and OCSWSSW also voiced competition over resources such as insurance companies and clients. A member from the CRPO mentioned a challenge the PA brought to relating to other professional colleges is professional “turf wars.” Another CRPO participant expanded:

I know members of each of these colleges [COTO, CNO, OCSWSSW] practicing psychotherapy without any education or experience in providing psychotherapy, and I think it is a major problem that these colleges have not created internal rules for who may practice. Members of the CRPO have much more specific and strict rules about who may practice psychotherapy than other colleges, and yet professionally we are treated as second-class in many organizations. For example, our pay scales tend to be significantly lower than those of other regulated health professionals or social workers doing the same job, at the same organization. This is highly evident in hospital and healthcare settings.
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 included in the PA. One OCSWSSW member shared a story of being hired at an agency who 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.

For CPO members, some worried that the PA “diluted” the profession and other colleges pose a threat to their access to clients. As one CPO member 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 CPO member explained that while other regulated mental health professionals may post 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.

While many professionals recognize these fears (especially of CPO members), some wonder if this is a valid concern. One OCSWSSW participant voiced that “there is no reason to be divided, as there is enough client work for all disciplines.” Echoing survey responses, a CPO interviewee explained that psychologists should not be very concerned over competition because demand for psychotherapy is high and supply is low—even with more professionals to legally allowed to practice psychotherapy. He also noted that professionals often have different specializations (i.e., populations, models, presenting concerns, etc.), which impacts who they can see. Hence, if the client’s needs do not fit within the professionals’ specialization, it is best if there are other professionals they can get services from.
5.6 Public and institutional recognition

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. 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. Lastly, participants named the necessity of advocating for recognition.

5.6.1 Lack of public awareness

Participants associated with CRPO, CPO, and OCSWSSW voiced struggles with public understanding of what the PA is and the implications this has on professional roles, specifically what is psychotherapy and who can practice it. One member of the OCSWSSW succinctly explained this, “[I] do not think that the public or clients understand or even know or care about the PA.” A CPO registrant mentioned that while the PA “gives clients’ more choices,” they may not know the “difference between professions.” Public confusion can create “a lot of misconception” as explained by another CPO member, despite trying to educate clients. This can have implications for service accessibility as people are unsure how to find a professional who can best suit their needs.

5.6.2 Third-party payers

Members of the CRPO, COTO, and OCSWSSW explained concerns over third-party payers’ lack of recognition. Lack of recognition has implications for insurance coverage, which impacts clients’ accessibility to certain services and professionals’ ability to bill independently. 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 will accept psychotherapy from an RP, let alone a Qualifying member (a category which infuriatingly few institutions recognize).” This impacts client’s accessibility to CRPO members, “I hear some clients prefer individuals from other colleges such as OCSWSSW since the insurance provider acknowledges them more than CRPO.” Another CRPO participant stated that the lack of recognition from insurance companies hinders their ability to bill independently:

Not all third-party payers are aware of the changes regarding the PA. Some health insures only recognize social workers for coverage but have not yet included psychotherapists. This is where it has been helpful to work under supervision of a social worker in order for clients to access psychotherapy from a psychotherapist even though I have more experience and competencies than my supervisor.

The lack of knowledge of the PA impacts recognition of certain members (particularly CRPO), which shape the relationships they have with various actors. In this case, the lack of knowledge from third-party payers impacts the RP’s relationship with them (i.e., they are not recognized for coverage) and their relationship with social workers (i.e., they need to be supervised by a social worker to be covered).

This struggle for recognition is also shared by COTO participants, who explained that their profession regularly goes unrecognized by insurance companies. As with CRPO members, COTO participants echoed difficulties for clients to claim insurance for psychotherapy performed by an OT, “it is difficult for my clients to claim insurance as psychotherapy by an OT is not in many insurance plans.”

Some COTO members noted that while they might be recognized under some insurance plans, they often need to educate them to not get “inappropriate referrals from insurance companies who like to go the inexpensive route.” Another COTO registrant expanded by
explaining that while they might be covered, “often times, they [insurance companies] don’t recognize enough to pay for additional time/resources that is needed to put in for the client in addition to regular occupational therapy we are already providing.”

CRPO and OCSWSSW participants also described noting a slow shift to third-party payers recognizing their professions and covering them. One CRPO member explained that their profession “is mostly in favour of the PA as it lends a certain legitimacy to the profession that was lacking before. This legitimacy has helped to expand some EHB providers to include psychotherapists as covered providers.” An OCSWSSW member also noted that “employers are more willing to include Registered Social Workers in their Employee Benefits.”

5.6.3 Advocating for recognition

Members of the CRPO, OCSWSSW, COTO, and CPO spoke to the need for advocating for public and institutional recognition in various ways. A CRPO member explained the importance of having the CRPO “lobby insurance companies so that we can access insurance coverage for our clients without a Psychologist’s name on our receipts.” An OCSWSSW member mentioned it is important for the social worker community to advocate for professional recognition as practicing psychotherapy. Another OCSWSSW participant expressed, “It’s still a shame we are, for the most part, under valued, under paid and often viewed as easily replaced by less qualified individuals.” COTO participants voiced the importance of individually advocating for professional recognition via actively educating clients and third-party payers on what they do, their qualifications, and through their title use. One COTO participant explained, “I always refer to myself as an OT, as I like to promote this profession, since it is more unknown compared to other professions.”
6 Discussion

This study explored the perceived effects of the PA on members of the six colleges who have access to the controlled act of psychotherapy through a multi-level lens that looked at intra-professional, inter-professional, and institutional changes of professional identity, boundaries and legitimacy. Though thematic analysis, six themes were produced. Firstly, professionals within the colleges had various understanding of the PA, which varied from little to no understanding, confusion, and complete understanding. Secondly, participants noted different impacts of the PA on professional boundaries, which rested on their understandings of their professional identity. This spanned between blurring boundaries, having no impact and clarifying boundaries. Thirdly, professionals commented on the college gatekeeping of the CRPO, naming challenges with supervision, getting grandparented into the CRPO during the transitionary period and continuous difficulty with registration. Fourthly, members of the six colleges described feeling more accountable to clients, fearing punishment from their college, and policing themselves and others more. Fifthly, participants explained the PA having various effects on institutional and public recognition of their profession, varying between lack of public education on the PA, differing perspectives of third-party payers’ recognition, and advocating for more professional recognition. Lastly, professionals described various levels of recognition from professional colleges within and outside of the PA, noting lack of knowledge of their profession from other professional colleges, more collaboration, competency concerns and competition for resources.

There were differences among the perceived effects of the PA for the six colleges. The differences between colleges members’ experience of the themes supports Powell and Oberg’s (2017) multi-leveled relational network understanding of professions and Deephouse and
colleagues (2017) conceptualizations of legitimacy in that professional groups’ degree of institutional embeddedness granted them various levels of legitimacy. Powell and Oberg (2017) explained that networks of interaction can be divided into institutions, which are comprised of a scaffolded network of close horizontal and vertical level relationships that actively share and co-create meaning. Professional groups become embedded into society when they “fit” into one of these institutional networks. For example, the CNO and CPSO are part of the medical institution that shares common values of scientific empirical inquiry. Within this institution, members of the CNO and CPSO interact with others intra-professionally (e.g. cardiac surgeons, gynecologists, family physicians within the CPSO), inter-professionally (e.g. CNO, CPSO, medical engineers, researchers), and other institutions (e.g. government, third-party payers). Deephouse and colleagues (2017) explain that when professions become institutionalized, it provides them with legitimacy, which is a protective factor against scrutiny. Ultimately, the institutionalization of a profession gains them power over un-institutionalized professionals because their professional identity is unquestioned, which warrants them more access to resources, more influence, and less threat to changing circumstances (Deephouse et al., 2017).

The present study supports connections between institutional embeddedness as defined by Powell and Oberg’s (2017) multi-level relational network model, professional legitimacy, and the impacts of regulation. CPSO and CNO were institutionally embedded in the medical system prior to the PA. CPSO and CNO are historically and ongoingly tied to medicine and science, which is highly valued in Western societies, including Canada (Caplan, 1998). This can be seen in the main practices of the CPSO and CNO, which focuses on physical medicine and is reflected in many of the controlled acts they have access to. Being an integral part of the medical institution awards
their profession access to funding through other institutions such as the Ontario government, which is shown in their service coverage under the Ontario Health Insurance Plan (OHIP). In the present study, CNO and CPSO members noted little to no intra-professional, inter-professional or institutional changes due to the PA. Their institutional embeddedness in a valued and influential institution grants them protection against noticeable effects of the Act. Additionally, the controlled act of psychotherapy is periphery to their primary professional identity which their professional legitimacy and power come from. As noted earlier, doctors and nurses need additional training to competently practice psychotherapy, a specialization few choose to pursue. Hence, 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 relationships established and have little impact on professional boundaries, identity, and legitimacy.

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 historic ties to medicine and scientific research, which also solidified their public, legal, and institutional recognition (Benjamin, 1986). The CPO is embedded in the medical institution, however less so than CPSO and CNO members who focus on physical medicine. While CPO draws from the medical knowledges 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. This can be seen in how CPO members are not included under OHIP but are accepted for coverage by many third-party payers. Prior to the PA, CPO held most claim and legitimacy of performing psychotherapy. However, the introduction of the PA legitimized the use of psychotherapy by 5 other professions, thus aligning those professions closer with the medical institution. In the present research, CPO members
experienced little impact intra-professionally and institutionally but voiced many inter-professional concerns. 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), which made some CPO members nervous about competition for resources (e.g. clientele, third-party payers) and brought about competency concerns. The CPO’s alignment with the medical institution granted them legitimacy, however their ties with the institution are not as great as the CPSO and CNO, which leaves them vulnerable to competition and loss of power or influence. Hence, legislation, such as the PA, challenges their professional boundaries with other colleges who can practice psychotherapy. However, a protective factor for the CPO is their adherence to the medical institution’s models of health, which the PA’s definition of psychotherapy is based on. This is seen in the definition’s central themes of “technique,” “disorder,” and “treatment” (Psychotherapy Act, 2007). While professional identity remained unchanged, psychologists’ relationships with colleagues from other colleges included in the PA appears to have been altered. CPO members may need to negotiate relationships with members of other colleges who now have access to the act that previously ‘belonged’ exclusively to psychologists. This is in line with Powell and Oberg’s (2017) relational conceptualization of professional groups because the PA shaped relationships between professional groups, which brought about tensions.

For professional groups who are newly created or do not fit with a dominant institution, regulation can bring professional groups into an institution by aligning their knowledges closer to them (Powell & Oberg, 2017). Aligning a profession closer to an institution has implications for actors they may be put in contact with and for their 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 OCSWSSW, CRPO, and COTO members
perceived more intra-professional, inter-professional, and institutional changes overall.

OCSWSSW, CRPO and COTO members may have aligned loosely with the medical institution prior to the PA through counselling, which placed them as part of the mental health field. Before the Act, members of COTO and OCSWSSW provided counselling services that were unregulated. After the PA was established, members needed to redefine their practices in accordance to 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 medicalized understandings of psychotherapy), brings members of these colleges closer to dominant knowledges 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. Members of the CRPO who entered through the transitionary period also needed to redefine themselves professionally to suit the CRPO guidelines and PA. Adapting to a new closeness with the medical institution also had implications for their 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 influence and recognition from other actors. 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 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. This study suggests that a profession’s level of institutional embeddedness impacts the amount of perceived change
regulation brings, which is also dependent on how closely the legislation speaks to the profession’s practices. Those who are institutionally cemented via existing legislation and align closely with the principle knowledges of the institution experience less relational changes overall from legislation that is not directly related to them. Those who are mostly aligned with an institution experience more inter-professional relational changes when they are implicated in legislation. Those who are loosely aligned with an institution experience more changes intra-professionally, inter-professionally, 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 inter-professional changes they face.

This research has implications for those creating and appraising policies, and professional groups. This can provide policy makers a more dynamic way of understanding the implications of legislation on health care workers. Through considering the implications of legislation from a multi-level relational perspective, governmental policy workers can better anticipate the effects of legislation on professional groups’ identity, professional boundaries, and interactions with other institutions. This can be helpful for producing and introducing policies in ways that support professionals in these transitions. Furthermore, this research can also support policy analysts in unpacking the effects of existing legislation to provide a more holistic understanding of its implications. A better understanding of the effects can help policy makers revise and create more helpful policies for the public, professional groups, and institutions. Additionally, it offers professionals within these colleges insights on how their peers are responding to the PA. This can help professional groups feel more connected and understanding of each other’s experiences, which can impact how they relate to their peers. Generally, this
research can offer some insights for professional colleges, associations, and individual practitioners on how the introduction of regulation may impact them. This can help them plan ahead and develop initiatives or internal policies in professional associations, colleges, or workplaces that may ease challenges that come with legislative change and best support professionals’ transition.

6.1 Limitations and future research

In acknowledging the usefulness of the study, it is also important to recognize its limitations. This research has unequal number of participants from the six colleges. For example, there were 31 CRPO members who participated and only 2 CPSO members. Thus, the experiences of some colleges’ members were more represented than others, and the experiences of some college members were not as developed or nuanced as others. Additionally, this study did not include the experiences of CNO or CPSO participants who were practicing psychotherapy. The participants included were registered with the college but did not hold competencies to practice psychotherapy. While this is useful for understanding the impacts of the PA for general members of these colleges, it does not capture the experiences of those who are have a closer relationship to the PA. Furthermore, data was gathered during the beginning of the COVID-19 pandemic, which limited the number of respondents from various colleges. This was especially true for CNO and CPSO members who noted they are extremely busy with increased demands for services and adapting to emergency regulations. Overall, given the limited data acquired of CNO and CPSO members, this research is unable to fully explore the different dimensions and dynamics of the impacts the PA had between colleges.

Future research could explore more in-depth the impacts of the PA on CNO and CPSO members who practice psychotherapy. This would help fill the limitation of this research and
provide a more nuanced understanding of their experiences. To fulfill a more dynamic understanding of the relational impacts of the PA on various levels of interaction, future research could explore how third-party payers, the public, and/or community agencies understand the PA and how the Act changed their relationship with the six professional colleges and their practices.

6.2 Conclusion

All in all, this research explored the perceived effects of the PA on the professional identity, boundaries, and legitimacy of the six professional colleges with access to the controlled act of psychotherapy through a relational, multi-level network prospective. The study supports Powell and Oberg’s (2017) multi-level relational network model by acknowledging the impacts of regulation on professional’s intra-professional, inter-professional and institutional relationships, and how these impacts exist in relation to each other. The research suggests that these relationships have varied impacts on professional identity, boundaries, and legitimacy, which is partly shaped by the professions’ proximity to the dominant institution the regulation is aligning them with and the proximity of the regulation to their professional practices.
References


Berger, R. (2015). Now I see it, now I don’t: researcher’s position and reflexivity in qualitative research. *Qualitative Research, 15* (2), 219-234. DOI: 10.1177/1468794112468475


http://dx.doi.org.ezproxy.library.yorku.ca/10.1037/h0086806


Appendix A – REB Certificate

RESEARCH ETHICS BOARDS
Certification of Ethical Acceptability of Research Involving Human Participants

APPROVAL PERIOD: June 30, 2020
EXPIRY DATE: June 29, 2021
REB: G
REB NUMBER: 20-04-010
TYPE OF REVIEW: Delegated
PRINCIPAL INVESTIGATOR: Smoliak, Olga (osmoliak@uoguelph.ca)
DEPARTMENT: Family Relations & Applied Nutrition
SPONSOR(S): N/A
TITLE OF PROJECT: Responses of Mental Health Professionals to the Regulation of Psychotherapy in Ontario

The members of the University of Guelph Research Ethics Board have examined the protocol which describes the participation of the human participants in the above-named research project and consider the procedures, as described by the applicant, to conform to the University's ethical standards and the Tri-Council Policy Statement, 2nd Edition.

The REB requires that researchers:
- Adhere to the protocol as last reviewed and approved by the REB.
- Receive approval from the REB for any modifications before they can be implemented.
- Report any change in the source of funding.
- Report unexpected events or incidental findings to the REB as soon as possible with an indication of how these events affect, in the view of the Principal Investigator, the safety of the participants, and the continuation of the protocol.
- Are responsible for ascertaining and complying with all applicable legal and regulatory requirements with respect to consent and the protection of privacy of participants in the jurisdiction of the research project.

The Principal Investigator must:
- Ensure that the ethical guidelines and approvals of facilities or institutions involved in the research are obtained and filed with the REB prior to the initiation of any research protocols.
- Submit an Annual Renewal to the REB upon completion of the project. If the
research is a multi-year project, a status report must be submitted annually prior to the expiry date. Failure to submit an annual status report will lead to your study being suspended and potentially terminated.

The approval for this protocol terminates on the **EXPIRY DATE**, or the term of your appointment or employment at the University of Guelph whichever comes first.

Signature:  
Date: June 30, 2020

Stephen P. Lewis  
Chair, Research Ethics Board-General
### Appendix B– Summary of Participant Demographics

<table>
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<th>College</th>
<th>College Status</th>
<th>Years of Practice</th>
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<td>Community organization- 14</td>
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<td>Hospital - 1</td>
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<td>16-20 – 3</td>
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Appendix C – Survey Questions and Interview Guide

Demographics – Multiple choice

1. What college are you a member of?
2. How long have you been a member of the college?
3. What is your status with the college?
4. To what other health professions do you belong?
5. What is your primary work setting?
6. How many years have you practiced?

Experiences of the PA

1. What is your understanding of the Psychotherapy Act (PA)?
2. How did you define or understand psychotherapy prior to the PA? How was your definition of psychotherapy changed (if it did) after the PA was introduced or came into force?
3. Which areas of your practice (supervision, assessment, therapy, consultation, etc.) have been impacted by the PA and how?
4. How has your practice changed (if it did) in response to the PA? What challenges and benefits have you experienced?
5. How has having access to the controlled act of psychotherapy shaped the way you related and work with clients?
6. How has the PA, in your opinion and experience, impacted or may impact clients’ accessibility to your services?
7. Has your sense of yourself as a professional (i.e. who you are, how you present yourself to others) changed as a result of the PA?
8. What role did psychotherapy play in your profession prior to the PA?
9. How has the PA impacted your profession?
10. How has your profession/peers responded to the PA?
11. How has the PA influenced how you relate to peers?
12. What challenges, tensions, and benefits (if any) did the PA bring in relating and interacting with other professionals and professional colleges?
13. How has the PA influenced how you relate to professionals from other professional colleges?
14. What effects (if any) has the PA had on your relationship with third party payers (i.e. health insurers)?
15. How has the PA effected how you interact with those outside a regulated body or who you refer clients to?
16. Is there anything in addition that you would like to share regarding your experiences with and views on the PA?