In 2007, the Ontario government proposed changes to the Regulated Health Professions Act that would establish a new college of psychotherapists, create a new controlled act for psychotherapy, and authorize only members of the colleges of medicine, nursing, occupational therapy, psychotherapy, psychology, and social workers and social service workers to perform the controlled act of psychotherapy. These new provisions have not as yet been proclaimed into law and the Transitional Council of the College of Registered Psychotherapists of Ontario is not at this time named as a College.

The Ministry of Health and Long-term Care is now considering options related to the controlled act of psychotherapy to enable child and youth workers, crisis counselors and other types of workers in the mental health system to continue to provide psychotherapy. It is now clear that these workers will not be regulated through the College of Registered Psychotherapists of Ontario at this time.

WHAT IS PSYCHOTHERAPY

The proposed controlled act of psychotherapy is described in section Q of Bill 171 as follows: as “to treat, by means of psychotherapy technique delivered through a therapeutic relationship, an individual’s serious disorder or thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual’s judgment, insight, behaviour, communication or social functioning.”

When determining whether counselling a patient is the controlled act of psychotherapy, it is important to break down the definition into understandable parts. The following features must be present in order for a treatment to be considered psychotherapy:

- The purpose of the treatment is treating the actual psychological disorder;
- A known psychotherapy technique must be used;
- A therapeutic relationship with the client must exist – the client and psychotherapists must understand that the purpose of the relationship is treating the psychological disorder;
- The disorder must be a serious disorder of cognition, mood, emotional regulation, perception or memory; and
- The serious disorder has the potential to result to serious impairment.

IMPACT ON PRACTICING DIETETICS

Some RDs who treat clients with eating disorders do provide psychotherapy. Until the controlled act is proclaimed into law, they may continue to practice psychotherapy. As soon as psychotherapy becomes a controlled act, RDs must not continue to do psychotherapy unless they have received a delegation from a professional who is legally authorized to do psychotherapy or unless they become a member of the new College of Registered Psychotherapists (CRPO).

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RDs who do psychotherapy in keeping with the above definition now have an opportunity to explore becoming a member of CRPO through a grandparenting application process.
HOW ABOUT PSYCHOSOCIAL COUNSELLING?

Psychosocial-counselling especially within the context of supporting a nutritional treatment plan is not performing the controlled act of psychotherapy. The RD scope of practice will continue to include providing psychosocial counselling/psychotherapy to clients who have disorders that are not serious or not likely to lead to serious impairment or for purposes other than treating an actual psychological disorder. Psycho-social counselling for nutrition conditions even when done with a known psychotherapy technique, such as cognitive or dialectical behavior therapies, are not psychotherapy as intended by the definition of the controlled act.

HOW DO I KNOW IF MY PSYCHOSOCIAL COUNSELLING CROSSES THE LINE INTO THE CONTROLLED ACT AS STATED IN THE RHPA?

The College is working on education material on the controlled act of psychotherapy using real practice scenarios to guide RDs in this area of practice. We plan to publish these scenarios in an upcoming issue of résumé.

Improving Your Effectiveness by Focusing on the Quality of Your Dietetic Practice

The College has heard from several RDs who are overwhelmed by the number of clients they are asked to see. These dietitians are carrying large caseloads due to a variety of issues, including staffing constraints.

HOW CAN RDS BE MORE EFFECTIVE WITH THE SAME OR FEWER RESOURCES?

As RDs, we have a professional obligation to provide safe, ethical and competent services to each and every client that we accept in our workloads. It is not acceptable to reduce the thoroughness of an assessment, intervention, follow-up or record-keeping in order to see more clients.\(^1\) This is supported by the Dietetics Act, 1991, Professional Misconduct Regulation, O. Reg. 680/93, which defines professional misconduct as:

5. Failing to maintain a standard of practice of the profession.

22. Failing to keep records as required.

The College fully appreciates the realities of today’s healthcare system and the heavy workloads carried by many dietitians. RDs do have a responsibility to maintain quality services and can refuse to accept new clients when they cannot provide safe service.\(^2\) However, in some practice settings, it is difficult or simply not possible to reduce the number of clients. Rather than refusing new clients, it may be more fruitful to concentrate on how to better serve them. To do this, RDs must look for ways to build capacity in their practices to manage challenging workloads.

BUILDING CAPACITY THROUGH QUALITY IMPROVEMENTS

One way to build capacity is through quality improvements. The illustration below shows the Six Quality Aims identified by the Institute of Medicine (National Academy Press: Washington, D.C., 2002), which are client safety, client-centered, effectiveness, efficiency, timeliness, and equity.\(^3\) Reflecting on these quality aspects, may help identify areas in your practice for quality improvements. Below are six suggestions for building capacity with these quality aims in mind.