OCRCC
ONTARIO COALITION OF RAPE CRISIS CENTRES

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Response to: Health Professions Regulatory Advisory Council (HRPAC)
Written Submissions on the Controlled Act of Psychotherapy

Summary

The Ontario Coalition of Rape Crisis Centres (OCRCC) thanks the Health Professions Regulatory Advisory Council (HRPAC) for the invitation to respond to Written Submissions on the Psychotherapy Controlled Act. When examined in a therapeutic setting (such as counselling, therapy or assessment) the impacts of sexual violence are most commonly understood and articulated via *trauma* or *mental health* frameworks. Yet sexual violence cannot be separated from a broader context – one in which the victim-survivor, the offender, and the violation itself (or threat of the violation) exist in a larger system of social norms, relations and inequities. Community-based sexual assault centre services for survivors, particularly supportive and crisis services, are rooted in a comprehensive and socially-contextualized analysis of sexual violence[1]. In this way, Centre counselling models can differ in essential ways from medical and mental health frameworks for understanding sexual violence prevalence and impacts. This creates complexities in our sector's (and workers') capacity to identify as practicing the Controlled Act of psychotherapy or not.

Specific responses to *Questions to Guide Written Submissions on the Psychotherapy Controlled Act* follow on page 5-6 of this submission.

Sexual Assault Centres and Sexual Violence: Backgrounder

When examined in a therapeutic setting (such as counselling, therapy or assessment) the impacts of sexual violence are most commonly understood and articulated via *trauma* or *mental health* frameworks. Yet sexual violence cannot be separated from a broader context – one in which the victim-survivor, the offender, and the violation itself (or threat of the violation) exist in a larger system of social norms, relations and inequities. Consider, for example:

- A 2011 summary on police reported crime, which found that sexual crimes were by far the most common offence committed against girls[1]
- Women and young women from marginalized racial, sexual and socioeconomic groups are more vulnerable to being targeted for sexual violence[2]
- Over 80% of women who are sexually assaulted do not report due to humiliation or fear of re-victimization in the legal process[3]
- Many prevailing societal attitudes justify, tolerate, normalize and minimize sexual violence against women and girls[4].

[1] Canadian Centre for Justice Statistics. Released on February 25, 2013. *Measuring violence against women: Statistical trends*. 15
[2] Wolfe and Chiodo, CAMH, 2008, p. 3.
[3] METRAC. *Sexual Assault Statistics Sheet.* Online: http://www.metrac.org/resources/downloads/sexual.assault.statistics.sheet.pdf
[4] World Health Organization. *Understanding and addressing violence against women*. Online: http://apps.who.int/iris/bitstream/10665/77433/1/WHO_RHR_12.35_eng.pdf)

Our sector contends that conventional biomedical understandings of trauma and mental health often do not account for the fact that "women and minorities experience different crime patterns, prejudice and bigotry" and other inequities, and that these experiences "lead to different life stresses and ways of coping"[5]. Even where attempts are made within a medicalized framework to address the intersections of violence with sexism, racism, ableism and other components of social location, it is often at a superficial level. Certainly, these limitations to conventional approaches have implications for victim-survivors of sexual violence.

Feminist-identified anti-violence support, such as peer counselling models, counselling models situated in acknowledging social justice discourse, other counselling models and advocacy for survivors of violence, were developed many years ago "as a reaction to the insufficiency and ill-fittingness of psychiatric and psychological responses to women's experiences of violence and social inequity." In particular, feminist approaches to therapeutic interactions act as "a corrective to the pathologization and misnaming of these experiences as illnesses and disorders"[6] in women's lives, emphasizing that women are not to be blamed for the violence they experience nor their traumatic reactions, including complex coping responses, to it.

The first rape crisis centre in Ontario opened in 1974[7], driven by an explicitly identified need for more comprehensive and socially-contextualized support to women survivor-victims. Today, there are 30 anglophone sexual assault centres in the province. Services include 24-hour crisis counselling; accompaniment to the hospital, court and/or police station; advocacy for victims and referrals; face to face counselling; outreach support including diversity work; information and support for partners, families and friends of survivors; and public education on sexual violence[8]. Sexual assault centre staff and volunteers hold expertise related to the realities of sexual violence, its prevalence, as well as the barriers facing survivor-victims in relation to their healing. Centres directly serve[9], without charge, hundreds of thousands of survivors[10] in Ontario who have experienced recent or historical sexual violence. Sexual violence addressed by centres includes any violence, physical or psychological, carried out through sexual means or by targeting sexuality including: sexual abuse, sexual assault, rape, incest or interfamilial sexual abuse, childhood sexual abuse and rape during armed conflict. It also includes sexual harassment, stalking, indecent or sexualized exposure, degrading sexual imagery, voyeurism, cyber harassment, and sexual exploitation. In addition, many centres have developed programs and services to meet the unique needs of individual communities including Aboriginal survivors of sexual violence, lesbian, gay, bisexual, trans and queer identified survivors of sexual violence, services for refugee, immigrant and racialized survivors of sexual violence (including women raped in the context of armed conflict), services for Deaf women and with disabilities and services for children, youth and men. Centres also offer specific services to groups of survivors in institutional settings, including those residing in correctional facilities, addiction treatment programs, shelters and youth residential programs.

Comprehensive community awareness and public education programs on sexual violence are also offered by all member centers of our Coalition as part of their core services in Ontario communities.

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[5] Whalen, M. and Karen P. Fowler-Lese, Jill S. Barber, Elizabeth Nutt Williams, Ann B. Judge, Johanna E. Nilsson, and Kozue Shibcizaki. "Counselling Practice With Feminist-Multicultural Perspectives". *Journal of multicultural Counselling and Development.* 2004, Vol. 32, 379

[6] Bonisteel, M. and Linda Green. "Implications of the Shrinking Space for Feminist Anti-violence Advocacy". Presented at the 2005 Canadian Social Welfare Policy Conference, *Forging Social Futures,* Fredericton, New Brunswick, Canada, 27

[7] Ontario Coalition of Rape Crisis Centres. *Herstory.* Online: http://www.sexualassaultsupport.ca/page-418416

[8] Ontario Coalition of Rape Crisis Centres. *About Us: Ontario Sexual Assault Centres in your Communities.* Online: http://www.sexualassaultsupport.ca/page-411845

[9] Ministry of the Attorney General notes that in one year alone, Ontario Sexual Assault centres responded to 50,000 crisis line calls. This does not include case management or ongoing counselling services to survivors.

[10] Today, many Centres are funded to provide services to male survivors of sexual violence as well. See: Government of Ontario. *Newsroom: Male Survivors Of Sexual Abuse*, April 13, 2011. Online: http://news.ontario.ca/mag/en/2011/04/male-survivors-of-sexual-abuse.html;

The Ontario Coalition of Rape Crisis Centres[11] (OCRCC), a network of Ontario sexual assault centres, is engaged in a broad range of research, public education and awareness activities dealing with sexual violence. In 2011, OCRCC's advocacy lead to the development of Ontario's first provincial Sexual Violence Action Plan[12]; in 2015, OCRCC remains actively involved in the 2015 *It's Never Okay: An Action Plan to End Sexual Violence and Harassment*[13]. Clearly, service providers in these centres – including frontline staff providing counselling support to women who have experienced sexual violence – maintain innovative practices and much expertise in these areas.

Community-based sexual assault centre services for survivors, particularly supportive and crisis services, are rooted in a comprehensive and socially-contextualized analysis of sexual violence[14]. In this way, Centre counselling models can differ in essential ways from medical and mental health frameworks for understanding sexual violence prevalence and its impacts. Anecdotal information suggests that specific sexual assault centre counselling competencies includes such things as:

- a holistic, anti-oppression approach that does not focus solely on symptoms or diagnoses
- the ability to therapeutically frame sexual violence as a social problem, as opposed to a mental health malfunction that the survivor must be cured of[15]
- an ongoing recognition of the skills and knowledge survivors bring to healing work
- holding "perpetrators accountable for [their acts of] violence" and the impact of these acts[16]
- a recognition of widespread societal sexual assault myths and misconceptions, which function to minimize sexual assault and its impact on women victim-survivors[17]
- a recognition that gender, race, age and other social determinants influence the targets of sexual violence[18].

Health researchers Chloe Bird and Patricia Reiker align with this approach, noting that: "Much of clinical research tends to minimize or ignore the social processes that can influence health differentiality and to reify biomedical models that portray men's and women's health disparities as inherently biological." Further, they agree that health researchers ought to "…recognize that both *social* and *biological* factors intersect in complex ways and that this interaction explains not only health or illness at the individual level but also the observed patterns of men's and women's health and longevity in general" (emphasis in original)[19].

The community-based work of sexual assault centres suggests a long history of incorporating social, relational and other contexts into their approach with service provision. In fact, much mainstream and medical understandings of complex issues experienced by survivors (i.e. self-harming coping strategies, dissociative responses such as eating problems, and concurrent challenges such as addictions and trauma) were informed by strategies developed by the anti-rape movement, including "community actions for survivors," various forms of feminist-informed counselling models, and

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[11] Ontario Coalition of Rape Crisis Centres. *About Us: Ontario Coalition of Rape Crisis Centres.* Online: http://www.sexualassaultsupport.ca/page-411845

[12] Ontario Women's Directorate, March 2011. *Changing Attitudes, Changing Lives: Ontario's Sexual Violence Action Plan*. Online: http://www.women.gov.on.ca/owd/docs/svap.pdf

[13] Office of the Premier. March 8, 2015. *It's Never Okay: An Action Plan to Stop Sexual Violence and Harassment*. Online: http://www.news.ontario.ca/opo/en/2015/03/concrete-measures-to-end-sexual-violence-and-harassment.html

[14] See: Ontario Coalition of Rape Crisis Centres. *Organizational Profile: Basis Of Unity.* Online: http://www.sexualassaultsupport.ca/page-418415

[15] Bonisteel, M. and Linda Green. "Implications of the Shrinking Space for Feminist Anti-violence Advocacy". Presented at the 2005 Canadian Social Welfare Policy Conference, *Forging Social Futures,* Fredericton, New Brunswick, Canada, 40

[16] Ibid, 25

[17] Sexual Assault centre Kingston. *Busting Myths.* Online: http://www.sackingston.com/Default.aspx?pageId=857971;
And The Learning Network. *Overcoming Barriers and Enhancing Supportive Responses: The Research on Sexual Violence Against Women A Resource Document.* May 2012: 14.

[18] METRAC Sexual Assault Fact Sheet. Online: http://www.metrac.org/programs/info/prevent/ass_fact.htm . As example, risk of victimization increases if one is very young, a woman of color, non-heterosexual or poor. 50 percent of all Canadian women will survive at least one incident of sexual or physical violence, for example; but for Aboriginal women in the same country, this number climbs to eight in ten (80 percent).

[19] Bird, Chloe E. and Patricia P. Rieker (2008). Gender and Health: The Effects of Constrained Choices and Social Policies. New York, NY: Cambridge University Press, 17.

publications on the subject of sexual violence and its impacts, "ranging from the work of feminists in medicine, such as Judith Herman (1992), to survivors' own stories"[20]. A lack of research querying non-biomedical models (such as the approach of sexual assault centres') means that "accepted notions of what it means to be 'mentally healthy' or 'ill' are assigned to women surviving physical and sexual violence"[21], often inappropriately. For these reasons, sexual assault centres have often strategically resisted alignment with mental health and medical approaches to understanding the impacts of violence.

The recent *It's Never Okay: An Action Plan to End Sexual Violence and Harassment*[22] acknowledges that sexual assault centres hold a unique role in sexual violence work in Ontario[23]. Yet, while this information is important, community-based sexual assault support services sector, due to moderate funding allocations[24], service sector pressures, and public resistance to systemic understandings of violence against women[25], has had limited capacity to explicitly articulate the distinct value of our approach to service. At times, this has resulted in a constructed deskilling of workers, an absence of a definitive framework, and an overall vulnerability of the sector and its accumulated expertise.

In contrast, we are aware that a regulatory body has been created to oversee the controlled act of psychotherapy in Ontario. The role of the Regulated Health Professions Advisory Council (HPRAC) is to regulate professionals who are psychotherapists, registered mental health workers or those "practicing psychotherapy" in the province. As part of this work, the HPRAC draws a distinction between psychotherapy and counselling as follows:

- *Psychotherapy* is "most often characterized by an intense client-therapist relationship which often involves the examination of deeply emotional experiences, destructive behaviour patterns and serious mental health issues"; and
- *Counselling* is "where the focus is on the provision of information, advice-giving, encouragement and instruction; and spiritual counselling, which is counselling related to religious or faith-based beliefs[26]."

The benefit of a regulatory body is that it aims to bring ethical guidelines, consistency and safety to service-users; they also aim to define accountability measures for professionals. However, there are disadvantages to this specifically for the sexual assault support services sector. Regulatory bodies can create further constructed-disparities between the approach identified by the HPRAC, and the efficacy of community-based support organizations such as sexual assault centres. This distinction is evident in the differentiation between "psychotherapy" and "counselling" where psychotherapy is more directly connected to a medical model and positioned as more complex, measurable or therapeutic work. Such constructed disparities can function to minimize the real expertise, efforts and value of sexual assault centre work, having a direct impact on the public's perception of sexual assault centres, their expertise, their capacity to support survivors of sexual violence and their work in Ontario communities. By extension, these trends can impact these agencies' viability and, thus, ultimately options for those who have experienced violence and are seeking support in their communities.

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[20] Bonisteel, M. and Linda Green. "Implications of the Shrinking Space for Feminist Anti-violence Advocacy". Presented at the 2005 Canadian Social Welfare Policy Conference, *Forging Social Futures,* Fredericton, New Brunswick, Canada, 27

[21] Ibid, 26

[22] Office of the Premier. March 8, 2015. *It's Never Okay: An Action Plan to Stop Sexual Violence and Harassment*. Online: http://www.news.ontario.ca/opo/en/2015/03/concrete-measures-to-end-sexual-violence-and-harassment.html

[23] Ontario Women's Directorate. *Changing Attitudes, Changing Lives: Ontario's Sexual Violence Action Plan*, March 2011: 12

[24] For many years, Ontario sexual assault centres saw cutbacks, (5% 1995) nominal increases (5% 2004-2005; 3% 2007-2008) and no core increases at all (2005-2007 and 2007-current). A component of the Sexual Violence Action Plan (2011 and again in 2015) includes a now-permanent commitment from the Ministry of the Attorney General to increase funding support to Ontario's Sexual Assault Centres.

[25] Johnson, K., in the Western Producer. August 28, 2014. *Harper's stance on crime fails missing and murdered women*. Online: http://www.producer.com/2014/08/harpers-stance-on-crime-fails-missing-and-murdered-women/

[26] Ontario Coalition of Mental Health Professionals. April 2006. *Executive Summary: Chapter 7 'Regulation of Psychotherapy' New Directions: Regulation of Health Professions in Ontario.* Health Professions Regulatory Advisory Council.

Questions to Guide Written Submissions on the Psychotherapy Controlled Act

1. In 2015, a Working Group consisting of five regulatory colleges[27] created a draft *Clarifying Document on the Psychotherapy Controlled Act*. HPRAC will be building on the excellent work of the Colleges. After reading this document (Attachment 2), do you feel that it clearly explains the Controlled Act? If not, why?

Yes, the draft *Clarifying Document on the Psychotherapy Controlled Act* explains the Controlled Act at a high (broad) level.

2. What changes would you suggest be made to improve the Clarifying Document so that the public and other health care providers (regulated and unregulated) have a better understanding of it?

We suggest that you include an index or appendix which clearly identifies the following terms/phrases included in the *Clarifying Document*:

- "therapeutic interventions or techniques" (found under *1, Treating*[28])
- "interventions or approaches based on recognized psychotherapeutic theories, models or frameworks and/or empirical evidence" (found under *2, By means of psychotherapy technique*[29]). We suggest a list of examples of these

This will support care providers (regulated and unregulated) in better understanding the phrases or criterion described. We imagine that some providers may understand what these techniques, interventions, models or frameworks may be, while others do not. We also imagine that sexual assault centre staffs providing counselling are engaged in some (though not all) of these interventions, techniques and interventions. However, in the current *Clarifying Document* and without clear definitions provided, it is hard for us to identify these similarities and differences.

3. Should other health care providers, either unregulated or regulated and <u>not</u> members of the six colleges[30] who would practice the controlled act of psychotherapy if this section of the *Regulated Health Professions Act, 1991* (RHPA) is proclaimed, be allowed to practice the controlled act?

We don't have a clear answer to this question. We wish to state that, as our above Backgrounder has identified, there are philosophical barriers to regulation impacting our sector – a sector which has historically (and often strategically) chosen not to align itself with medical models of supportive treatment, even though we do provide many varieties of support.

We also wish to state that there are financial barriers to regulation (fees associated with ongoing membership to a regulatory body, for example, including the systemic realities of an under-funded sector[31]) to our sector, as non-profit organizations and as a collective of workers (care providers). These barriers impact some individual providers who practice some aspects of the controlled act, and may wish to consider being a member of a regulatory body.

[27] College of Registered Psychotherapists of Ontario (CRPO), College of Occupational Therapists of Ontario (COTO), Ontario College of Social Workers and Social Service Workers (OCSWSSW), College of Nurses of Ontario (CNO) and the College of Psychologists of Ontario (CPO)

[28] Health Professions Regulatory Advisory Council (HRPAC) and Working Group consisting of five regulatory colleges, 2015. Draft *Clarifying Document on the Psychotherapy Controlled Act*.

[29] Ibid.

[30] This is in reference to the above five colleges plus the College of Physicians and Surgeons of Ontario (CPSO).

[31] For many years, Ontario sexual assault centres saw cutbacks, (5% 1995) nominal increases (5% 2004-2005; 3% 2007-2008) and no core increases at all (2005-2007 and 2007-current). A component of the Sexual Violence Action Plan (2011 and again in 2015) includes a now-permanent commitment from the Ministry of the Attorney General to increase funding support to Ontario's Sexual Assault Centres.

In addition, some providers in community-based violence against women support agencies may be using some of the techniques, interventions, models or frameworks referenced in the *Clarifying Document;* while others are not.

Moreover, choosing to be/not be a member of a regulatory body has implications for the reputability of our work, and the work of all other community-based violence against women agencies, whether we join or not. For example, one agency staffed by regulated providers can incidentally appear to de-legitimize or minimize the skills and expertise of all other sister women's agencies staffed by non-regulated providers.

With these contexts in mind, an "either/or" option (that is, to choose to be formally regulated, or not to be regulated) does not resolve these challenges for us.

4. Are there conditions under which health care providers, either unregulated or regulated and not members of the six colleges who would practice the controlled act of psychotherapy if this section of the *Regulated Health Professions Act, 1991* (RHPA) is proclaimed, be allowed to practice the controlled act? If so, which health care providers and under which conditions?

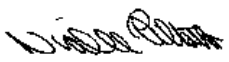
Please see our above responses to (3) and in the Backgrounder, above. We believe that this summary creates legitimate conditions under which care providers in the community-based sexual assault centre sector who practice the controlled act of psychotherapy (if this section of the *Regulated Health Professions Act, 1991* (RHPA) is proclaimed) should be allowed to practice the controlled act, even if they are not regulated.

We do not wish to see our interventions, techniques and interventions -- which in some cases, align with those of the controlled act of psychotherapy -- become (1) invisibilized under the contexts outlined here, and/or (2) deskilled, as a result of an "either-or" system of categorization, as developed by the Health Professions Regulatory Advisory Council.

5. The five regulated colleges, along with the College of Physicians and Surgeons of Ontario (CPSO) will be able to use the title "Psychotherapists" once the Controlled Act is proclaimed. How important is it that the title "Psychotherapist" be protected?'

Workers (care providers) at community-based violence against women support agencies do not use the title "Psychotherapist" in our work/agencies. We are not the right population to speak to the importance of the title "Psychotherapist" being protected. We hope that you receive more helpful responses from self-identified psychotherapists on this question!

Thank you again for the invitation to respond to Written Submissions on the Psychotherapy Controlled Act. If you have any questions or comments on this submission, please do not hesitate to contact me at 905-299-4428 or ocrcccoordinator@hotmail.com.
Sincerely,



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