# Medical Psychotherapy Association Canada

# EDUCATION, CREDENTIALING AND MAINTENANCE OF COMPETENCE FOR MEMBERS OF THE MDPAC

**Approved by GPPA Board of Directors, July 19th, 2001**
**Approved by the Membership, November 15th, 2001,**

**Revised, February, 2002, February, 2003, April 2003, June, 2004 and June 2006, October 2017**

MDPAC ACPMD
MEDICAL PSYCHOTHERAPY ASSOCIATION CANADA
ASSOCIATION CANADIENNE DE PSYCHOTHÉRAPIE MÉDICALE

**The contents of this document have been reviewed and are approved by the Professional Development Committee of the Medical Psychotherapy Association Canada: Muriel van Lierop (Chair), Helena Chekina, Jennifer Rae, Stephen J. Sutherland, Barbara Whelan**

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## I BACKGROUND

The Medical Psychotherapy Association Canada (MDPAC) is an incorporated non-profit organization that was created in 1984 by Drs. Terry Burrows and Bob James to support and encourage quality psychotherapy by physicians in Canada and to encourage physician psychotherapists to develop sustaining collegial relationships (Salole et al, 1996, 2). The accomplishments of the MDPAC and formerly the General Practice Psychotherapy Association attest to the validity and significance of their vision (Salole et al, 1996, 1-2).

Psychotherapy by physicians evolved during the 1980's as a primary care treatment modality from the historic culture of family medicine. This was a natural fit because of family medicine's emphasis on the therapeutic power of the long term doctor-patient relationship in the context of continuing comprehensive care. Physician psychotherapy emphasized treating the patient as a whole person, with biological, psychological, and social contributors to health, and using a wellness vs. a sickness model of health care delivery.

As a continuance of Burrows and James' work, this proposal discusses the needs, strategy recommendations, and credentialing criteria that address competence of MDPAC members. This is believed to be a vital step in the continuing quality improvement of the provision of psychotherapy by medical professionals.

## II SPECTRUM OF PHYSICIAN PSYCHOTHERAPY

Health is influenced by multiple determinants. Broadly speaking, biological, psychological, and social contributors often overlap, and can be predisposing, precipitating or perpetuating (McDowell and Newell, 1987; Moriarty and Chanko, 1988; Stewart et al, 1995, xix). Patients present to their primary care physicians for preventive health care or with undifferentiated problems. The physician's role is to establish a therapeutic alliance with each patient that will permit further exploration and understanding of the relative weight of contributors to that patient's state of health, and what would help prevent worsening (Vincent, 1973; Moriarty and Chanko, 1988; Rosser, 1999). The family physician must integrate knowledge of these components, and skills in dealing with them, in order to continue the collaboration with each patient to formulate, implement, and evaluate treatment plans (Rosser, 1999). These plans may include services provided by the primary care physician and/or services coordinated by the family physician but provided by family practice sub-specialists (such as physician psychotherapists), medical specialists (including psychiatrists), and other health care or social service regulated professionals.

In some cases, patients may benefit from non-psychotherapeutic counselling with educators, or religious, faith-based information supplied by religious personnel.

All licensed physicians practising psychotherapy share the following:

i) application of learned communication skills to establish and continually build a therapeutic alliance in order to assist patients to address the unique problems they bring to the doctor, and, in general to prevent disease, treat illness, relieve symptoms, and comfort distress;

ii) have undertaken education that enables them to specify multi-axial biological, psychological, and social diagnoses, and, when helpful for the patient and other health care professionals sharing care, to use a recognized system of diagnosis.

iii) have the capacity to integrate biological, psychological, and social treatments;

iv) diagnosis and treatment within the ethical boundaries of the medical profession;

v) treatment within the therapist's level of competence or with support from a colleague with more advanced training and experience, with referral decisions based on the individual physician's skills, interest, and experience, the patient's preference, and on the local availability of other resources;

vi) sufficient self-awareness to understand the impact of therapy on both patient and physician;

vii) sufficient self-care skills to protect themselves from burnout, substance abuse, boundary violations etc. (Petrucelli, 2001)

The different physician psychotherapist groups include:

i) primary care physicians and non-psychiatrist specialists who incorporate psychotherapy into their daily practices on an as-needed basis;
ii) primary care physicians and non-psychiatrist specialists who devote a portion of their practices to scheduled focused psychotherapy;
iii) primary care physicians and non-psychiatrist specialists who devote their entire practices to scheduled focused psychotherapy;
iv) psychiatrists who devote varying portions of their time to scheduled focused psychotherapy and as-needed psychotherapy during the course of psychiatric care.

Physician Psychotherapy is the deliberate establishment by licensed physicians of a professional relationship with patients for the purpose of communication and collaboration to address potential or actual health-impacting problems. Such communication/collaboration can assist investigation and differentiation of factors affecting each individual's health. Once the biological, psychological, and social risk factors are differentiated, the professional relationship can foster and nurture the positive attitude and emotional strength necessary to take actions to prevent illness or to accelerate recovery from identified problem(s), with resumption of everyday life if possible, or at least with minimization of discomfort and despair (Salole et al, 1996, 7-8, 10).

In Ontario legislation, and the fee schedule of the Ontario Health Insurance Plan, both primary mental health care and scheduled, focused psychotherapy by licensed physicians has been recognized.

The evidence for effectiveness of various psychotherapeutic methods is generally positive (Gurman and Messer, 1995; Richardson, 1997; Cameron et al, 1998), although there are significant difficulties in comparing the different psychotherapies, for example due to the length of follow-up necessary to permit meaningful evaluation, multiple potentially confounding factors, and lack of blindability of therapy (Richardson, 1997).

## III NEEDS

**Summary:**

1. **Public access to psychotherapy with physicians to meet a spectrum of health needs**
2. **Verifiable credentials for physician psychotherapists who either sub-specialize or have a special focus in psychotherapy in their practices to assist the public, referring health care professionals, and the legal system to access therapy or provide shared care for patient health problems requiring more time and/or skill**
3. **Public confidence that physicians maintain psychotherapeutic skills**

### 1. Public access to psychotherapy with physicians to meet a spectrum of health needs

Like MDPAC/GPPA founders Drs. Burrows and James, primary care physicians (and indeed family practice sub-specialists and medical specialists) have been drawn into doing more and more psychotherapy because of demand from their patients. The public need for physician psychotherapy is not surprising given the following:

i) heightened stress secondary to rapid technological changes, unemployment, poverty, dislocation, family breakdown, violence, substance abuse etc., while at the same time there are fewer family, religious, and community resources. This has left patients with "increasingly nowhere else to turn but to their GP- for support, understanding and counseling about the emotional, physical and behavioural consequences of the increasing stresses…" (Burrows, 1989).

ii) stigma attached to having or being labeled with emotional or psychiatric problems delays help-seeking, and may lead patients to present to their family physicians with 'more acceptable' physical problems (Vincent, 1973).

iii) high prevalence of major depression in the medically ill (Cassem, 1995; Silverstone, 1996).

iv) high population prevalence of mental illnesses (Graham, 1988, 3).

v) an aging population with increased suffering and disabilities related to chronic diseases and multiple losses, and need to make "end of life" decisions (Nazerali, 1995).

vi) increased potential for complicating, difficult-to-differentiate neuropsychiatric and somatic sequelae secondary to pharmacological interventions, particularly associated with polypharmacy (Harrison's 13th Edition, 1994).

vii) de-institutionalization of the seriously mentally ill who "are the most

> disadvantaged members of our society" with severe economic, housing, and other social problems (Graham, 1988, 19-20).

These needs have increased the spectrum and complexity of services required, with the primary care physicians primarily fielding the demands. For example:

- Several authors have noted that more mental health care is provided by primary care physicians than by specialty mental health care providers (Borins and Morris, 1995, Christie-Seeley 1995, Lesage et al 1997, Parikh et al, 1997).

- A random survey of 9953 household residents in Ontario showed more people seek mental health services from their family physicians than from psychiatrists, social workers, or psychologists (Lesage, Goering, Lin, 1997), putting family physicians in the crucial position for primary and secondary prevention of population mental health problems.

- Primary care physicians spend up to 30% of their time handling emotional or psychiatric problems (Graham, 1988, 3; Institute for Clinical Evaluative Sciences [ICES], 1996,1.) The demand has considerably exceeded what psychiatrists, psychologists and social workers have been able to provide (Silburt, 1988), and so at least 50% of all psychiatric problems are being handled by family physicians (Graham, 1988, 19; ICES, 1996,1).

- The mental illnesses of individuals seen only by primary care physicians are relatively similar in complexity to those seen exclusively in the specialty mental health sector (Parikh, Lin, Lesage, 1997).

- Family physicians encounter and treat patients with a range of disorders: bipolar disorder, dementia, somatization disorder, alcoholism and chronic schizophrenia, as well as behaviour problems, eating disorders, drug abuse and unplanned pregnancies in children and adolescents (ICES, 1996, 2).

- The prevalence, severity, and complexity of mental health problems that primary care physicians deal with are not likely to diminish. Indeed, Parikh et al (1997) state that "effective and efficient mental health care delivery must include substantial resource allocation for the primary care setting".

Of significance in these shifting trends and demands is that the number of primary care physicians is decreasing because of a 10% reduction in medical school enrolments since 1992 that has been completely absorbed by family medicine (Rosser, 1999). The remaining physician population is aging (Bailey, 1999), and the Janus Project of the College of Family Physicians of Canada reported major difficulties in accessing care from family physicians in under-serviced areas, and significant difficulties even in "over-doctored" areas (Rosser, 1999). This has limited the capacity of primary care physicians to do scheduled, focused psychotherapy, although they still must provide time-consuming psychotherapy on an ongoing as-needed basis in order to promote patient and family health and reduce illness recidivism.

Furthermore, the availability of psychiatrists to do scheduled, focused psychotherapy has been hampered by restrictive entry to residency programs and by inconsistent

provincial licensing regulations and lack of support for immigrant physicians (el-Guebaly, 1999).

Training in psychiatry has had an emphasis on pharmacotherapy with adjunctive psychotherapy or vice versa for conditions that meet the criteria for DSM-IV, or now V diagnosis (Cameron et al, 1998), a specialty 'illness' model as opposed to a primary care 'wellness' model.

Given these realities, the need has escalated for sub-specialist physician psychotherapists who have advanced training that can assist patients and primary care physicians in dealing with the more difficult, time-consuming mental health problems via contracted, focused psychotherapy.

It has been a long tradition of Family and Community Medicine for generalist family physicians to obtain the post graduate training necessary to serve specific needs in diverse patient populations and to develop expertise in particular areas of clinical interest. They may place limits in their practices to accommodate the scheduling and facilities required to practise in the field(s) of special interest, experience and expertise (Salole, 1996: 3) (e.g. anaesthesia, emergency medicine, psychotherapy, obstetrics).

In this current environment, it is essential that there be adequate acknowledgment and support for the spectrum of psychotherapeutic services provided by physicians, or there is risk of much higher health care costs related to unidentified and therefore untreated mental health problems, or to chronicity/recidivism related to inadequate management.

**2. Verifiable credentials for physician psychotherapists who either sub-specialize or have a special focus in psychotherapy in their practices to assist the public, referring health care professionals, and the legal system to access therapy or provide shared care for patient health problems that require more time and skill.**

The public and referring health care professionals would be assisted in finding appropriately qualified sub-specialty or specially focused physician psychotherapists to assist with particular types of problems if they had visible, verifiable credentials. The legal system would be able to access physician psychotherapists with expertise more focused to the cases in question.

**3. Public Confidence that Physicians Maintain Psychotherapeutic Skills**

The public requires assurances that physicians maintain psychotherapeutic, as well as other medical and surgical skills. Medical regulatory bodies have expressed concern that a significant proportion of complaints are related to inadequate doctor-patient communication and boundary issues. In 1998, 45% of complaints to the College of Physicians and Surgeons of Ontario (CPSO) were regarding communication and conduct/behaviour issues (Complaints Committee Report, 1999). CPSO has asked for suggestions as to what training would be appropriate for physicians shifting to psychotherapy practice. Task forces in Ontario (Task Force on Sexual Abuse of Patients, 1991) and British Columbia (Committee on Physician Sexual Misconduct, 1992) have outlined the highly negative consequences of boundary violations in medical care.

MDPAC developed Guidelines for the Practice of Psychotherapy by Physicians, published in 2010, and updated in early 2017, which include the principles for the practice of safe, effective psychotherapy, and an evolving core curriculum for post-graduate training. Membership criteria for MDPAC outline the requirements for credentialing and maintenance of competence for various categories of membership.

## IV. STRATEGIES TO MEET THE NEEDS

To advance the MDPAC/GPPA's original mandates, continuous quality improvement of psychotherapy by Canadian physicians, and support for general practitioners doing psychotherapy, the following strategies are suggested.

### 1. Access

i) Increase awareness of the role and need for physician psychotherapists to governing bodies and funding agencies.

ii) With regard to continual improvement of education, training, supervision, personal growth, and self-care opportunities for all physicians practising psychotherapy, continue to liaise with the College of Family Physicians of Canada and its provincial affiliates, university departments of Family and Community Medicine, and the relevant sections and programs of provincial medical associations (e.g. GPP, Hypnosis, Addiction Medicine and Family Practice Sections, and Physician Health Programs).

iii) Continue to work with the College of Family Physicians of Canada and its provincial affiliates, psychiatrists and other Royal College specialties, psychologists, and social workers to improve interdisciplinary understanding and collaboration to share care more effectively. Broaden skills and perspectives by deliberately doing outreach to other psychotherapeutic disciplines (e.g. through a special networking conference and invitation to the MDPAC annual conference).

iv) Maintain shared care or mentoring models where experienced physician psychotherapists assist primary care doctors to deliver outpatient mental health services.

v) Maintain a public website and devise a pamphlet with information on physician psychotherapy.

vi) Develop a list of members, with training and experience in various psychotherapeutic modalities, who have also developed, or are willing to develop, the skills to be case/practice reviewers and/or expert witnesses with regard to psychotherapy..

### 2. Credentialing (See Section V)

i) Institute a system of collegial support, graduated education and credentialing for physician psychotherapists that emphasizes personal and skill development.

ii) Introduce medical students and family practice and specialty residents to MDPAC and training possibilities through personal invitation to the MDPAC annual conference (registration fees at cost)

iii) Have a staffed booth at the MDPAC annual conference to discuss credentialing with any interested attendees, plus have a designated Credentials Committee volunteer to answer questions

iv) Qualify supervisors/mentors and have the MDPAC act as a resource for physicians to access supervisors and mentors.

v) Work with provincial medical association Central Tariff Committees, health insurance plans, and regulatory bodies to help provide appropriate funding of psychotherapy. It is crucial that psychotherapy billing codes not be restricted as to number per patient per year as they represent the main entry point to the mental health care system, and the most important vehicle for primary and secondary prevention and treatment of stress/psychological problems.

### 3. Maintenance of Competence and Growth (See Section V)

i) Graduated credentialing system will encourage growth to the next level of training.

ii) Continued membership at the level attained will require demonstration of maintenance of competence through accepted CME and other membership criteria, as outlined.

## V. CREDENTIALING CRITERIA

### 1. Criteria Components

i) Redefine current membership criteria with respect to post-graduate training to reflect graduated credentialing.

ii) Expand the professional support criteria to include case supervision (individual or group), scheduled collegial consultation/interaction, self-development (personal experiential training to enhance self-awareness and self-care) and other focused peer interaction/consultation regarding academic or patient care issues in psychotherapy.

### 2. Membership Categories

There will be ten membership categories: Associate, Clinical Member, CPSO/CPD Clinical Member, Certificant, Mentor, Mentor Emerita or Emiritus, Honorary Member, Student Member, Inactive Member, and an Individual Assessment category, if necessary..

The categories of Clinical Member, CPSO/CPD Clinical Member, Certificant, Mentor and Mentor Emerita or Emeritus are summarized below and in Table I.

Fees for the different categories of membership shall be determined by the Board from time to time.

**i) Associate Member:**

*Criteria:* Any physician who is licensed to practice medicine by the provincial licensing authority, and practices under the Canadian Medical Association Code of Ethics.

*Privileges:* Journal and other communications, but no voting or committee participation

**ii) Clinical Member:**

*Criteria:* Any physician who is licensed to practice medicine by the provincial licensing authority, and practices under the Canadian Medical Association Code of Ethics.

*Maintenance of Competence (MOCOMP):* Minimum 12 hours per year or 36 hours every 3 years (e.g. October 1, 2014-September 30, 2017- pro-rated for newer members) of psychotherapy-related continuing education (CE) and minimum 12 hours per year or 36 hours over 3 years e.g. (October 1, 2014-September 30, 2017- pro-rated for newer members) of individual or group professional support activities (any combination of supervision and other focused peer interaction)

*Privileges:* Journal and other communications, Membership Directory (listing in and a copy), membership, if desired, in professional e-mail discussion group (Listserv), voting rights, and committee participation; reduced registration fees for MDPAC conferences and courses.

**iii) Clinical CPSO/CPD Member (Ontario Only):**

*Criteria:* Any physician who is licensed to practice medicine by the provincial licensing authority, and practices under the Canadian Medical Association Code of Ethics and practices a minimum of 51% psychotherapy, mental health and/or addictions, and who signs a consent form..

*Maintenance of Competence (MOCOMP):* 25 hours per year or 75 hours every 3 years (e.g. October 1, 2014-September 30, 2017- pro-rated for newer members) of psychotherapy/psychiatry-related continuing education (CE) and minimum 25 hours per year or 75 hours over 3 years (October 1, 2014-September 30, 2017- pro-rated for newer members) of Continuing Collegial Interaction (CCI) individual or group professional support activities (any combination of supervision and other focused peer interaction). Half of these hours must be reported every year i.e.25 hours (any combination of CE/CCI each year).

*Privileges:* Confirmation for Ontario members to the CPSO of educational credits; journal and other communications; Membership Directory (listing in and a copy); membership in professional e-mail discussion group (Listserv), voting rights and committee participation; reduced registration fees for MDPAC conferences and courses.

**iv) Certificant (MDPAC(C)):**

*Criteria:*
A Clinical MDPAC member, who has paid one-time application fee of $250.00

- Qualified clinical member plus 200 hours minimum practice experience ---- Completion of a short essay describing why you choose to practice
- psychotherapy
- Completion of 50 hours of personal growth work* (individual or group) Completion of 100 hours of supervision (individual or peer group/collegial interaction????)
- Two references, one of which should be from a colleague familiar with the
- applicant's psychotherapeutic work
- Attendance at the MDPAC annual conference or equivalent intensive
- psychotherapy conference in 2 of the 4 years prior to application
- Provision of a curriculum vitae
- Satisfaction of the training criteria from one of the categories listed below:

  *(1) formal training* - minimum of 90 hours of MDPAC-approved psychotherapy-related training (with the specified content outlined-see 5.2 Guidelines for the Practice of Psychotherapy by Physicians),
  *(2) practice-eligible training* – 1000 hr of paid professional work as a psychotherapist engaged in scheduled focused psychotherapy. This criterion may be time limited.

*MOCOMP:* 25 hours psychotherapy-related continuing education (CE) per year or 75 hours over 3 years (e.g. October 1, 2014-September 30, 2017, prorated for newer members) and 25 hours per year or 75 hours per 3 years (e.g October 1, 2014-September 30, 2017, prorated for newer members) of individual or group professional support activities (any combination of supervision and other focused peer interaction). It is also required that half of these hours be reported each year i.e. 25 hours, any combination of CE/CCI, each year.

*Privileges:* Journal and other communications; Membership Directory (listing in and a copy), membership in professional e-mail discussion group (Listserv); reduced registration fees for MDPAC conferences and courses; voting and committee participation; confirmation to CPSO of educational credits, if desired, registration with MDPAC as a Certificant; entitled to use MDPAC(C) after name and other degrees.

* **Personal Growth Work:** Personal growth work concerns activities that promote greater self-awareness and understanding of our own psychological make up and issues, as well as how these issues manifest in our lives both personal and professional. We do this for our own self-awareness, self-care and the hope that this will make us more skilful and conscious therapists.

Typically this takes the form of personal therapy, which we strongly encourage, and/or courses that include an experiential element.

### v) Mentor (MDPAC(M)):

Mentors will be expected to:
1) Provide a resource for other members through support, education, consultation, supervision
2) Provide a service to MDPAC through committee work, public relations, public education
3) Be a role model, teacher and catalyst to the growth of other members, to MDPAC, and to psychotherapy
4) Maintain their status as Mentors through their ongoing growth, Continuing Education, and service to their colleagues and organization.

The recognition of individuals who have achieved Mentor Membership provides them an opportunity to apply their experience to the service of their colleagues, their organization and their community – to the mutual benefit of all. MDPAC holds that as maturity in psychotherapeutic practice progresses, the personal qualities and life experiences of the therapist are of equal importance to, and complement, what he or she knows and does as a practitioner. Therefore, applicants for Mentor Membership will be evaluated in the areas of their:
1) character and maturity as a person
2) capacity for compassion and ethical judgement
3) ability to teach and enhance the growth of others, and
4) specific knowledge and skills in medical psychotherapy.

*Criteria:*

- Qualified Certificant who has paid one-time application fee of $250.00.
- Formal comprehensive psychotherapy training in at least one recognized discipline and 2,000 hours minimum psychotherapy experience; or 8,000 hours paid psychotherapy with submission of individual training history
- 100 hours individual supervision with at least two independent supervisors;
- 50 hours of individual or group personal psychotherapy;
- Successful completion of an essay examination and/or possible oral interview as determined by the Mentor Review Subcommittee of the Professional Development Committee;
- Has undertaken MDPAC-approved supervisory training;
- Has submitted two references, one from a colleague familiar with the applicant's psychotherapeutic work, and one from a recent supervisor.

*MOCOMP:*
25 hours psychotherapy-related continuing education (CE) per year or 75 hours over 3 years (e.g. October 1, 2014-September 30, 2017, prorated for newer members) and 25 hours per year or 75 hours per 3 years (e.g. October 1, 2014-September 30, 2017, prorated for newer members) of individual or group professional support activities (any combination of supervision and other focused peer interaction). It is also required that half of these hours be reported each year i.e. 25 hours, any combination of CE/CCI, each year.

*Privileges:*
Journal and other communications; Membership Directory (listing in and a copy), membership in professional e-mail discussion group (Listserv); reduced registration fees for GPPA conferences and courses; voting and committee participation; confirmation to CPSO of educational credits, if desired, registration with MDPAC as a mentor; entitled to use MDPAC(M) after name and other degrees.

**(vi) Mentor Emerita or Emeritus:**

*Criteria:* Mentors who are no longer in active practice, but wish to retain their Mentor status in order to teach or supervise.

*MOCOMP:*
25 hours psychotherapy-related continuing education (CE) per year or 75 hours over 3 years (October 1, 2014-September 30, 2017, prorated for newer members) and 25 hours per year or 75 hours per 3 years (October 1, 2014-September 30, 2017, prorated for newer members) of individual or group professional support activities (any combination of supervision and other focused peer interaction). It is also required that half of these hours be reported each year i.e. 25 hours, any combination of CE/CCI, each year.

*Privileges:*
Journal and other communications; Membership Directory (listing in and a copy), participation in professional e-mail discussion group (Listserv); committee participation and voting rights; reduced registration fees for GPPA conferences and courses; confirmation to CPSO of educational credits, if desired, registration with MDPAC as a mentor, entitlement to use MDPAC (M) after name and other degrees..

**vii) Honorary Member:**

This designation may be granted by the Board of Directors in recognition of exemplary contribution to MDPAC, and is for life. There are no academic or practice requirements, no MOCOMP, and no annual fee. Privileges include the Journal and other communications, a copy of the Membership Directory, but no voting or committee membership, although the Honorary Member may be consulted by the Board or MDPAC committees from time to time. The current Honorary Members are the surviving founder of MDPAC/GPPA Dr. Terry Burrows, as well as Dr. Dianne McGibbon, and Dr. Roy Salole.

**(viii) Student Member**

*Criteria:* Medical student enrolled in one of the Faculties of Medicine in a Canadian University or foreign medical graduates enrolled in a formal pre-residency training program through one of the Canadian Faculties of Medicine. Send details of where enrolled and year of study.

*Privileges:* Journal and other communications, but no voting or committee participation. Reduced registration fees for GPPA conferences and courses.

**(ix) Inactive Member - not working for remuneration in Canada**

**a) <u>Retired</u> –**
*Criteria:* Clinical member, Certificant Member or Mentor, retired from clinical practice.

*Privileges:* Journal and other communications; copy of Membership Directory; membership in professional e-mail discussion group (Listserv); committee participation; reduced registration fees for MDPAC conferences and courses. No voting rights.

b) **<u>Out of Country</u>** –
*Criteria:* Clinical member, Certificant member or Mentor, not practicing in Canada for a 12-month period.

*Privileges:* Journal and other communications, but no voting or committee participation.

c) **<u>Totally Disabled Member</u> or on Leave of Absence**-
*Criteria:* Clinical member, Clinical CPSO/CPD member, Certificant member or Mentor, on full disability (no earned income). Please provide a letter attesting full disability. Leave of absence may be for a variety of reasons during which the member has no earned income. Give start date.

*Privileges:* Journal and other communications; copy of Membership Directory; membership in professional e-mail discussion group (Listserv); committee participation and voting rights; reduced registration fees for GPPA conferences and courses.

(x) **Individual Assessment**
*Criteria:* Clinical member, Clinical CPSO/CPD member, Certificant member or Mentor for whom payment of dues will result in undue financial hardship. Please provide letter with respect to your expected earnings from all sources and expenses for the coming year. (Please note you may be requested to provide additional details.)

*Privileges:* Journal and other communications; listed in and a copy of Membership Directory; membership in professional e-mail discussion group (Listserv); committee participation and voting rights; reduced registration fees for MDPAC conferences and courses.

**Table 1**

# Medical Psychotherapy Association Canada
## CREDENTIALS AND MAINTENANCE OF COMPETENCE

| Category | 1. Clinical Member | 2. Clinical CPSO/CPD | Certificant Member (MDPAC(C)<br><br>One-time application fee | 1.Mentor Member<br>2.Mentor Emeritus<br>( MDPAC(M))<br>One-time application fee |
|---|---|---|---|---|
| **Graduate Criteria** | MD | MD | MD | MD |
| **Post-grad Training** | .Medical school training in psychotherapy (PT) | Medical school training in psychotherapy (PT) | Qualified Clinical Member with 90 hrs minimum MDPAC-approved PT training (including specified topics),<br>or<br>1000 hr paid professional work in scheduled focused PT | Qualified Certificant who has formal comprehensive PT training in at least 1 recognized discipline; or 8,000 hrs paid clinical PT with submission of individual training history; and<br>supervisory training (MDPAC- approved) |
| **Psychotherapy Practice Experience** | | Clinical CPSO-CPD Member practices a minimum of 51% psychotherapy, Mental Health, and/or Addictions | 200 hrs minimum | 2000 hrs minimum |
| **Supervision, Individual or Peer Group Collegial Interaction (CI)** | | | 100 hrs supervision, individual or peer group CI | 100 hrs individual supervision with at least two independent supervisors |
| **Personal Growth Work/Psychotherapy** | | | 50 hrs individual or group<br>personal growth work | 50 hrs personal psychotherapy |
| **MOCOMP – CE** | .PT related CE -12 hrs/yr or<br>36 hrs q 3 yrs minimum | Clinical CPSO-CPD Member-25 hrs/yr or 75 hrs/3 yrs min. | PT related CE - 25 hrs/yr minimum or 75 hrs/3 yrs | PT related CE - 25 hrs/yr minimum or 75 hrs/3 yrs |
| **MOCOMP- CI Ongoing Supervision or Collegial Interaction** | 12 hrs/yr individual or group (any combination of supervision and other focused peer interaction) or 36 hrs/3 yrs | Clinical CPSO-CPD Member-25 hrs/yr or 75 hrs/3 yrs min. | 25 hrs/yr individual or group CI or 75 hrs/3 yrs | 25 hrs/yr individual or group or 75 hrs/3yrs |
| **Reporting** | Clinical - report 12 hrs (any combination CE/CCI) each year | Clinical CPSO-CDP-report 25 hrs (any combination CE/CCI) each year | Report 25 hrs (any combination CE/CCI) each year | 1.,2.Report 25 hrs (any combination CE/CCI) each year |
| **References** | | | One from a colleague familiar with applicant's PT work | 2: One from a colleague familiar with applicant's PT work +<br>one from a recent supervisor |
| **Exams** | LMCC | LMCC | LMCC + short essay about why you chose to practice psychotherapy | LMCC + successful completion of MDPAC-approved supervisory training + essay + possible interview |
| **Ethics** | CMA Code | CMA Code | CMA Code | CMA Code |

## REFERENCES:


American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, American Psychiatric Association, Washington, DC, 1998.

Bailey S. Doctors are aging and harder to find, Globe and Mail, Aug 12, 1999, A8.

Borins M., Morris B. Role of family physicians in psychotherapy and counseling, Canadian Family Physician, Vol. 41, May, 1995, 757.

Burrows T. Towards GPP standards, GP Psychotherapist, Nov.1, 1989, 5-7.

Cameron P, Ennis J, Deadman J. Standards and guidelines for the psychotherapies, University of Toronto Press Inc, Toronto, 1998.

Cassem EH. Depressive disorders in the medically ill, Psychosomatics, Vol. 36, 1995.

Christie-Seely J. Counselling tips, techniques and caveats, Canadian Family Physician, Vol 41: May, 1995, 817-825.

Committee on Physician Sexual Misconduct, College of Physicians and Surgeons of British Columbia. Report of the Committee on Physician Sexual Misconduct: Crossing the Boundaries, Vancouver, 1992.

Complaints Committee, College of Physicians and Surgeons of Ontario, Walker D and Gerace R, Co-Chairs, Annual Committee Report to Council, Members' Dialogue, January/February, 1999, 10.

El- Guebaly N. Thirty-five years of psychiatrist workforce planning: What do we have to show for it? Canadian Psychiatric Association, Bulletin, Vol 31, No 4, Aug, 1999, 101-102.

Graham R (Chairman), The Provincial Community Mental Health Committee. Building community support for people: a plan for mental health in Ontario, Ontario Ministry of Health, July 28, 1988.

Gurman Alan, Messer Stanley. Essential psychotherapies- theory and practice, Guilford Press, 1995.

ICES publication: Briefing Note. Ontario Mental Health Study Group. Mental Health Practices of Ontario Family Physicians: A Study Using Qualitative Methodology, 1996.

Lesage AD, Goering P, Lin E. Family physicians and the mental health care system-report from the Mental Health Supplement to the Ontario Health Survey, Can Fam Physician 1997; 43-251-256.

McCauley RG. Certification V. Continuing Education: A Comment, Canadian Family Physician, Mar, 1973, 15.

McDowell I, Newell C. Measuring Health,Oxford University Press, 1987, 4.

Moriarty, Dick; Chanko, Cathy. Predisposing, Precipitating, Perpetuating, Professional Help, and Prevention Factors of Eating Disorders. 17 Nov, 1988: 32p.; Paper presented at the Annual Meeting of the Bulimia and Anorexia Nervosa Association (3rd, Essex, Ontario, Canada, November 17, 1988).

Nazerali N. Counselling the elderly on decision making for the end of life, Can Fam Phys, May, 1995.

Parikh SV, Lin E, Lesage AD. Mental health treatment in Ontario: selected comparisons between the primary care and specialty sectors, Can J of Psychiatry, Vol 42, No 9, November, 1997, 929-934.

Petrucelli Elizabeth. Chicken soup for the doctor's soul: *unique day in physician health a resounding success,* Ontario Medical Review, February 2001, 29-30.

Richardson Phil. ABC of mental health: psychological treatments, BMJ 1997;315:733-735 (20 September).

Rosser WW. Inaugural address from the President, Ontario College of Family Physicians, Chapter, Vol 11, No 1, Jan, 1999, 4.

Salole R. (Chair), Goodman M., Faris G., Steinhart N., Gabel M. (Ed.). The role of psychotherapy in primary care. Discussion papers on GP psychotherapy prepared for and approved by the GPPA Board of Directors, and Membership (vote 70 to 3), GPPA, 1996.

Silburt D. Why are GPs embracing psychotherapy? Canadian Doctor, May, 1988,1, 5.

Silverstone PH, Lemay T, Elliott J, Hsu V, Starko R. The prevalence of major depressive disorder and low self esteem in medical inpatients, Can J Psychiatry, Vol. 41, Mar, 1996, 67-74.

Stewart M, Brown, JB, Weston WW, McWhinney IR, McWilliam CL, Freeman TR. Patient-centered medicine, transforming the clinical method, Sage Publications Inc., Thousand Oaks, California 91320, 1995.

Task Force on Sexual Abuse of Patients, College of Physicians and Surgeons of Ontario. Final Report of the Task Force on Sexual Abuse of Patients, Toronto, 1991.
Vincent MO. Help stamp out psychiatrists, Canadian Family Physician, March, 1973, 69-71.