RECOGNIZING SINGLE-SESSION THERAPY AS PSYCHOTHERAPY

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Single sessions of therapy have long been established as a legitimate and scientifically supported form of psychotherapy. However, a controversy arose in Ontario when a new regulatory college for psychotherapists began rejecting single-session therapy hours for grandparenting applicants attempting to become registered psychotherapists. This article details this controversy, the responses to the controversy, and the eventual recommendation of an independent appeal board in 2019 to accept single-session therapy hours as psychotherapy. This article also provides and expands on the arguments that persuaded the appeal board in its decision. The authors hope that making these arguments available will assist in possible future challenges to single-session therapy being recognized as psychotherapy.

Keywords: single-session therapy, psychotherapy, therapeutic relationship

Is single-session therapy psychotherapy? There has been controversy in the Province of Ontario regarding the acceptance of single-session therapy (SST) as psychotherapy. Our purpose in writing this article is to provide support and clarity for SST as psychotherapy. As this was questioned recently in Ontario, it is possible that the biases that are at the root of this questioning will continue to resurface in other ways and in other places around the world. It is our hope that this article might provide a credible reference for those who are searching for support for the legitimacy of SST as psychotherapy. Before describing the controversy, we will define SST and show its importance in delivering psychotherapy.
WHAT IS SINGLE-SESSION THERAPY?

Therapists have sometimes seen clients for one visit of successful therapy since the time of Freud (Bloom, 1981, 1992; Hoyt, Bobele, Slive, Young, & Talmon, 2018; Sproel, 1975). Both history and current practices illustrate that rapid change is not only possible, but also common (Bobele & Slive, 2014; Budman & Gurman, 1988). Despite traditional theoretical biases that attempt to dominate the field of psychotherapy, evidence shows that there is no established direct correlation between the severity and duration of a problem and the duration of effective treatment (Hoyt et al., 2018; Hoyt, Rosenbaum, & Talmon, 1992; Talmon, 1990). Current research does not support past taken-for-granted thinking that success should be equated with the length of therapy rather than the quality of therapy (Hoyt & Talmon, 2018; Duvall, Young, & Kayes-Burden, 2012; Slive & Bobele, 2011).

Hoyt and Talmon (2018) asked us to consider: “How is it that change can occur in one session? How can it occur in any number of sessions?” (p. 4). SST is an approach that the therapist, and perhaps the client, expects, from the beginning, to comprise a single visit. The therapist acts as if the first session is both the first and could be the last, making the most of the session in terms of therapeutic impact.

The specific therapeutic approach used in SST may vary and could include such methods as solution-focused, narrative, cognitive-behavioral, motivational interviewing, and other therapies (Hoyt & Talmon, 2018; K. Young, Dick, Herring, & Lee, 2008). These are all recognized as systemic and collaborative psychotherapy approaches by the College of Registered Psychotherapists of Ontario (CRPO, 2018). SST and brief therapy cannot be distinguished by the specific therapeutic approach, as the duration of therapy norms vary and include single sessions across all approaches (Budman & Gurman, 1988; Hoyt & Talmon, 2018). The mindset shared across approaches when applied to SST is the expectation that some kind of beneficial change (in thinking, feeling, action) is possible in SST. The conversation is competency-focused, where the therapist and client together discover knowledge, abilities, skills, values, and commitments that the client has but may not initially be in touch with, and when noticed, described, and expanded upon create the possibility for change.

SST therapists are trained to create an optimal environment for therapeutic change (K. Young, Hibel, Tartar, & Fernandez, 2017) in each session through high degrees of collaboration and by maintaining a competency focus (Duvall et al., 2012). SST therapists facilitate sessions through the use of established therapeutic models. They then take responsibility for creating a partnership with the client that is aimed at the session creating movement from the clients’ current known and familiar concepts and actions to what is possible for them to know in new territories of knowledge and possible actions (White, 2007). SST therapists take time to review the process and the progress toward goals for the session, staying focused on the purpose of the session. As the session moves toward an end, therapists highlight movement toward identified goals and how clients can take
new realizations forward in their lives, therefore ending the session in a way that identifies progress and supports post-session change sustaining.

SST can be delivered by quick access to an appointment or by walking in with no appointment, in person or by telephone or virtual platforms. Recognizing the change potential of SST is crucial in today’s world; many people are able to benefit from quick access to a therapy session that is affordable, comes at a time that is meaningful to the client, and reduces barriers to getting help. For many people SST will be enough (Talmon, 1990), leaving more intensive longer-term resources available for those who want or need more.

Increasing accessibility and affordability of therapy is a social justice issue. Hoyt and Talmon (2018) wrote:

Recognizing the potential of single-session therapy is especially important nowadays as so many more people would benefit from mental-health services if they were affordable and did not carry the daunting stigma of seemingly endless dependency. Resources are limited, and SST has a valuable ecological function: it preserves time and money. More is not better; better is better (Hoyt, 1995, p. 327)—and better can sometimes be achieved here and now, even in one visit. (pp. 7–8)

In Ontario, now and constantly growing since 2000, there are more quick access services to SST than anywhere else in the world. Currently there are about 80 organizations operating walk-in therapy clinics in Ontario (for a list of walk-in therapy clinics in Ontario, see www.windzinstitute.com). The provincial government, through the Ministry of Child and Youth Services, mandated in 2016 that all children’s mental health organizations in Ontario offer quick access to SST through service delivery mechanisms such as walk-in clinics. This shift in mandate was precipitated by the government’s request for a policy paper on brief therapy. The request for a policy paper was made mainly because of lengthy waiting lists for services, often resulting in children, youth, and families waiting up to 3 years for service.

In a recent policy paper, Duvall, Young, and Kayes-Burden (2012) provided evidence and recommendations for the implementation of services that offer quick access to a single session of therapy to children, youth, and families in Ontario. This policy paper and the shift in policy it supported also sparked other funders and organizations to implement walk-in clinics. Walk-in therapy clinics are now operated by children’s mental health centers, adult mental health services, family health teams, universities, colleges, and Indigenous services. Statistics from SST services across Ontario demonstrate that the average percentage of clients that decide after one session that they received all the help they needed is about 50% (Duvall et al., 2014; Hymmen, Stalker, & Cait, 2013; Slive & Bobele, 2011; K. Young, 2018; J. Young & Rycroft, 2012; J. Young, Rycroft, & Weir, 2014). This means that many thousands of clients who would have in the past waited for help on long waiting lists, now received help that they considered enough, and when they needed it. The presence of walk-in therapy clinics in Ontario has made therapy available and accessible when people need therapy.
With this background, we now describe a controversy in Ontario regarding a refusal to recognize SST as psychotherapy by Ontario’s regulatory body for psychotherapists.

WHAT SPARKED THE CONTROVERSY?

On April 1, 2015, the Psychotherapy Act was proclaimed and, along with it, the College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario (CRPO) was created (prior to April 1, 2015, a transitional council of the CRPO was in operation for many years). Also on April 1, 2015, the Registration Regulation under the Psychotherapy Act came into force. Unless an individual was approved to practice psychotherapy by another college,1 anyone using the title “psychotherapist” must have registered with the CRPO on or before December 31, 2019.

The Registration Regulation established a 2-year period for qualified applicants to be registered by being grandparented. Thus, until March 31, 2017, there were two general routes of admission to the CRPO: the grandparenting route and the regular route.

The CRPO developed guidelines to be applied in determining whether the requirements for grandparenting were met for a given application. Those requirements included a minimum of 800 direct client contact (DCC) hours within the scope of practice of psychotherapy. When an application for registration was submitted, if the registrar and/or senior staff had doubts, on reasonable grounds, about whether an applicant fulfilled the registration requirements, then the application was referred to a panel of the Registration Committee of the CRPO. If the Registration Committee panel directed the registrar to refuse to issue a certificate of registration, then the panel was required to give notice of, and written reasons for, its order (see section 20(1) of the Health Professions Procedural Code). Upon receiving the Registration Committee panel decision, an applicant had 30 days to appeal the decision to the Health Professions Appeal and Review Board (HPARB), an independent administrative tribunal.

In and around 2016, a controversy arose when the CRPO began refusing grandparenting applications on the basis that an applicant’s SST hours did not count towards fulfilling the grandparenting requirements. Specifically, the CRPO was taking the position that the 800 DCC hours requirement for grandparenting could not be satisfied with SST.

1Members of the following five colleges in Ontario who are authorized to perform the controlled act of psychotherapy may practice psychotherapy and use the title psychotherapist in accordance with the colleges’ governing laws without registering with the CRPO: College of Psychologists of Ontario, Ontario College of Social Workers and Social Service Workers, College of Nurses of Ontario, College of Occupational Therapists of Ontario, and College of Physicians and Surgeons of Ontario.
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APPEALS OF CRPO DECISIONS

In response, some applicants challenged the CRPO’s position that SST is not psychotherapy by appealing CRPO’s decisions to HPARB. The first reported decision of HPARB that involved an appeal of the CRPO’s refusal to count SST hours towards the DCC hours requirement is *S.C.W. v. College of Registered Psychotherapists of Ontario*. In that case, the CRPO Registration Committee did not accept the applicant’s SST hours towards the DCC requirement because of its view that those hours did not fall within the scope of practice of psychotherapy. The CRPO’s view was that a therapeutic relationship could develop and evolve only over time and, thus, could not develop through single sessions of therapy. The CRPO’s position was that SST was counseling, designed for crisis intervention or de-escalation, not psychotherapy (see paragraphs 23 to 26 of the *S.C.W* decision). After a written review, HPARB confirmed the order of the CRPO Registration Committee refusing a certificate of registration.

In the *S.C.W* decision, the CRPO submitted one expert opinion into evidence. This expert’s opinion was that an applicant “who has practiced only a single-session model could not demonstrate the many key competencies articulated in the College’s profile of competencies required to safely practice psychotherapy” (see paragraph 52 of the *S.C.W* decision). It is important to note that this was the only expert evidence submitted in the *S.C.W* case. HPARB, like other administrative tribunals and the courts, bases its decisions on the evidence presented. Based on the only uncontradicted expert evidence before it, HPARB accepted that “a practice based on a single session model will qualitatively affect the breadth and nature of professional competencies employed in the therapeutic relationship” (see paragraph 53 of the *S.C.W* decision).

The CRPO relied on the *S.C.W* decision in a subsequent case before HPARB to submit that HPARB has accepted the Registration Committee’s conclusion that an applicant’s SST hours were insufficient for grandparenting purposes (see paragraph 27 of *B.S. v. College of Registered Psychotherapists of Ontario*).

In another case, *N.H. v. Ontario*, HPARB was again confronted with the issue of whether SST constituted psychotherapy. The CRPO Registration Committee took similar positions in *N.H.* as it did in the *S.C.W* case. The Registration Committee found that “ongoing psychotherapy gives clients time to build trust with the therapist and create a safe space in which to explore issues on a deeper level before seeking to address the root causes.” It noted that “a relationship of this nature develops and evolves over time—usually weeks, months or even years.” The Registration Committee concluded that “a therapist cannot develop a well-rounded competence if most of their client work is single-session with occasional, limited follow-up” (see paragraph 25 of the *N.H.* decision). The CRPO again submitted the same expert opinion to support the Registration Committee’s decision, and this was the only expert opinion before HPARB. HPARB confirmed the order of the CRPO Registration Committee refusing a certificate of registration.
In summary, the CRPO’s position from 2016 to 2019 was that SST was not psychotherapy and therefore any hours of SST could not be used towards satisfying the requirements of DCC hours in the grandparenting route to admission. It also appeared from these early decisions that HPARB agreed with the CRPO. In the remainder of this article, we intend to demonstrate that the CRPO’s position that SST is not psychotherapy is not supportable. We first start with a detailed review of the literature regarding SST, its effectiveness as psychotherapy, and its importance in Ontario. We then examine a 2019 decision of HPARB that accepts many of the arguments in this article to conclude that SST can be psychotherapy.

IS SINGLE-SESSION THERAPY PSYCHOTHERAPY?

A single session is the most common number of sessions in psychotherapy (Talmon, 1990). Many clients will attend only one session whether that is planned or not. Substantial improvements in the earliest stages of therapy (the first six to eight) are followed by ever-decreasing improvements as therapy continues (Baldwin, Berkeljon, & Atkins, 2009; Feaster, Newman, & Rice, 2003; Harnett, O’Donovan, & Lambert, 2010; Wolgast Puschner, & Lambert, 2008). SST is utilized widely in many of the existing advanced methods of psychotherapy, is evidenced-based, and is supported by international research with replicated positive outcomes (Hoyt et al., 2018; Slive & Bobele, 2011; Miller, Duncan, & Johnson, 2000). In addition to the book by Moshe Talmon (1990), which has been translated into many languages, two other works with extensive research reviews and numerous case examples are Hoyt and Talmon (2014) and Hoyt, Bobele, Slive, Young, and Talmon (2018). Two more comprehensive references are Slive and Bobele (2011) and Dryden (2018).

Psychotherapy is neither long nor short; to view it as such sets up a false dichotomy (Rosenbaum, 2008). Psychotherapy depends on moments that are “therapeutic” where something profound or meaningful shifts for a client. This can happen in one or in more than one session. It is not about length; it is about quality and creating impactful moments in the conversation.

The position that single-session therapy is not psychotherapy is very hard to defend in light of the literature. It seems an impossible task to attempt to define how many sessions would constitute psychotherapy.

Evidence for the Effectiveness of Single-Session Therapy as Psychotherapy

Both research and experience show that change can and often does occur in one session. In an extensive evaluation study of multiple walk-in therapy clinics in Ontario in 2014 (Hoyt et al., 2018; K. Young & Bhanot-Malhotra, 2014) there was strong evidence for the effectiveness of SST. The data from 494 client measures indicated that a significant amount of change can occur after SST and that these
effects can be maintained after 3 months. Statistically significant shifts occurred in all measured dimensions after a single session and at 3-month follow-up. The clients studied in this evaluation had a wide variety of presenting problems including anxiety, depression, and family conflict.

Ramey, Young, and Tarulli (2010) analyzed single sessions of narrative therapy using observational coding to demonstrate both the presence of narrative therapy practices, in particular scaffolding maps (White, 2007), and that change, or concept development, occurred in single sessions. The research demonstrated that in single sessions of therapy children and youth experienced the development of new concept formation, and therefore that change happened in these single sessions. New understandings, realizations, and concept development are crucial elements for change in psychotherapy, as psychotherapy is intended to be insight oriented. K. Young, Hibel, Tartar, and Fernandez (2017) reviewed new research in the area of neuroscience and SST that demonstrated powerful neurobiological effects of brief narrative therapy delivered in single sessions.

Recently there has been an extensive review of the available research on the effectiveness of SST (Hoyt et al., 2018). Hoyt and Talmon (2014) provided an appendix with an extensive annotated bibliography that offers many examples of research on SST. Some of the highlights of this summary of research include:

- Brief therapy reduces medical utilization because of decreased emotional stress.
- Significant improvements for patients diagnosed with neurosis after SST are reported.
- 78 to 88% of patients in studies reported continuing benefits and much improvement after SST.
- Single sessions could significantly reduce alcohol and drug abuse and self-harm (cutting and overdoses).
- Single sessions yielded positive results in studies involving people struggling with anxiety and PTSD.
- Walk-in clients improved faster and were less distressed than the clients who were served at a clinic where clients were seen in multiple sessions by appointment after being on a waitlist.

Single-Session Therapy and the Therapeutic Relationship

In SST the therapeutic relationship is considered essential and represents a strong predictor of positive therapeutic outcome (Lambert, 1992; Lambert & Bergin, 1994). Talmon recently wrote: “The essence of any psychotherapy is the same as that of SST. It is based on the abilities of the therapist and patient to create a therapeutic alliance in the here-and-now of each therapeutic encounter” (as quoted in Hoyt et al., 2018, p. 149). Training in SST includes how to enter into a therapeutic relationship with clients from the moment the session starts and to maintain this meaningful connection throughout the session. SST teaches therapists how to “do” relation-
ships through positioning as a caring, warm, nonjudgmental, respectful, and curious listener; becoming a facilitator of the client’s knowledge and abilities; and being curious about multiple viewpoints in ways that can reconstruct beliefs and narratives that deeply affect people’s lives.

The therapeutic relationship is not a thing; it is a practice. It is how we are that shapes the therapeutic relationship we create with people in each session, including in SST. The CRPO (n.d.) on its website states that psychotherapy is delivered “through a therapeutic relationship.” No time factor is specified in this definition. The literature does not support the idea that a relationship can occur only over time. A therapeutic relationship is an experience of relationship that occurs because of how the therapist connects with the client during the therapeutic encounter, however long or short. For example, in this special section, Fullen (2019) provides research analysis of how a therapeutic relationship develops in a one-hour single session. How would anyone determine that a longer episode of therapy actually produced a therapeutic alliance?

In Ontario, there is a growing body of evidence supporting the validity of SST and evidence of the establishment of an adequate therapeutic relationship. In an extensive evaluation study of multiple walk-in clinics (K. Young & Bhanot-Malhotra, 2014), the Session Rating Scale (SRS) was administered after walk-in sessions. The SRS (Miller et al., 2000) is an internationally recognized measure with high degrees of validity and reliability. It measures four dimensions of therapeutic alliance: a relational bond between the therapist and client, agreement on the goals of therapy, agreement on the tasks of therapy, and overall client perceptions of the session. Each scale has a range of values from 0 to 10, which are summed to compute the overall SRS score, with a maximum score of 40 indicating high therapeutic alliance.

In the K. Young and Bhanot-Malhotra (2014) study a sample of 344 clients completed the SRS; the average score was 35.14 (out of a maximum score of 40). Approximately 20% of the clients reported a score of 40. The average scores on the individual scales were: 8.98 (relational bond between the therapist and client), 8.67/10 (agreement on the goals of therapy), 8.89/10 (agreement on the tasks of therapy), and 8.59/10 (overall client perceptions of the session). Overall, these findings suggest that it is possible to have a high level of therapeutic alliance and a strong therapeutic relationship during SST.

Many organizations utilize the SRS to gather reliable information about therapeutic relationship in SST. In a recent evaluation of SST at a child and family treatment agency north of Toronto, the average score across the subscales of the SRS measuring therapeutic relationship was 9.7 out of 10 (Point in Time Centre for Children, Youth & Parents, 2017). These scales ask clients to report on the extent to which they felt heard, understood, and respected, worked on things that were important to them, and felt the approach was a good fit and that the overall session was right for them.

In a recent evaluation, the Houston-Galveston Institute in Texas found that the average SRS score in its SST is 35.4 out of 40, compared to the average score in its regular longer-term program of 36 (Levin, Gil-Wilkerson, & Rapini De Yatim,
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2018). This clearly shows that there was no significant difference in the quality of the therapeutic relationship between SST and long-term therapy.

K. Young and Cooper (2008) analyzed transcripts of feedback from clients who attended SST and then reviewed the recordings of the sessions with researchers. Clients thereby offered moment-to-moment feedback about what was important and meaningful in the single sessions of therapy. One of the consistent themes from clients was described as the “effects of the therapist posture” on the clients and the session. Clients described feeling accepted by the therapist, feeling trust for the therapist, and having a sense of being at the same level as the therapist—an equal, experiencing being listened to and being reassured, with the therapist was not just making assumptions but actively listening.

Single-Session Therapy Is Not Just for the Easy Clients

Psychotherapy is defined by the CRPO (2018) as “primarily a talk-based therapy intended to help individuals improve their mental health and well-being. Psychotherapy occurs when the Registered Psychotherapist and client enter into a psychotherapeutic relationship where both work together to bring about positive change in the client’s thinking, feeling, behaviour and social functioning” (p. 4).

The CRPO also states that “individuals usually seek psychotherapy when they have thoughts, feelings, moods and behaviours that are adversely affecting their day-to-day lives, relationships and the ability to enjoy life” (p. 4). A study completed by Yorktown Child and Family Centre and Sick Children’s Hospital (Barwick et al., 2013, described below) clearly demonstrated that clients came to SST with mental health problems that were significantly and adversely affecting their lives.

In the study (Barwick et al., 2013) the outcomes of clients who accessed treatment as usual (intake, assessment, and longer-term therapy) and SST at the walk-in therapy clinic were compared. The types of problems that the clients brought to “intake as usual” versus the walk-in clinic were also compared. It was found that the level of mental health functioning (determined by the clients completing a recognized standardized assessment tool) of the clients attending the walk-in clinic was “more impaired” than those attending the regular route. This is evidence that clients who attended SST delivery mechanisms were experiencing “serious disorders of thought, cognition, mood, emotional regulation, perception, or memory; and that the client’s disorder may seriously impair . . . functioning” (CRPO, 2018, p. 11).

Furthermore, the outcomes from this research showed that the walk-in clients had significantly greater rates of improvement in a number of areas of functioning (areas measured by the standardized assessment tool such as behavior, mood, thought), and that the clients sustained that improvement at a 3-month post assessment. This research contradicts opinions that SST is mere counseling and not psychotherapy both in terms of the complex presenting mental health issues brought to SST and the strength and duration of the outcomes. This is important because in Ontario the CRPO (2018) distinguishes between counseling and psychotherapy.
Further to this, research on change during the course of treatment (Duncan & Miller, 2000; Lambert, 1992) has found that changes are most likely to occur earlier in the course of treatment (usually anywhere from one session to three sessions, maximum of six). Again, in these studies the clients were not just the “easy clients,” and significant change was demonstrated after as few sessions as one.

There are numerous case examples of SST being successfully used with clients experiencing what are typically seen as very challenging struggles, such as clients experiencing the effects of trauma, poverty and marginalization, victimization from crime, and other crises (Hoyt & Talmon, 2014; Hoyt et al., 2018).

In the above sections we have established that both a therapeutic relationship and positive change can occur in SST as evidenced in the literature and research. The scientific support for recognizing SST as psychotherapy is overwhelming. The issue, until recently, was CRPO’s refusal to recognize SST as psychotherapy, and HPARB’s approval of that position in its earlier decisions, as described above.

A Shift Towards Recognizing SST as Psychotherapy

Fortunately, more recently, HPARB has accepted that SST can be psychotherapy. The most recent HPARB decision addressing the issue of whether SST is psychotherapy is *S.H.C. v. College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario*, released on May 13, 2019. The authors of the present article were directly involved in the *S.H.C.* case. Joseph Jebreen acted as S.H.C.’s lawyer, and Karen Young was retained to provide an expert opinion.

In this case the CRPO again refused to accept any of the single-session hours submitted by the applicant in her grandparenting application because, in its opinion, those hours did not fall within the scope of practice of psychotherapy. The CRPO once again supported its position with the same expert opinion. However, in this case, the applicant presented the expert opinion evidence of Karen Young in support of the position that SST is psychotherapy. Karen relied on many of the same opinions, references, and arguments that are discussed here.

Based on the evidence before it, HPARB made several significant key findings:

1. Ms. Young’s testimony and her written report, in which she cites a considerable amount of peer-reviewed literature, support that SST can be a legitimate and effective form of psychotherapy (see paragraph 115 of the *S.H.C.* decision).
2. The legislated definition of the practice of psychotherapy does not preclude SST with the client and it does not require the establishment of a long-term therapeutic relationship with a client for it to fall within the scope of the practice of psychotherapy (see paragraph 117 of the *S.H.C.* decision).
3. The uncontested evidence before the Board was that psychotherapeutic means, such as solution-focused, narrative, cognitive-behavioral, motivational interviewing, and other therapies can be used in SST to assess and treat cognitive, emotional, or behavioral disturbances (see paragraph 118 of the *S.H.C.* decision).
4. The Board prefers the opinion provided by Ms. Young given her more robust experience with SST together with the peer-reviewed literature provided that a therapist can establish a therapeutic relationship in brief sessions such as SST (see paragraph 118 of the S.H.C. decision).

5. The Board accepts Ms. Young’s opinion that the presence of the actions described in the CRPO’s Self-Assessment Tool for Unregulated Practitioners is what should guide the determination that a therapeutic relationship falls within the scope of the practice of psychotherapy. The Board does not accept that the presence of a more time-consuming process of collaborative exploration, as proposed by the CRPO’s expert, should guide the determination (see paragraph 118 of the S.H.C. decision).

HPARB concluded that SST can meet the definition of the practice of psychotherapy under section 3 of the Psychotherapy Act. HPARB further concluded that many of the applicant’s single-session hours in fact met the requirements of section 3 of the Psychotherapy Act and that they should be counted as DCC hours. Finally, HPARB accepted that, considering all of S.H.C.’s application, she acquired the breadth and scope of competency to practice psychotherapy.

HPARB ordered that the matter be returned to the CRPO Registration Committee for reconsideration with its recommendation to issue a certificate of registration to S.H.C. as she has met all the requirements for registration. The authors can confirm that the CRPO did not appeal HPARB’s decision and that the CRPO issued a certificate of registration to S.H.C with the “Registered Psychotherapist” designation.

CONCLUSION

In Ontario there are approximately 80 walk-in therapy clinics, and walk-in clinics are also a growing method of SST service delivery internationally. SST is and will continue to be a leading-edge evolution in the world of psychotherapy, as it ought to be, given its contribution to quick access to therapy for so many people.

Although the grandparenting route in Ontario ended on March 31, 2017, the issue of recognition of SST as psychotherapy may resurface, as CRPO members are required to renew their registrations and may be required to provide proof of currency hours. We hope that HPARB’s clear findings in 2019 that SST can be psychotherapy and CRPO’s choice not to appeal the S.H.C. decision is a sign that SST will be accepted as psychotherapy within Ontario’s regulatory context. This shift would bring the CRPO into line with the actual delivery of psychotherapy in Ontario.

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