

Professional Practice & Jurisprudence

for Registered Psychotherapists

September 2017

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OVERVIEW

The purpose of this handbook is to provide information on the ethical and legal framework within which Registered Psychotherapists (RPs) practise in Ontario.

There are three main sections to this document. Section 1 discusses professionalism and self-regulation and how these concepts apply to therapists. It explains the regulatory framework that governs self-regulated health professions in Ontario, including setting out the role of the regulatory college. Section 2 looks at client-therapist relationships; how open communication with clients and colleagues is fundamental to professional practice; and how this fits within the self-regulatory framework. The third and final section reviews the various laws that RPs are most likely to deal with in their practices.

GLOSSARY OF TERMS AND ABBREVIATIONS

In this document a number of Acts are referred to by their abbreviations, including the following:

- AODA - Accessibility for Ontarians with Disabilities Act, 2005
- CFSA - Child and Family Services Act, 1990
- HCCA - Health Care Consent Act, 1996
- MHA – Mental Health Act, 1990
- PHIPA – Personal Health Information Protection Act, 2004
- PIPEDA – Personal Information Protection and Electronic Documents Act, 2000
- RHPA – Regulated Health Professions Act, 1991

Other abbreviations include the following:

- CAS – Children’s Aid Society
- CCB – Consent and Capacity Board
- CTO – Community Treatment Orders
- HPARB – Health Professions Appeal and Review Board
- HPRAC – Health Professions Regulatory Advisory Council
- ICRC – Inquiries, Complaints and Reports Committee
- QA Program - Quality Assurance Program
- RP – Registered Psychotherapist
- SDM – Substitute Decision-Maker.

SECTION 1: PROFESSIONALISM AND SELF-REGULATION

A. THE CONCEPT OF SELF-REGULATION

Registered Psychotherapists (RPs) are Members of a self-regulated profession and as such have special duties and responsibilities to the clients they serve, to their coworkers and to their regulatory college, which is the College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario (the College), also known as the College of Registered Psychotherapists of Ontario. RPs are also subject to a number of laws and regulations. As part of the self-regulatory framework, the College sets out by-laws which apply to its Members and a code of ethics to provide guidance. Members also work within a scope of practice and must follow specific standards of practice.

In Ontario, many health professions are self-regulated under statute. In other jurisdictions, similar professions may be regulated directly by government or through general consumer protection laws. Ontario's regulatory model serves as the basis for professional regulation in several other jurisdictions, and is seen by many as a model of choice.

I. The Self-Regulatory Framework

Self-regulation under statute is a relatively new concept for psychotherapists in Ontario. RPs will be regulated under the *Regulated Health Professions Act (RHPA)* and the *Psychotherapy Act* when the latter comes fully into force. The *Psychotherapy Act* is the profession-specific statute for the College and is integrated with the *RHPA*. Together, the two Acts provide the regulatory framework for the practice of psychotherapy in Ontario, and may be treated as one Act.

The *RHPA* provides a framework for self-regulation for all regulated health professions in Ontario. This statute helps to protect the public from harm that could arise in interactions between patients (or clients) and regulated health professionals, by ensuring that health professionals meet certain standards of practice and competence.

The *RHPA* defines how regulated health professionals enter their profession and also establishes a framework to support continuing professional development and competence. It sets limits on the activities regulated health professionals can engage in, and on who may hold themselves out as such. For example, the *RHPA* protects the use of the titles, *Psychotherapist*, *Registered Psychotherapist (RP)* and *Registered Mental Health Therapist (RMHT)*; individuals who are not members of this College may not hold themselves out as an RP or RMHT. Members of five other regulated professions may use the title "psychotherapist" along with their regulated title. They are: social workers and social service workers, psychologists, occupational therapists, nurses, and physicians.

II. The Role of the College

The *RHPA* authorizes the creation of a number of regulatory colleges to regulate various health professions. These colleges are regulatory bodies, not educational institutions. A college's mandate is to protect the public interest and not the interests of the profession (e.g. a college cannot set fees charged to clients. Nor can it advocate to government on behalf of the interests of the profession). Professional self-interest activities are the role of professional associations, not the regulatory college.

A college also has a number of roles (or objects) which it carries out to further its mandate. These include developing standards of qualification for entry-to-practice, standards of knowledge, requirements for ongoing professional development and standards for professional ethics.

A college also has a role in the discipline of its members. It may take disciplinary action against a member for reasons of professional misconduct or incompetence. It may also investigate and intervene where a member demonstrates incapacity; i.e. a mental or physical condition or disorder that may impair the member's ability to practise safely and effectively.

Under the *RHPA*, there are a number of statutory committees that each college must establish to carry out these roles. They are:

- Executive Committee
- Registration Committee
- Inquiries, Complaints and Reports Committee (ICRC)
- Discipline Committee
- Fitness to Practise Committee
- Quality Assurance Committee
- Patient Relations Committee (or Client Relations Committee)

There are a number of safeguards, set out in the *RHPA*, which ensure that a college serves the public interest, including the following:

- Each college has a Council, similar to a board of directors of a corporation, which governs the activities of the college and its members. Public members are appointed to Council by the government and may also serve on college committees. Generally, public members are not members of the profession. For example, in this College, an RP could not become a public member, but could run for election to a position on Council (if eligible).
- Council meetings and discipline hearings are open to the public. Anyone may attend and watch the proceedings.
- The college must consult with members of the profession and the public before establishing a regulation or by-law.
- Decisions of college committees may be reviewed by other statutory bodies. For example, decisions of the Registration Committee or the ICRC may be appealed to the Health Professions Appeal and Review Board (HPRAC). Decisions of the Discipline Committee or the Fitness to Practise Committee may be appealed to Divisional Court.
- The government has appointed two bodies to ensure that regulatory colleges act in the public interest. The Office of the Fairness Commissioner makes sure that registration practices are transparent, objective, impartial and fair. In addition, the Minister of Health and Long-Term Care may refer concerns about a college's regulations or programs to the Health Professions Regulatory Advisory Council (HPRAC) for review.
- Colleges are accountable to the Minister of Health and Long-Term Care. They must report annually to the Minister, and provide additional reports to the Minister if requested. The Minister may make recommendations or even issue directives to the Council of the college. If there are serious concerns, the Minister may audit the operations of the college, and has the power to appoint a supervisor to take over its administration.

These safeguards help ensure that all health regulatory colleges serve the public interest in a fair and open manner.

The *RHPA* also sets out a number of controlled acts that members of approved professions may carry out. Members of this College will be authorized to perform one controlled act, the controlled act of psychotherapy, once it is proclaimed into force. The proposed controlled act of psychotherapy is worded as follows:

to treat, by means of psychotherapy technique delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgment, insight, behaviour, communication or social functioning.

Regulatory colleges work with each other to develop standards relating to the performance of controlled acts common to several health professions. In the case of psychotherapy, five other regulated professions will be authorized to perform the controlled act, once it is legally in force. They are: psychologists/psychological associates, physicians, nurses, occupational therapists and social workers/social service workers.

Interprofessional Collaboration is a key value set out in the *RHPA*. This College promotes interprofessional collaboration among its own Members and with other health regulatory colleges, and encourages collaboration among the members of the various regulated health professions. It also promotes and enhances relations among key stakeholders and the public.

It is important that RPs are familiar with the College, its committees and any standards developed by the College.

III. The Role of the College Council

Each college has a Council, similar to a board of directors of a corporation, which governs the activities of the college and its members. Council members have a duty of loyalty and good faith to the mandate of the organization, which is to protect the public interest. The majority of Council members are elected by the profession, while a sizeable minority consists of public members appointed by the government. Professional and public members work together to ensure that the views of clients and the public are represented in the regulatory process.

For each college, the Council establishes the policies and processes of the college. For example, it develops the Professional Misconduct Regulation, oversees administration of regulatory activities of the college and establishes the budget of the quality assurance (QA) program, among other responsibilities.

Given the public interest mandate of the college, a Council member's only constituency is the public as a whole. When making decisions, Council members must keep in mind that they do not represent the members who voted for them, nor any particular regional or professional interest; their duty is to serve and protect the broader public interest.

Sample Question

Which sentence best describes the role of the college versus the role of a professional association?

- i. The college serves the public interest and professional associations serve the interests of the profession.
- ii. The college and professional associations both serve the public interest.
- iii. The college and professional associations both serve the interests of the profession.
- iv. The professional associations direct the operations of the college.

The best answer is i. The college's mandate is to regulate the profession in order to serve and protect the public.

Answer ii is not the best answer because professional associations are designed to serve the interests of their members. While professional associations care about the public interest and often take actions that assist the public interest, they are under no statutory duty to do so and are accountable only to their members.

Answer iii is not the best answer because the college is not permitted to serve the interests of its Members under its statute. While the college tries to ensure that it regulates its Members fairly and justly, and consults with its Members, the college's mandate is to protect the public interest.

Answer iv is not correct. While the college may consult with professional associations and consider their views, it is not under the control of any professional association.

B. ETHICS, PROFESSIONAL STANDARDS, PROFESSIONAL MISCONDUCT, INCOMPETENCE & INCAPACITY

An important part of the college's role is developing professional practice standards, and supporting its Members in adhering to those standards, mainly through education, continuing professional development and Members' participation in the quality assurance program (QA program).

The college may also take action when concerns arise about a Member's professional conduct, incompetence or incapacity – particularly, when a Member fails to address the concern through other means. Professional conduct, incompetence and incapacity are important concepts, described in greater detail below.

I. Code of Ethics

In addition to developing regulations and professional practice standards, the college is authorized under its statute to develop a code of ethics for its Members. The college's Code of Ethics takes precedence over any other code of ethics, such as one developed by a professional association.

The college's Code of Ethics sets out certain principles of professional practice – ideals that Members should aspire to in their professional practice and community roles. These principles differ from practice standards included in the Professional Misconduct Regulation and those developed by the college based on generally accepted standards of the profession. Practice standards can be thought of as the minimum standard of professional practice expected of all Members, whereas the principles included in the Code of Ethics are ideals that Members should strive to uphold.

Code of Ethics

As a Member of the College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario, I strive to practise safely, effectively and ethically, and to uphold the following principles:

Autonomy & Dignity of All Persons

To respect diversity, and the dignity and rights of all persons; to reject all forms of harassment and abuse; and to maintain appropriate therapeutic boundaries at all times.

Excellence in Professional Practice

To work in the best interests of clients; to work within my abilities and competencies; and to pursue personal and professional growth throughout my career.

Integrity

To openly inform clients about options, potential risks and benefits of professional services; to recognize and strive to challenge my own professional and personal biases; and to consult on ethical dilemmas.

Justice

To stand against oppression and discrimination, and strive to support justice and fairness in my professional and personal dealings.

Responsible Citizenship

To participate in my community as a responsible citizen, always mindful of my role as a trusted professional; and to consult on potential conflicts-of-interest and other personal-professional challenges.

Responsible Research

To conduct only such research as potentially benefits society, and to do so safely, ethically and with the informed consent of all participants.

Support for Colleagues

To respect colleagues, co-workers, students, and members of other disciplines; to supervise responsibly; to work collaboratively; and to inspire others to excellence.

Ethics Scenario

Ethan, who is an RP, is finding that his personal life is becoming overwhelming. He lives on a large suburban lot, with a large garden which is expensive and time consuming to maintain. Ethan is in debt and therefore works long hours to try to catch up.

A client of Ethan's is an underemployed gardener. The client is unable to pay Ethan. Ethan decides to barter his psychotherapy services (one hour a week) for six hours a week of gardening services by the client.

Ethan consults with his clinical supervisor who raises concerns about Ethan's plan for a number of reasons.

- *It creates a dual relationship with the client;*
- *it discloses details about Ethan's personal life; and*
- *it demeans the client's services (six hours are required to match one hour of Ethan's services).*

Ethan decides to hire someone else.

II. Professional Practice Standards

Professional practice standards relate to the ways in which members of a profession are expected to practise the profession. These standards are learned through formal education, professional reading, independent study, clinical practice experience and collaboration with colleagues, among other means.

Professional practice standards may be written or unwritten. Standards set out in legislation, in regulations and in documents developed by a college are examples of written standards. Unwritten standards are based on generally understood and accepted standards of the profession.

To date, the written standards of this College deal with matters such as informed consent, confidentiality, record-keeping, conflict-of-interest, business practices, advertising, client referral and supervision of students, among others. These standards are based on various statutes and the College's Professional Misconduct Regulation and are set out in greater detail in the Professional Practice Standards and Guidelines developed by the College.

Clinical practice standards, on the other hand, consist of the accumulated knowledge and understanding of clinical practice methods, acquired through formal study, clinical supervision and experiential learning, continuing education, discussion with colleagues, research and other professional activities. Regulatory colleges may develop limited written practice standards or guidelines on specific clinical topics, usually in response to an identified need on the part of members.

The purpose of written standards and guidelines developed by the college is to assist Members in the safe, ethical, and effective practice of the profession. They are developed by Members of the profession, and generally will be posted on the college website. Written standards are created and adjusted over time, as the profession matures and as the college gains experience in matters of professional misconduct or incompetence. Often such standards are developed to assist Members in evolving areas of practice, or in the use of new technology or practice methods.

Ultimately, the test of whether a Member has failed to uphold a practice standard (written or unwritten) is based on what a knowledgeable and prudent practitioner would have done in similar circumstances, as judged by a panel of his/her peers. In a discipline hearing, this decision is made by a panel of Members from the college's Discipline Committee, often after hearing expert evidence on the issue.

Discontinuing Professional Services Scenario

Krishna, an RP, wants to stop working with a particular client because the client has stopped paying him. He reads an article in the College's newsletter suggesting that an RP should provide at least two weeks notice to a client before terminating the therapeutic relationship, to allow the client to find a new therapist. Krishna does not take this advice, and stops seeing the client.

The client experiences significant emotional distress once the therapy stops and misses 10 days of work before he is able to find another RP who will see him. The client complains to the College. After investigating the complaint, the College requires Krishna to appear before a panel of the College to receive a verbal caution.

Krishna is cautioned that he should have made it clear at the beginning of the relationship that non-payment of services would result in discontinuation of service. He is reminded that in future, in similar circumstances, in addition to giving adequate notice, Krishna should offer assistance in finding alternative services, such as referring the client to family services and reminding the client that in an emergency the client may go to the emergency department. The fact that a therapist has not been paid by a client does not remove her/his duty to a client who was in significant emotional distress.

III. Professional Misconduct

Professional misconduct is conduct that falls below minimum expectations of the profession. Provisions governing professional misconduct are contained either in statutes or regulations and apply to all Members of the college. More detail is provided in Section 3. As noted above, college publications will assist Members in recognizing how to avoid engaging in professional misconduct.

Professional misconduct may lead to disciplinary proceedings that could result in a fine, suspension or even revocation of a Member's certificate of registration.

Permitting Illegal Conduct Scenario

Jacob, a psychotherapist, is registered with the College and was a partner with his father in a joint practice. Jacob's father is no longer registered with the College, and no longer a partner in the practice, but he sometimes drops into Jacob's office to see his former long-term clients. Jacob's father books these appointments with Jacob's knowledge. A client complains to the College when her insurance company refuses to pay for Jacob's father's services because he is unregistered. Is Jacob at risk for his father's conduct?

The answer is yes. It is professional misconduct to permit a person to hold him/herself out as qualified to practise the profession when s/he is not registered. Jacob condoned the conduct that occurred at his office, and, as a registered practitioner, gave credibility and status to the illegal conduct of his father. Jacob could face a discipline hearing.

IV. Incompetence

An RP may be deemed incompetent if s/he shows a serious lack of knowledge, skill or judgment when assessing or treating a client. A concern that a Member is incompetent may be investigated by the College and, in serious cases, may result in a discipline hearing. If the Discipline Committee finds that an RP is incompetent, it could impose restrictions on the Member's registration, such as not allowing the Member to work with children. Alternatively, it could suspend or revoke the Member's registration.

In any investigation of incompetence, the college will usually look at the Member's records and speak with him/her directly. It will also interview the client (or clients) involved, and ask other therapists whether they think the conduct shows incompetence. The investigating committee and/or deliberating committee (i.e. the Inquiries, Complaints and Reports Committee (ICRC) or the Discipline Committee) will include RPs to assist in determining the difference between good and bad practice.

Incompetence Scenario

Donna, an RP, does not properly assess her clients. She just asks her clients what's wrong and then gives all of them the same kind of counselling. A client, Paula, came in with a serious condition that almost certainly would have been revealed through a proper assessment. Donna did not recognize it. Paula's condition got worse; Donna still did not recognize it. After three months, Paula went to the emergency department of a hospital and was quickly diagnosed and treated appropriately. Paula complained to the College about Donna's incompetence.

The ICRC looked at Donna's records and heard Donna's explanation. It sent the case to discipline. The Discipline Committee agreed that Donna showed a lack of knowledge, skill and judgment. It ordered Donna to undertake further education and training.

V. Incapacity

An RP is incapable when a health condition prevents him/her from practising safely. Usually the health condition is one that interferes with the therapist's ability to think clearly. Often incapacity is related to substance abuse, addiction or illness (mental and physical) that impairs the Member's professional judgment; for example, a therapist, addicted to alcohol or drugs, who provides therapy to clients while under the influence.

Under the law, incapable RPs are not treated as if they have engaged in professional misconduct or incompetence. The investigation looks at the Member's health condition and the treatment s/he is receiving or may need. The College may require the RP to undergo a specialist examination. If the concern is justified, the Member will be referred to the Fitness to Practise Committee for a hearing. The Committee may order the Member to undergo treatment or receive medical monitoring, or it may restrict the therapist's practice. In an extreme case (e.g. where the Member continues to see clients while impaired), the Fitness to Practise Committee may suspend or revoke the Member's registration, in order to protect the public.

Incapacity Scenario

Kearan, a psychotherapist, has been drinking a lot more alcohol the last few months. One day Kearan comes back from lunch drunk. Paul, a client, notices that Kearan smells of alcohol and is stumbling around the office. Paul also notices that Kearan has forgotten what Paul told him during recent visits and that he has been inappropriate and rambling in some of his comments. Paul reports this to the College.

At first Kearan denies there is a problem. However, during the investigation, the College learns that some of Kearan's colleagues have noticed a significant change in his behaviour in recent months. The College also learns that he has been charged with impaired driving. The College sends Kearan to a medical specialist who diagnoses him as having a serious substance abuse disorder.

The matter is referred to the Fitness to Practise Committee. Kearan and the College agree to an order requiring that he stop drinking, attend Alcoholics Anonymous group meetings, and see an addiction counsellor regularly. The College also assigns a colleague to monitor Kearan at work and send regular reports to the College.

Sample Question

The sentence “RPs are sensitive to the cultural background and dignity of their clients” is most likely to be found in which of the following?

- i. The definition of incapacity.
- ii. The definition of incompetence.
- iii. The definition of professional misconduct.
- iv. Professional standards published by the College.
- v. The Code of Ethics.

The best answer is v. Sensitivity is an ideal that Members should always strive to achieve.

Answer i is not the best answer because incapacity deals with a Member’s health condition. Seriously insensitive behaviour may accompany some illnesses (e.g. addictions), but it is the illness that must be treated first.

Answer ii is not the best answer because incompetence deals with the level of knowledge, skill or judgment of a Member.

Answer iii is not the best answer because professional misconduct deals with the minimum conduct that is necessary to avoid discipline.

Answer iv is not the best answer because professional standards deal with ways to practise safely, effectively and professionally.

SECTION 2: CLIENT-THERAPIST RELATIONSHIPS

A. INTRODUCTION

Good communication is important in establishing and maintaining good relationships with clients. It is also important to maintain good communication with the college and other Members of the profession. Many complaints against Members could be avoided by good communication with clients, staff and colleagues.

Good communication first involves listening to others. Understanding a person's wishes, expectations and values before initiating therapy is important. Asking questions to clarify and expand on what the client or colleague is saying is important as well. One technique often used by therapists is to restate what the client has said in the therapist's own words. This may help to ensure that both parties understand one another; it also reassures the client that the RP has been listening.

Good communication also involves making sure the other person knows what you are going to do, why you are going to do it and what is likely to happen. This is the concept of informed consent, discussed below.

B. INFORMED CONSENT

Clients have the right to control their health care. Members do not have the right to assess or provide therapy to a client unless the client agrees. This is known as consent. A Member who provides an intervention without the client's consent could face criminal charges (e.g. for assault), a civil suit (e.g. for damages) or professional consequences (e.g. a disciplinary action by the college).

The rules on obtaining informed consent come from the *Health Care Consent Act (HCCA)*. All Members should familiarize themselves with this statute; however the key principles are covered here. RPs may learn about informed consent, including the requirements of the *HCCA*, from a number of sources, including books, articles, websites and Section 3 of this handbook. The College may develop additional materials on the subject for Members, which would be posted to the website.

I. Consent

To be valid, a client's consent must:

Relate to the assessment or therapy

An RP cannot receive consent for one purpose (e.g. taking a history of the client's health for personal therapy) and then use it for a different purpose (e.g. disclosing it in group therapy). The client's consent must be for the purpose stated.

Be specific

An RP cannot ask for a general or a vague consent. One must explain the assessment or therapy that is being proposed. This means that the Member may need to obtain the client's consent many times as changes in therapy become advisable. This also means that a Member cannot seek blanket consent to cover every intervention when the client first comes in.

Be informed

It is necessary that the client understand what s/he is agreeing to. The Member must provide information to the client before asking the client to give consent, and must respond appropriately to client requests for additional information. (See Section 2, The Concept of Informed Consent, p.22.)

Be voluntary

The therapist cannot force a client to consent to an intervention. This is particularly important when dealing with younger or older clients who may be overly influenced by family members or friends. This is also important where the assessment or therapy will have financial consequences for the client (e.g. the client will lose his/her job or will lose financial benefits if the client refuses to consent). The Member should inform the client that consent is his/her choice.

No misrepresentation or fraud

An RP must not make claims about the assessment or therapy that are not true, for example telling the client that a particular therapy will cure when in fact the results are uncertain. Consent obtained through misrepresentation or fraud, as demonstrated in this example, would not be considered true consent. Clients must be given accurate, factual information and opinions based in truth and fact.

Consent Scenario No. 1

Isabella, an RP, proposes that her client Liam, who has indicated that he is overwhelmed in groups, go on a rural retreat. After Liam arrives at the retreat, he learns that there will be strictly enforced rules of total silence. There is no way for Liam to leave and he finds the silence emotionally excruciating. Liam complains to the College.

Isabella tells the College that she was relying on Liam's implied consent by his description of feeling overwhelmed by people in groups. Isabella was afraid Liam would not go if he knew about the strict silence. The ICRC issues a decision critical of Isabella for not obtaining informed consent because:

she did not explain the nature of the retreat, how the retreat would help Liam, or set out alternatives; and

she misrepresented the benefits of the retreat, as there was little evidence to support her view that a strict regime of total silence would help Liam; she did not explain the emotional risks of attending the retreat.

II. The Concept of Informed Consent

In order for consent to be considered informed, the client must understand what s/he is agreeing to. Generally speaking, the following information should be provided to a client when seeking his/her consent:

Nature of the assessment or therapy	The client must have a reasonable understanding of what the RP is proposing to do. For example, before beginning therapy, a therapist should explain why s/he is asking personal questions and why the client should be candid.
Who will be doing the assessment or therapy?	Will the therapist be doing the intervention personally or will an assistant or colleague do it? If it is an assistant or colleague, is s/he registered with the College, another college, or unregistered?
Reasons for the assessment or therapy	The therapist must explain why s/he is proposing the intervention. What are the expected benefits? How does the intervention fit in with the overall treatment goals? How likely is it that the hoped for benefits will occur?
Material risks and side-effects	The RP must explain any <i>material</i> risks and side-effects. A risk or side-effect is material if a reasonable person would want to know about it. For example, if there is a high likelihood of a modest side-effect (e.g. emotional distress), the client should be told. Similarly, if there is even a low risk of a serious side effect (e.g. self-harm), the client needs to be told.
Alternatives	If there are reasonable alternatives to the intervention, the client must be told. Even if the therapist does not recommend the option (e.g. it is more aggressive or carries more risk), the therapist should describe the option and tell the client why s/he is not recommending it. Also, even if the therapist does not offer the alternative intervention (e.g. it is provided by a member of a different profession, such as a physician), s/he must inform the client, if it is a reasonable option.
Consequences of no intervention	One option for a client is to do nothing. The therapist should explain to the client what could happen if the client chooses not to consent to the intervention. If it is not clear what will happen, the therapist should say so, providing outcome scenarios if possible.
Particular client concerns	If some aspect of the intervention would be of special interest or concern to the client, the client should be informed. This requires that the therapist be reasonably aware of and sensitive to particular client concerns or interests, such as strongly held values or beliefs, or even certain personal considerations. For example, a client ascribing to a particular religion would need to know if an aspect of the intervention would violate his/her beliefs.

III. Ways of Receiving Consent

There are three different ways in which an RP is able to receive consent. Each has its advantages and disadvantages.

Written Consent

A client may give consent by signing a written document agreeing to the intervention. Written consent provides some evidence that the client gave consent. A disadvantage of written consent is that some Members may confuse a signature with consent. For example, a client who signs a form without actually understanding the nature, risks and possible alternatives to the intervention has not provided consent that could be considered informed. Written consent may actually inhibit full disclosure between the client and therapist about consent, thereby affecting the therapist's ability to gauge whether the client understands the information and is providing informed consent.

Verbal Consent

A client may give consent by a verbal statement. Verbal consent is the best way for the therapist and client to discuss the information and ensure the client really understands it. Making a brief note of the discussion in the client record may provide useful evidence later on, if there is a complaint.

Implied Consent

A client may give consent by his/her actions. For example, in Consent Scenario No. 2 (below) the client, Emma, simply nods her head to indicate consent. In this example, the action is considered implied consent and Ava, the therapist, is able to proceed. The main disadvantage of implied consent is that the RP has no opportunity to check with the client to make sure that s/he truly understands what is being agreed to.

Consent Scenario No. 2

Ava, a therapist, meets a new client, Emma. Emma complains about feeling stressed and tired. Ava says: "I would like to better understand your personal and family background and your health history. There could be a lot of things making you feel tired and stressed, and this information will help me understand what you're going through. If you are uncomfortable with any of my questions, please let me know. OK?" Emma nods her head.

Ava can assume that she has obtained implied consent to proceed, but must remain sensitive to any changes in Emma's body language. It would be prudent of Ava to reaffirm consent at appropriate intervals during the session, especially if there is a change in Emma's body language.

IV. Consent Where the Client is Incapable

A client is not capable of giving consent when s/he does not understand the information provided, or when s/he does not appreciate the reasonably foreseeable consequences of the decision.

An RP may assume a client is capable and does not need to conduct an incapacity assessment unless there is evidence that the client may be incapable. The therapist can assess the capacity of the client by discussing the proposed intervention with him/her and determining whether the client understands the information and appreciates its consequences.

A client may be capable of giving consent for one intervention but not for another. For example, a 15-year-old client might be capable of consenting to group counselling about handling stresses at school, but not be capable of consenting to therapy for a major eating disorder. There is no minimum age of consent for health care treatment. In each case the Member must look at the maturity of the minor.

V. Substitute Decision-Maker

In cases where the client is found to be incapable, a substitute decision-maker must be identified. Unless it is an emergency, the RP must obtain consent from the substitute decision-maker before commencing therapy. According to the *HCCA*, the substitute must meet the following requirements. S/he must:

- be at least 16 years of age. However, there is an exception where the substitute is the parent of the client, for example a 15-year-old mother can be the substitute decision-maker for the care of her child;
- be capable. In other words, the substitute, him/herself must understand the information and appreciate the consequences of the decision;
- be able to act (i.e. available) and willing to assume the responsibility of giving or refusing consent;
- not be prohibited by court order or separation agreement from acting as the client's substitute decision-maker; and
- there must be no higher ranked substitute who wishes to make the decision. (See *Rankings for the Substitute Decision-Maker*, p.26.)

If an RP concludes that the client is not capable of providing consent for therapy or other intervention, the therapist should tell the client. The therapist should also discuss the selection of the substitute decision-maker with the client, and should include the client in discussions about the therapy (e.g. plans or goals, options and progress) as much as possible. Of course, there are circumstances where involving an incapable client in discussions will not be possible (e.g. if such discussions would be upsetting to the client, or if the client is unconscious).

The *HCCA* also lays out the principles on which a substitute decision-maker must base his/her decisions. They are:

- The substitute must act in accordance with the last known capable wishes of the client. For example, if a terminally ill client, while still thinking clearly, said: "Don't send me to the hospital, I want to die at home," the substitute needs to obey those wishes, in so far as it is possible to do so.
- If the substitute is not aware of the last known capable wishes of the client, or if the last known wishes are unattainable, the substitute must act in the client's best interests. For example, if a proposed therapy is simple and painless, would make the client more comfortable through a difficult illness and has little risk of harm, the substitute decision-maker should, in general, consent to it.

Where it becomes clear that a substitute decision-maker is not following the principles above, the therapist should speak with him/her about it. If the substitute decision-maker is still not following the principles and is making decisions that, in the opinion of the therapist, will harm the client, the therapist should call the office of the Public Guardian and Trustee. The contact information for the Public Guardian and Trustee of Ontario is available on the internet.

Rankings for the Substitute Decision-Maker

The ranking of the substitute decision-maker is as follows (from highest ranked to lowest ranked):

1. A court appointed guardian of the person.
2. A person who has been appointed attorney for personal care. The client would have signed a document appointing the substitute to act on the client's behalf in health care matters if the client ever became incapable.
3. A person appointed by the Consent and Capacity Board to make a health decision in a specific matter.
4. The spouse or partner of the client. A partner can include a same-sex partner. It may also include a non-sexual partner (e.g. two elderly sisters who live together).
5. A child of the client or a parent of the client or the Children's Aid Society who has been given wardship of the client.
6. A parent of the client who does not have custody of the client.
7. A brother or sister of the client.
8. Any other relative.
9. The Public Guardian or Trustee if there is no one else.

If there are two equally ranked substitute decision-makers (e.g. two sisters of the client), and they cannot agree, the Public Guardian and Trustee may then make the decision.

Consent Scenario No. 3

Olivia, a psychotherapist, proposes an intervention for her client Ryan. Ryan does not understand what is being proposed and is clearly incapable. Olivia knows that Ryan appointed his friend Sarah to be his power-of-attorney for personal care. However, Sarah is travelling outside of the country. She cannot be reached and is not able to make the decision.

Olivia contacts Ryan's elderly mother, who is frail herself and does not feel confident (or willing) to act as a substitute decision-maker. Ryan's sister is willing and able to make the decision and appears to understand the information and its consequences for Ryan. Ryan's sister is able to give the consent even though she is not the highest ranked substitute.

Consent Scenario No. 4

Aashi an RP, proposes supportive therapy for her client Sara. Sara does not understand the proposed intervention at all and is clearly incapable. Aashi knows that Sara appointed her friend Reena to be her power-of-attorney for personal care. Reena is going to inherit a significant amount of Sara's money when Sara dies. Sara is likely to die within a few months. The proposed intervention is simple, painless and poses little risk of harm. It would make Sara more comfortable through a difficult illness.

Aashi is convinced that Reena is refusing to consent to the proposed intervention in order to inherit her money sooner. Sara's family is very upset because they want her to receive the best possible care. Aashi suggests that the family contact the office of the Public Guardian and Trustee.

VI. Emergencies

In an emergency, an exception to the requirement for informed consent can be made. There are two kinds of emergencies:

- The client is incapable and a delay in treatment would cause suffering or serious bodily harm to the client.
- There is a communication barrier (e.g. language, disability) despite efforts to overcome this barrier, and a delay in treatment would cause suffering or serious bodily harm to the client.

In either case, the therapist must attempt to obtain consent as soon as possible, even if it is after the fact, either by finding a substitute decision-maker (as in the first case) or by finding a means of communication with the client (as in the second case).

Consent Scenario No. 5

Anna, a therapist, is seeing her client Paula at the office. Paula suddenly collapses in an apparent heart attack. There is a defibrillator in the room across the hall from Anna's office. Without trying to get consent from a substitute decision-maker, Anna uses the defibrillator. It was appropriate for Anna to act without consent in these circumstances.

Across the city, Sherif, an RP, is seeing his client Emily at the office. Emily has terminal cancer and has filled out a wallet card saying that she does not want any measures taken to resuscitate her should she have a cardiovascular episode. Emily has mentioned this to Sherif. Emily suddenly collapses in an apparent heart attack. Sherif also has access to a defibrillator. Sherif is not able to act without consent in these circumstances because he already has a refusal from Emily that applies to these circumstances.

Sample Question

Obtaining a broad consent, often called a blanket consent in writing from the client on his/her arrival at the office is usually a bad idea because:

- i. The client does not know if s/he will need a ride home afterwards.
- ii. The client does not have confidence in the RP yet.
- iii. The client does not know what s/he is agreeing to.
- iv. The client does not know how long the visit will be.

The best answer is iii. Informed consent requires the client to understand the nature, risks and side-effects of the specific intervention proposed by the therapist. It is impossible for the client to know these things upon arrival at the office.

Answer i is not the best answer because it focuses on a side-issue and does not address the main issue.

Answer ii is not the best answer because having confidence in the therapist does not constitute informed consent. A client may trust the therapist and this may motivate the giving of consent, but the client still needs to know what s/he is agreeing to.

Answer iv is not the best answer because it focuses on a side-issue and does not address the main issue.

Sample Question

Which of the following is the highest ranked substitute decision-maker (assuming that everyone is willing and able to give consent):

- i. Someone appointed as attorney for personal care for the client.
- ii. The client's live-in boyfriend.
- iii. The client's mother.
- iv. The client's son.

The best answer is i. Only a court-appointed guardian is higher ranked than a power-of-attorney for personal care.

Answer ii is not the best answer because the client's spouse or partner is a lower ranked substitute decision-maker. In addition, it is not clear that the live-in boyfriend is a spouse. Under the HCCA, the couple must have been living together for at least one year, have had a child together or have a written cohabitation agreement to be spouses.

Answers iii and iv are not the best answers because they are lower ranked than both an attorney for personal care or a client's spouse. In addition, the client's mother and son are equally ranked so either they would have to give the same consent or would have to sort out which one would give consent.

C. BOUNDARIES

Members must be cognizant at all times of their primary role as psychotherapists and not act in any other capacity or personal relationship with clients. Maintaining healthy professional boundaries is always the responsibility of the RP and not the client.

Becoming too personal or familiar with a client could make them feel uncomfortable and may cause confusion that would undermine the psychotherapy by blurring the distinction between a professional and a personal relationship. An effective therapeutic relationship requires maintenance of boundaries. For example, the therapist may find it easier to be honest and more objective about a client's issue or problem, or be better able to ask challenging questions of a client when professional distance is maintained.

This section highlights some situations in which Members should exercise prudence, and strive to maintain appropriate professional boundaries.

I. Self-Disclosure

Therapists must be cautious when disclosing personal information about themselves to clients. Revealing personal details must be of therapeutic benefit, and be shared in a professional manner. When a Member shares personal details about his/her private life in a non-therapeutic manner, it may confuse or upset the client.

Non-therapeutic self-disclosure suggests that the professional relationship is serving a personal need for the therapist rather than serving the client's best interests. Non-therapeutic self-disclosure may be damaging to the therapeutic relationship and the client. For example, this kind of self-disclosure could result in the therapist becoming dependent on the client to serve his/her own emotional needs, or the client may feel that the therapist wishes to have more than a professional relationship.

Self-Disclosure Scenario

Kim, a therapist, is treating Subasna for workplace-related stress. Subasna is having trouble deciding whether to marry her boyfriend and talks to Kim about this issue a lot during therapy sessions. To help Subasna make up her mind, Kim decides to tell Subasna details of her doubts in accepting the proposal from her first husband. Kim talks about how those doubts gradually ruined her first marriage resulting in both her and her husband having affairs.

Subasna is offended by Kim's disclosure and stops coming for therapy.

II. Giving or Receiving of Gifts

Giving and receiving gifts is potentially dangerous to the professional relationship. A small token of appreciation by the client purchased while on a vacation, around a holiday, or given at the end of therapy may be acceptable. However, anything beyond small gifts may indicate that the relationship is becoming personal.

In addition, the therapist must be sensitive to the client's culture. In some cultures, refusing a gift is considered a serious insult. However, if a gift is large, the client may be developing an inappropriate attachment to the therapist. The client may even expect something in return. The therapist must use discretion in accepting gifts.

As well, gift-giving by a therapist, even if the gift is small, may confuse a client. While many clients would find a holiday season card from an RP to be a nice gesture, some clients might feel obliged to send one in return, and others with different cultural backgrounds may not be familiar with the custom, or may not know how to respond to the gesture.

Gift Giving Scenario

Robyn, an RP, has a client from a Mediterranean culture who brings food for every visit. Robyn thanks her, but tries not to treat it as an expectation. On one visit Robyn happens to mention her home-made pizza recipe. The client insists that Robyn visit her home over Thanksgiving to bring some home-made pizza. Robyn politely declines the invitation, giving the client a written recipe instead. In the weeks following this exchange, the client stops bringing in food, is less friendly and starts missing appointments.

Robyn did not do anything wrong in this scenario, but it shows the confusion that may occur when the boundaries between client and therapist start to blur.

III. Dual Relationships

A dual relationship exists when the client has an additional connection to the RP outside the therapeutic relationship (e.g. the client is also the coach of the therapist's son's hockey team). In any dual relationship, it is possible that the other relationship can interfere with the professional one.

It is best to avoid dual relationships. This is true of dual professional relationships (for example between a student and a supervisor) and the same due diligence required in managing dual personal relationships must be applied.

Where the other relationship predates the professional one (e.g. a relative, a pre-existing friend), it would be prudent and best practice to refer the client to another RP. Where a referral is not possible (e.g. in a small town, where availability of therapists may be limited), special safeguards are essential, such as discussing the dual relationship with the client at the first session, agreeing with the client to be formal during visits and never talking about the therapy outside the office setting.

Dual Relationships Scenario

David's son plays hockey in a local league for young children. At the start of the season, David, who is an RP, notices that one of the other parents is a relatively new client of his. He thinks nothing of it, but as the season progresses, the client becomes coach of the hockey team. David notices that his son seems to be getting less ice time than usual. He attempts to speak with the coach but feels uncomfortable with the response. The next therapy session seems strained and rapport seems to have been lost.

With the client's agreement, David refers him to another therapist. Although the coach is no longer his client, during hockey games David still feels that his son is treated differently than the other players.

The example is intended to highlight the difficulty that exists when drawn into a dual relationship and how problematic it may be to extricate one-self and re-establish normal relationships.

IV. Ignoring Established Customs

Ignoring a custom or normal business practice may confuse the nature of the professional relationship. For example, therapy sessions are usually held during regular business hours at a clinic. If a therapist were to ignore this custom by holding a session at a restaurant, for example, confusion could result. The client might think that the meeting is a social visit, or could feel that s/he has to pay for the meal. Treating a client as special, or different from other clients, may be easily misinterpreted.

V. Personal Opinions

Everyone has personal opinions and RPs are no exception. However, therapists should not use their position

to promote personal opinions or causes with clients (e.g. religion, politics, or even a lifestyle choice). Similarly, personal reactions should not be shared, unless doing so serves a therapeutic purpose.

Personal Opinions Scenario

Helen pushes for her therapist's views on immigration. At first Karen, the therapist, resists, but eventually says she has some concerns about the abuses of the immigration system.

Karen says she has heard, often directly from clients, about how they have lied to immigration authorities. Helen criticizes the immigration authorities for allowing too many immigrants into the country.

This loud talk could be heard by clients in the waiting room, some of whom are new Canadians. One of the clients tells other staff at the clinic that he feels uncomfortable with either Karen or Helen around.

VI. Becoming Friends

Becoming a personal friend with a client is a form of dual relationship. Members should be aware that it is difficult for all but the most assertive of clients to tell their therapist they do not want to be friends. Moreover, a client should never feel as though s/he must become a friend of the therapist in order to receive ongoing care. It is the Member's responsibility to maintain professional boundaries and to prevent personal friendships from developing.

VII. Touching

Touching may be easily misinterpreted. A client may view an act of encouragement by an RP, such as a hug, as a crossing of client-therapist boundaries or even a sexual gesture. When it comes to touch between a therapist and client, even if that touch is initiated by the client (e.g. asking for a hug), Members are encouraged to act prudently and with extreme caution.

D. SEXUAL ABUSE

Sexual abuse is considered an extreme boundary violation. Because of its potential to cause harm to clients, it is addressed specifically in the RHPA.

Clients have a right to receive care from a Member in a manner that respects the professional boundary between the client and the health professional, and in a manner which ensures the client is free from harm. Given the inherent power imbalance between a Member and their client, there is the potential for any sexual contact to cause serious harm to the client.

The RHPA considers any form of sexual contact between a regulated health professional and their clients a serious form of professional misconduct. The term sexual abuse is defined broadly and includes the following conduct by RPs:

- sexual intercourse or other forms of physical sexual relations between a Member and a client;
- touching, of a sexual nature, of the client by the Member; or
- behaviour or remarks of a sexual nature by Member towards a client.

Even if a client appears to initiate sexual contact, such contact is prohibited. Due to the power differential between an RP and a client – the Member being in a position of power and authority – a client cannot give valid consent to sexual contact. The foundation of the therapeutic alliance is a safe and trusting relationship, and any form of sexual contact is a breach of the therapeutic relationship.

I. Examples of Sexual Abuse

A wide range of actions constitute sexual abuse. For example, telling a client a sexual joke or hanging a sexually explicit calendar on a wall where it would be seen by clients are examples of sexual abuse. Non-clinical comments about a client's physical appearance, such as, "You look sexy today," also constitute sexual abuse. Dating or asking a client on a date is also sexual abuse.

Remarks of a clinical nature are not sexual abuse. For example, if information about the client's sexual/romantic history is required for a therapeutic purpose, the RP may ask about the history. However, asking about a client's sexual/romantic life to satisfy the personal interests of the therapist is considered sexual abuse.

It is always the responsibility of the Member to prevent sexual abuse. Members should consider ways of preventing the perception of sexual abuse. For example, if a client begins to tell a sexual joke, or makes comments about the appearance or romantic life of the therapist, the therapist must act to stop it. If the client asks for a date or initiates sexual touching, the RP must say no, explain why such behaviour between a client and therapist is inappropriate, discourage future incidents and set appropriate boundaries.

The following are suggestions for preventing even the perception of sexual abuse:

- maintaining established customs (e.g. do not change your office hours to accommodate a specific client);
- if a client initiates sexual behaviour, put a stop to it – be sensitive, but firm when doing so;
- do not socialize with clients; avoid non-therapeutic self-disclosure;
- avoid comments that might be misinterpreted, such as, "You're looking good today;"
- be cautious in touching a client;
- do not make gratuitous or inappropriate comments about a client's body or romantic life;
- document well any discussion of relevant sexual matters or any incidents of a sexual nature; and
- avoid being in contact with clients through any social media (e.g. Facebook, Twitter, Instagram, etc.).

A therapist who "develops sexual or romantic feelings for" or "an attraction to" a client, and who believes that the client returns the feeling and "consents" to the personal relationship would be engaging in sexual abuse if they were to proceed with any kind of romantic or sexual contact. Similarly, when a client develops feelings for the therapist, the RP must take action to stop an inappropriate relationship from proceeding. Members are reminded that in the context of the therapeutic relationship, the client is never a mutual participant due to imbalance of power. By definition clients come to an RP because they are seeking care from that professional. Given this, "consent" is not valid or legitimate.

Sexual Abuse Scenario No. 1

Zyanya, a psychotherapist, while speaking to a colleague in their office, tells the colleague about her romantic weekend with her husband in Niagara-on-the-Lake for their anniversary. Zyanya makes a joke about how wine has the opposite effect on the libido of men and women. Unbeknownst to Zyanya, her client, Kiah, is sitting in the reception area and overhears. When in session with Zyanya, Kiah mentions that she overheard the remark and is curious as to what Zyanya meant by this, as in her experience, wine helps the libido of both partners. Has Zyanya engaged in sexual abuse?

Zyanya clearly has crossed boundaries by making the comment in a place where a client could overhear it. However, the initial comment was not directed towards Kiah and was not meant to be heard by her. It would certainly be sexual abuse for Zyanya to discuss her own personal experiences in response to Kiah's question. Zyanya should apologize for making the comment in a place where Kiah could hear it, and state that Zyanya needs to focus on Kiah's therapy, which may include responding to the question in a professional manner.

II. Treating a Spouse or Partner

Treating a spouse or partner is also considered sexual abuse. A number of court decisions have established that a regulated health professional cannot treat his/her spouse, except in very limited circumstances, like an emergency. RPs must not provide assessments or therapy to a spouse or partner, and need to transfer care to another practitioner.

Under the law, it does not matter that the spousal relationship came first. For example, the Court of Appeal in Ontario held that a chiropractor who became sexually involved with a person, and some months later began to treat her, had committed sexual abuse. The Court said that even though the personal relationship had come first, it was still inappropriate for the chiropractor to treat his partner, even occasionally. In this case, the treatment was not simply providing household advice or temporary physical comfort to a family member in physical pain, rather it was a formal assessment and treatment plan of the patient.

III. Dating Former Clients and Handling Sexual / Romantic Feelings for Clients

Where a Member has developed sexual/romantic feelings for a client, they should either:

1. seek supervision or personal therapy to resolve the feelings; or
2. transfer the care of the client to another RP immediately.

Dating former clients is a sensitive issue. Technically, it is not sexual abuse because the person is no longer the RP's client. However, it may be unprofessional for an RP to date a former client because of the inherent power differential that continues to exist between them. There should be an appropriate *cooling off* period. This will be dictated by Bill 87 and CRPO policy.

Sexual Abuse Scenario No. 2

Michael, an RP, is attracted to his client Adoerte. Michael notices that he is looking forward to working on the days when Adoerte will be there. Michael extends the sessions a few minutes in order to chat informally with Adoerte and thinks that Adoerte might be interested in him as well by the way that he makes eye contact. Michael notices that he is touching Adoerte on the back and the arm more often.

Michael decides to ask Adoerte to join him for a coffee after his next visit to discuss whether Adoerte is interested in him romantically. If Adoerte is interested, he will transfer Adoerte's care to a colleague. If Adoerte is not interested then he will make the relationship purely professional. Michael decides to ask a colleague, Donna, for advice.

Donna cautions Michael that he and Adoerte are both at significant risk. Donna also says that it is important for Michael to transfer the care of Adoerte right away and recommends that he wait some time before asking Adoerte to join him for a coffee. Donna is correct in her assessment of the situation and her recommendations are sound.

IV. Handling of Allegations of Sexual Abuse by the College

The College takes all complaints regarding sexual abuse very seriously. There are a number of special provisions that address the handling of sexual abuse matters throughout the complaints and discipline process.

**If a complaint involves sexual touching and if there is evidence to support the complaint, a referral to the Discipline Committee for a discipline hearing is likely.

At the discipline hearing the identity of the client is protected. The client may have a role at the hearing; for example, if a finding is made, the client might be invited to make a statement on the impact of the sexual abuse. Where the sexual abuse involves sexual intercourse or similar sexual acts, and a finding is made, there is a mandatory minimum penalty; the therapist's registration will be revoked for a period of at least five years.

In all cases where a finding of sexual abuse has been made, the Member will be reprimanded and may be ordered to pay for the costs of any counselling and therapy needed by the client.

Where an allegation of sexual abuse is made, and the client makes an application to the college, the college is also responsible for paying at least some of the costs of any counselling or therapy needed by the client.

If a Member has reasonable grounds to believe that a regulated health professional (whether a member of this College or another college) has engaged in sexual abuse, the Member is **required by law** to make a report. In this case, the report is made to the Registrar of the college where the health professional is a member. For example, if a client tells an RP that she was fondled by her physiotherapist, the RP must make a written report to the Registrar of the College of Physiotherapists of Ontario. This reporting obligation is discussed in detail in the section *Mandatory Reports*. (See Section 3, *Mandatory Reports*, p.51.)

Because sexual abuse is such an important issue, colleges take it very seriously. Each college must take steps to prevent sexual abuse by its members; for example, the Client Relations Committee of the College is required to develop a sexual abuse prevention plan that will educate RPs in this regard. In addition, the College will develop sexual abuse prevention training programs for employers of RPs and for the public.

Sample Question

Which of the following is clearly sexual abuse:

- i. Taking a sexual history when it is clinically necessary to do.
- ii. Using glamour shots of scantily dressed Hollywood stars as your interior design theme in order to attract younger clients.
- iii. Telling an employee a sexual joke when there are no clients around.
- iv. Dating a former client.

The best answer is ii. These pictures sexualize the atmosphere at the clinic which is inappropriate in a health care setting.

Answer i is not the best answer because taking a sexual history is appropriate when it is needed to assess the client and it is done professionally.

Answer iii is not the best answer because the sexual abuse rules only apply to clients. Sexual behaviour with employees may, however, constitute sexual harassment under the Human Rights Code and could otherwise be unprofessional.

Answer iv invites consideration but is not the best answer because the person is not a client at the time of dating. However, it might still be unprofessional to date a former client without a suitable cooling-off period, particularly if the RP had an intense or intimate role in the assessment or therapy of the client.

E. INTERPROFESSIONAL COLLABORATION

In 2007, the *RHPA* was amended to require all colleges to promote interprofessional collaboration, among colleges as well as among practitioners.

On a practical level, collaboration helps to ensure that care is coordinated and as effective as possible. Collaboration reduces the risk of giving conflicting or inconsistent advice and also reduces the chance that a client

receives inconsistent information or advice. These measures contribute to enhanced safety and improvement in client experience – clients benefit from the shared knowledge of health professionals who can work together to meet their needs.

The public is looking to healthcare professionals to provide the safest, most efficient care possible, and there is an expectation that health care professionals will interact with each other in a professional manner to achieve these goals.

Ontario has been looking to interprofessional collaboration to help address health human resource shortages. The province's health care system faces a number of human resource pressures: the population is aging and life expectancies continue to rise, thereby increasing the demand for care.

As the population ages, the average age of health care workers is also rising. In addition, the incidence of people living with complex chronic conditions is increasing, while attracting and retaining health care professionals remains a challenge. Demands on the health care system and its professionals will intensify as a result of these factors.

The College supports collaboration in a number of ways. These include working with other colleges (e.g. sharing information on investigations, collaborating on standards development to promote consistency), and encouraging RPs to collaborate with members of other health care professions regarding the care of mutual clients, when it is appropriate to do so and not counter-therapeutic.

Open and ongoing communication with other health care providers is a key component of successful collaboration. Members must make reasonable attempts to communicate with relevant health care providers with respect to a client's care, except in instances where the client refuses to consent to this communication or if the communication is counter-therapeutic or unnecessary. Failing to do so could be considered professional misconduct.

I. The Role of the Client

The client controls the extent of interprofessional collaboration in a specific circumstance. If a client is uncomfortable with any aspect of collaboration, s/he may direct the RP not to share his/her personal health information with others. The Member must comply with such a direction unless one of the exceptions in the *Personal Health Information Protection Act (PHIPA)* applies. (See Section 3, *Personal Health Information Protection Act*, p.83.)

Members should discuss any planned interprofessional collaboration with the client. However, there are circumstances where prior client consent is not possible, such as when a client is in an emergency situation and another health provider requests information about any interventions the client has received. In such a case, an RP may disclose the information needed for the treatment of the client without consent, so long as the client has not prohibited the RP from doing so.

II. Issues for RPs to Consider

Where interprofessional collaboration involves working in a multi-disciplinary setting (i.e. a place where members of different professions work together and where clients may be seen by multiple health care providers), other issues may arise, including the following:

- Will the setting have shared records or will the RP have separate records?
- If the records are shared, will the RP keep any private notes outside of the shared record? If so, how will s/he make sure that the other health care providers have access to any needed information? (See Section 3, Record-keeping, for more information.)
- How does the setting deal with the wording used in the records? Will everyone use the same abbreviations?

- What happens to the records if the RP leaves to practice elsewhere? Will the client be told where the therapist has gone? Will another therapist from the setting take over the client's care? Will the client be given a choice? (The client should be given a choice, although some settings will only do so if the client asks.)
- Who is the health information custodian that owns the records?
- Will there be one person who has overall responsibility for the care of the client? If so, who? If not, how will the client's care be coordinated?
- How will disagreements in the approach to the care of the client be dealt with? If it is the RP who is in disagreement, when and how does s/he tell the client?
- Is the client aware of any of the above?

Collaboration in a multi-disciplinary setting is one of the many areas in which a Member should consider consulting his/her own lawyer.

Interprofessional Collaboration Scenario

Asa, an RP, prefers to practice on her own. She provides alternative approaches to therapy compared to most other therapists, and certainly when compared to members of traditional Western medicine. Asa's client, Liam, also has a family doctor. Liam's family doctor calls unexpectedly to say that Liam is not responding to his medication as the MD had expected. The doctor wonders if anything Asa is doing might interfere with Liam's medication. Asa has hinted to Liam that she is not supportive of the medication that he is on. Asa wonders if Liam has stopped taking the medication without telling the doctor. What should Asa say?

In many respects, there has already been a failure of interprofessional collaboration in this case. Rather than hint at her concerns about the medication that Liam is on, Asa should have discussed the concerns openly with Liam and requested permission to speak with his doctor. At this point, however, Asa should probably speak to Liam first before talking to the doctor. It is not clear that Liam would want such a discussion to take place, and this is not an emergency. Asa should obtain Liam's permission to speak to the doctor.

F. BILLING

Establishing professional fees charged by Members is not within the mandate of the College, and the College does not set the fees for Members' services. In fact, the college does not regulate the amount a Member may charge a client, unless the fee is excessive. A fee is considered excessive if it takes advantage of a vulnerable client or is so high that the profession would conclude that the RP is exploiting a client.

I. Informing a Client About Fees

While the college does not set fees for services provided by Members, it does regulate the way in which Members may bill clients. Generally speaking, billing must be open and honest. Clients must be informed about the Member's fees for services and/or products before they are provided. Any penalties for late payment must also be disclosed in advance.

The best way to inform clients about fees is to provide a written list or description of the fees. Such a list must include a summary of the services and any products provided by the Member and their associated cost. In addition, if there are penalties for late payment, these should be included. Clients may also be told verbally, or Members may post a sign clearly displaying the fees in a highly visible location, such as a reception area. The problem with relying on verbal or posted methods is that the client might forget important information.

Itemizing Bills for Clients

Members must provide an itemized bill for any client who requests one. The bill must describe the services and products that were provided. Any document relating to fees (e.g. an invoice, bill or receipt) must be accurate. The following are examples of inaccurate billing, which could be a breach of billing practices and considered unacceptable by the College:

- Indicating that the Member provided the service when someone else did.
- Indicating the wrong date for the service; for example, putting in a date when the client had insurance coverage, when the service actually occurred on a date when the client did not have insurance coverage.
- Indicating that one service was performed when, in fact, another service was provided; for example, indicating that the fee was for a follow-up visit when in fact there was only a telephone conversation.
- Billing for services at more than the Member's usual rate because the service is being paid for by an insurance company.
- Indicating that a service was performed when, in fact, no service was performed; for example, indicating that a client visit occurred when, in fact, the client missed the appointment. (See below for billing and cancellations.)
- Billing for a product at a rate that is more than its actual cost. The actual cost may include a reasonable amount to cover staff time, storage and handling.

II. Billing When No Service Is Provided

No fee may be billed when no service was provided. The only exception is when a client misses an appointment or cancels an appointment on very short notice, in which case a fee may be charged. However, most insurance companies will not pay for a missed appointment and the fee must be charged directly to the client.

Members cannot offer a reduction in the amount charged if it is paid immediately, as such a practice would give affluent clients an advantage over other clients. However, an RP may charge interest on overdue accounts, as there is an actual cost to the Member in collecting them.

III. Billing Reductions and Free Consultations

Some RPs may choose to offer free initial consultations, as this can be an effective tool to promote a practice. If a Member wishes to do this, s/he must ensure that any such offer is completely honest, and that the service is provided as advertised. Any free initial consultation must be complete and not just a partial service. There must be no requirement to attend a second time, and no hidden charges are permitted. The offer must be open to everyone.

Billing Scenario

Arav, an RP, has a posted rate of \$120 per visit in the reception area of his office. In fact, if the client is paying for the service personally and does not have extended health insurance coverage, Arav provides a credit reducing the rate to \$99 per visit. If a client has special financial needs, Arav will consider reducing his rate even further; in fact he has three regular clients who pay only \$5 per visit.

The above scenario is contrary to the Professional Misconduct Regulation. In effect, Arav's posted fees are not honest and accurate. Arav is, in effect, billing clients with insurance more than his actual regular fee.

It is acceptable, however, for Arav to lower his actual fee in individual cases of financial hardship. Arav must do this on a case by case basis, and not through a general policy intended to hide his true fee.

SECTION 3: LAW

A. TYPES OF LAW

Legislation is passed by provincial legislatures and the federal parliament. When draft legislation is first introduced in the legislature (or parliament), it is known as a *Bill* (e.g. Bill C141). After it is passed into law, it becomes an Act, also referred to as a statute. Many Acts include clauses that provide for the subsequent creation of regulations under the Act. Regulations provide more details on how the Act will be implemented. It is important to note that the *Canadian Charter of Rights and Freedoms*, and certain other overriding statutes, may take priority over other statutes.

The Acts that apply most directly to RPs are the *Regulated Health Professions Act (RHPA)* and the *Psychotherapy Act*. In certain circumstances, a number of other acts apply as well. These laws are discussed in Section E, Other Laws.

Regulations are made by government when a statute permits that to be done. Under the *RHPA*, regulations can be proposed by the college (e.g. registration, professional misconduct, quality assurance program regulation) or by the Minister of Health and Long-Term Care (e.g. controlled acts, professional corporations).

By-laws are made by the college and deal primarily with the internal operations of the college and some matters relating to membership, such as fees and professional liability insurance.

In addition to developing regulations and by-laws, the college publishes official documents such as professional practice standards, and may also publish guidelines, policy statements and position statements. Practice standards set out the minimum standard of professional practice and conduct required of Members of the college in the practice of the profession. While standards are not actually law, the Professional Misconduct Regulation of this College states that it is professional misconduct to contravene a standard established by the College. The college may also issue guidelines, which provide additional information and direction for Members, to help them understand how to meet practice standards. Policy statements and position statements generally provide guidance to Members on specific issues, and also share the college's position on issues with the public.

Court decisions, referred to as case law, are used as a guide by lawyers and judges when similar issues arise at a later date. Court decisions are particularly important in guiding the procedures of college committees (e.g. investigations by the ICRC and decisions of the Discipline Committee).

B. REGULATED HEALTH PROFESSIONS ACT (RHPA)

The *Regulated Health Professions Act (RHPA)* sets out the regulatory framework for the health regulatory colleges in Ontario, with the goal of protecting the public from harm. The *RHPA* includes a Risk of Harm provision that prohibits a person from treating or advising a person “with respect to his or her health in circumstances in which it is reasonably foreseeable that serious bodily harm may result from the treatment or advice or from an omission from them” (Section 3, *RHPA*).

To carry out this mandate, the *RHPA*, together with the profession-specific acts, establishes a number of controlled acts, restricts the use of certain titles and sets the scope of practice for each regulated health professions. These concepts are important for therapists to be familiar with, and are discussed in more detail below.

I. Controlled Acts and Delegation

There are certain health care procedures, called controlled acts, that are potentially dangerous and should only be performed by a properly qualified professional. No one can perform a controlled act without legal authority.

Thirteen controlled acts are listed in the *RHPA*, with the controlled act of psychotherapy proposed as the fourteenth. (See box on next page for complete list of controlled acts.)

In the future, RPs will be authorized to perform one controlled act – the controlled act of psychotherapy, defined in the *RHPA* as:

Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgment, insight, behaviour, communication or social functioning.

Members should be aware of the complete list of controlled acts so they are able to recognize when they may inadvertently engage in a controlled act. Examples of controlled acts include communicating a diagnosis, performing a procedure below the dermis, prescribing drugs and administering forms of energy.

While Members are not permitted to use any of the forms of energy listed below, therapeutic ultrasound is not a controlled act and may be used by anyone, including RPs. Forms of energy that may not be used by RPs include: use of electricity for aversive conditioning, cardiac pacemaker therapy, cardioversion, defibrillation, electrocoagulation, electroconvulsive shock therapy, electromyography, fulguration, nerve conduction studies, transcutaneous cardiac pacing, electromagnetism for magnetic resonance imaging, and soundwaves for diagnostic ultrasound, and lithotripsy. (See subsection on Exceptions, p.45.)

Therapists may need to do some research or obtain advice when dealing with a specific substance to determine whether it is a drug. As a general rule, if a substance has a DIN (Drug Identification Number), it is usually considered to be a drug. Some non-drug substances have different kinds of drug numberings, such as a Natural Product Number (NPN) or Homeopathic Medicine Number (DIN-HM). These products are generally not considered to be drugs.

THE CONTROLLED ACTS

The controlled acts listed in the *RHPA* are as follows:

1. Communicating a diagnosis to the individual or his/her personal representative identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his/her personal representative will rely on the diagnosis.
2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
3. Setting or casting a fracture of a bone or a dislocation of a joint.
4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger, beyond the external ear canal, beyond the point in the nasal passages where they normally narrow, beyond the larynx, beyond the opening of the urethra, beyond the labia majora, beyond the anal verge, or into an artificial opening into the body.
7. Applying or ordering the application of a form of energy prescribed by the regulations under this Act.
8. Prescribing, dispensing, selling or compounding a drug as defined in the Drug and Pharmacies Regulation Act, or supervising the part of a pharmacy where such drugs are kept.
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.
10. Prescribing a hearing aid for a hearing impaired person.
11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.
12. Managing labour or conducting the delivery of a baby.
13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.
14. Note that the following controlled act is proposed, and not yet legally in force: Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgment, insight, behaviour, communication or social functioning.

Controlled Acts Scenario No. 1

David, an RP, sees his client Kye. Kye mentions an earache he has had for two days. David takes a look and sees that a bug has gotten into his ear and has been jammed deep into the inner ear canal, perhaps with a cotton stick. David takes some tweezers and gently works his way into the inner ear canal and removes the bug. Kye is grateful. David mentions the incident to a colleague who advises David that he has just performed a controlled act that is not authorized to RPs. David checks the RHPA and realizes that his colleague is correct.

There are four ways in which a health care provider can receive the legal authority to perform a controlled act (details provided below):

1. if authorized to do so;
2. as an exception, in limited situations;
3. as a result of an exemption; and
4. in certain circumstances, if a controlled act is delegated.

Authorizing a Controlled Act

Members of a regulated health profession may be authorized by their governing statute to perform a controlled act. For example, the *Psychotherapy Act* authorizes RPs to perform the controlled act of psychotherapy.

Exceptions

The *RHPA* identifies a number of exceptions permitting those not authorized to perform controlled acts to do so in certain circumstances including:

- if helping someone in an emergency;
- under supervision while in formal training to become a member of a college authorized to perform the controlled act;
- if treatment is by prayer or spiritual means pursuant to one's religion;
- when done for a member of one's household. However, this applies only to the following controlled acts: communicating a diagnosis (e.g. a medical doctor telling his or her child that she has a cold), administering a substance by injection or inhalation, or entering a body opening);
- when helping a person with his/her routine activities of daily living such as administering a substance by injection or inhalation or entering a bodily orifice (e.g. on a home visit helping a client with an insulin injection);
- if providing aboriginal healing within the aboriginal community; and
- if counselling, as long as this does not amount to communicating a diagnosis or providing psychotherapy.

Exemptions

In addition to the exceptions listed in the *RHPA*, the Minister of Health and Long-Term Care has provided a number of exemptions in a Minister's regulation, most of which are limited in scope (e.g. dentists are permitted to apply electricity for electrocoagulation). A few of the exemptions have broader applications and include tasks that anyone can perform, such as cosmetic body piercings and tattooing, electrolysis, and male circumcision.

The Minister of Health and Long-Term Care also permits members of seven colleges to perform acupuncture under exemption, including chiropodists, chiropractors, massage therapists, nurses, occupational therapists, physiotherapists and dentists. Naturopaths will soon be added to the list. Members of other regulated professions, such as practitioners of traditional Chinese medicine and physicians, can perform acupuncture under the authorization of their profession-specific Acts. RPs are not permitted to perform acupuncture under the *Psychotherapy Act* or by exemption.

Delegating a Controlled Act

A health care provider who is authorized to perform a controlled act can delegate the controlled act to another health care provider or to an unregistered person. However, the following rules govern the delegation of a controlled act:

- The person giving the delegation is limited by any regulations or professional standards of his/her college.
- The person receiving delegation is also limited by any regulations or professional standards of his/her college.
- The person delegating the procedure is responsible for the actions of the person receiving the delegation.

Controlled Acts Scenario No. 2

Diana, a Member, provides psychotherapy to her client Petra. Psychotherapy is a controlled act authorized to RPs under the *Psychotherapy Act*. Diana is authorized to perform that controlled act.

Controlled Acts Scenario No. 3

Frank, an RP, has a plate of cookies in his waiting room. Connor, a client, eats one and goes into anaphylactic shock. Frank recalls that Connor has a peanut allergy and realizes that the cookies may have peanuts in them. Frank looks inside Connor's briefcase and finds an EpiPen containing a measured dose of epinephrine. Frank injects the epinephrine into Connor's muscle and calls 911. Connor recovers. While Frank did perform a controlled act not authorized to him (injecting a drug), he did so under an emergency which is a recognized exception to the controlled acts rule.

Controlled Acts Scenario No. 4

Karen, a therapist, only works part time. Her other job is to perform artistic body piercings. Even though such piercings go beyond the dermis, this procedure is exempted under the Minister's regulation on controlled acts.

Controlled Acts Scenario No. 5

Daniela, an RP, works with a physician. Because of Daniela's knowledge of pharmacology, the physician trusts Daniela to dispense samples of some medications while the physician is not present. The physician delegates this intervention to Daniela through a written medical directive. Daniela is permitted by the delegation to provide these medications. However, both Daniela and the physician will be responsible if something goes wrong.

Sample Question

Which of the following is a controlled act:

- i. Removing broken glass that has been deeply embedded in a child's leg.
- ii. Cleaning a scrape on a child's elbow with soap and water.
- iii. Applying alcohol to that scrape on a child's elbow.
- iv. Wrapping the child's wounds.

The best answer is i. Deeply embedded glass has almost certainly gone beyond the dermis and is sitting in deeper tissue. There may be an issue as to whether this is an emergency (likely not as in most cases it would be possible to take the child to a hospital or physician's clinic for treatment), but that does not change the fact that removing the glass is a controlled act. Similarly, the household exemption does not apply to these sorts of procedures.

Answer ii is not the best answer because a scrape on the skin implies that it has not gone beneath the dermis.

Answer iii is not the best answer because applying a substance to the skin is not administering a substance by inhalation or injection.

Answer iv is not the best answer because the procedure is above the skin and does not fall within any of the other controlled acts.

II. Scope of Practice

A regulated health profession's scope of practice is a general description of what that profession does. Under the Psychotherapy Act, the scope of practice statement reads as follows:

The practice of psychotherapy is the assessment and treatment of cognitive, emotional or behavioural disturbances by psychotherapeutic means, delivered through a therapeutic relationship based primarily on verbal or non-verbal communication.

No profession has an exclusive scope of practice. As long as it is within their scope of practice, members of other professions can do the same things that RPs can do.

The regulated health profession's scope of practice is intended to protect the public from harm by ensuring that regulated health professionals do not engage in activities which pose risk for their clients if they are not trained in these activities. For example, if a Member treated a client's cancer by using procedures outside of his/her scope, such as surgery, the therapist could face discipline or even prosecution.

Members are permitted to provide information that lies outside of their scope of practice, as long as it is not inherently dangerous, and provided the client understands that the information comes from the therapist's personal experience only.

Scope of Practice and Risk of Harm Scenario

Ava, a Member, is seeing Margot, a client diagnosed with Stage IV cancer. Margot is scheduled for surgery the following week, to be followed by chemotherapy. Margot's physician says that the treatment has a 50% chance of success (meaning she will be alive and cancer free in five years' time, and that without treatment, Margot has a less than 50% chance of surviving for five years.)

After a careful assessment, Ava advises the client to cancel both the surgery and the chemotherapy. She recommends a combination of relaxation tapes and a fasting cleansing program followed by an all fruit diet. Margot dies within two months and the family goes to the police asking that Ava be prosecuted under the risk of harm clause.

In this case, Ava provided treatment that is outside of the scope of practice of a Member of the College. The treatment also appears to have no evidence to support it. There was an inherent risk of harm in advising the client to reject the proposed medical treatment that had evidence of a reasonable chance of recovery, in favour of a treatment that had not been fully researched.

III. Use of Titles

The *RHPA* restricts the use of titles, including the use of Doctor, and those titles conferred by health profession regulatory colleges.

► The Doctor Title

The *RHPA* restricts use of the title *Doctor* to members of certain regulated professions. If a person is not a member of one of the approved health professions, s/he cannot use the title *Doctor* in a clinical setting, even if the person has an earned doctoral degree (i.e. the person holds a Ph.D). Under this provision, the title *Doctor* can be used in other settings, such as socially or in a purely teaching setting, where there are no clients.

Registered Psychotherapists are not permitted to use the title *Doctor* in a clinical setting. In addition, allowing a staff member to call an RP *Doctor* in a clinical setting would constitute an offence.

► RP / Registered Psychotherapist and RMHT / Registered Mental Health Therapist titles

The *RHPA* states that only Members of this College can use the titles RP, Registered Psychotherapist, RMHT, Registered Mental Health Therapist or any variation of those titles. Moreover, Members may only use the title associated with their class of registration.

Note: Consideration of who may be registered in the RMHT category has been deferred until after the *Psychotherapy Act* has been proclaimed. Until such time as a future Council determines how the title will be used, no one will be registered using that title.

Anyone not registered with the College is restricted from using these titles or any variations. In addition, a person who is not registered with the College is prohibited from holding him/ herself out as someone qualified to practise psychotherapy in Ontario. These restrictions prevent people from pretending they are RPs or RMHTs when they are not. An exception exists for members of five other regulated professions authorized to practise psychotherapy, including nurses, occupational therapists, physicians, psychologists & psychological associates, and social workers & social service workers.

According to the standards of the College, Members are able to use a title indicating specialization, but only where the title has been earned, is conferred by a recognized credentialing body and meets established standards. Prominence must be given to the Member's regulated title.

Finally, there are general Professional Misconduct Regulations prohibiting Members from using misleading titles or designations, or engaging in false or misleading advertising. For example, it would be professional misconduct for an RP to refer to an educational degree that has not been earned.

Use of Titles Scenario No. 1

Laura, a Member with a Ph.D., teaches at a school that trains students in the practice of psychotherapy. The school operates a clinic where clients are seen. Laura supervises the students at the clinic and the students refer to her as "Doctor Laura" at the clinic. The Dean of the school pulls Laura aside and tells her to ask her students to stop calling her Doctor in the clinic where there are clients. It is OK in the classroom, but not the clinic. Laura reviews the RHPA and realizes that the Dean is correct. Laura is assisting with the therapy of clients in the clinic and thus is not permitted to call herself (or allow others to call her) Doctor. Laura also recognizes that she was being a poor role model for the students.

Use of Titles Scenario No. 2

Marla, an RP with a specialty designation, has decided to start a private practice and has just designed her new business cards, brochures and an internet advertisement. Marla shows her designs to a colleague who notes that on all her advertising she accurately gives prominence to her RP regulated title, except in the internet ad.

Marla explains that she was limited to the number of words she could use in the ad and wanted to most accurately describe what she does in her practice.

The colleague rightly points out to Marla that she must always use and give prominence to her regulated title, and advises that she either purchase a larger ad or remove the specialty title in favour of her regulated title. Marla consults College guidelines on the use of titles and confirms that her colleague gave her correct advice.

IV. Mandatory Reports

There are a number of specific reports that Members are required by law to file. For example, RPs are compelled to file a mandatory report when another regulated health professional is sexually abusing a client.

Members are protected in a number of ways when filing these reports; both the *RHPA* and case law provide immunity to members of a regulated health profession who make a mandatory report in good faith. The mandatory reporting requirements also create an exception to the Member's duty of confidentiality. In circumstances where a report must be filed with a college, the *PHIPA* allows exceptions to the expectation of privacy.

► Sexual Abuse Mandatory Report

Members must report sexual abuse by another regulated health professional if there are reasonable grounds to believe that the health professional has sexually abused a client.

Reasonable grounds means the information would cause a reasonable person, who is not familiar with the individual involved, to conclude that it is more likely than not that the information is correct. Reasonable grounds could arise even if the Member did not personally observe the sexual abuse. It would likely constitute reasonable grounds, for example, if a client tells his/her RP details of the abuse.

The report must follow these requirements:

- The report must be made, in writing, within 30 days of receiving the information;
- if it appears that a client is continuing to be harmed and there is an urgent need for intervention, the report must be made right away;
- it should be directed to the Registrar of the college to which the alleged sexual abuser belongs;
- the reporting RP's name and the alleged grounds of the report must be included; and
- to protect the privacy of potentially vulnerable clients, the report cannot include the client's name unless the client consents in writing.

There is an additional mandatory reporting obligation where the Member is providing psychotherapy to another regulated health professional (e.g. a Member providing psychotherapy to a client who is an RP or a chiropractor, dentist, nurse, etc.). It may happen that the Member learns, or has reasonable grounds to suspect, that the health professional has sexually abused one of his/her clients. In such cases, the Member must file a mandatory report with the Registrar of the college to which the alleged sexual abuser belongs, even though this breaches client-therapist confidentiality.

In addition to the requirements noted above, the mandatory report must also contain an opinion as to whether the alleged abuser is likely to sexually abuse clients in the future, if the Member is able to form such an opinion.

If the alleged abuser ceases psychotherapy with the Member, the Member must immediately file an additional report with the college to which the alleged abuser belongs. Again, the report must include an opinion as to whether the health care provider is likely to abuse again, if the Member is able to form such an opinion.

It is also mandatory for the operator of a facility (e.g. clinic, hospital, agency) to file a report if s/he has reasonable grounds to believe that a Member of this College (or any other college) has sexually abused a client. An operator of a facility may or may not be a regulated health professional, but has this duty nonetheless. Such a report must be filed with the Registrar of the college to which the alleged sexual abuser belongs, in accordance with the requirements noted above.

Sexual Abuse Mandatory Report Scenario

Prisha, an RP, is told by her client, Ivy, that Ivy had an affair with her family doctor who was treating her while the affair was going on.

Prisha tells Ivy that she is required by law to report this information to the Registrar of the College of Physicians and Surgeons of Ontario (CPSO). Prisha explains that the CPSO will want to investigate the report. The CPSO will likely want to interview Ivy about the affair. The investigation could lead to a discipline hearing.

However, the law is clear that Prisha cannot include Ivy's name and contact information in her report, unless Ivy is prepared to sign a written consent permitting Prisha to do so. Prisha says that they can call the CPSO right now, on an anonymous basis, to see what the process would be like. Ivy agrees to the telephone call. After the call Ivy says that she will not give her consent to include her name and contact information. Prisha then provides the report in writing without identifying Ivy.

► Incompetence, Incapacity and Professional Misconduct Mandatory Report

A Member must file a report if s/he ends a business relationship with another regulated health professional (e.g. a partnership, employee/employer relationship, a corporation, or space sharing arrangement) on the basis that the other professional is incompetent, incapacitated or engaged in professional misconduct. The report must be made even if the other person in question quit or resigned before the business arrangement ended.

The report must:

- be made in writing within 30 days of receiving the information;
- be made right away if clients are continuing to be harmed and there is an urgent need for intervention;
- should be directed to the Registrar of the college to which the subject of the report belongs; and
- must include the RP's name and the alleged grounds for the report.

Under this mandatory reporting obligation, the name of affected clients can be included without their consent.

As previously mentioned, the operator of a facility (e.g. clinic, hospital, agency) may or may not be a regulated health professional; however, s/he has reporting obligations nonetheless. It is mandatory that the operator of a facility file a report if s/he has reasonable grounds to believe that a Member of this College (or any other college) who practises in the facility is incompetent or incapacitated. Such a report must be made even if the business relationship with the regulated health professional who is the subject of the report continues. For example, if an RP operating a facility knows that a regulated health professional working there is in a treatment program for drug addiction, a report would still have to be made. The report should be filed according to the requirements noted above. (See Section 3, *Mandatory Reports*, p.51.)

Incompetence, Incapacity and Professional Misconduct Mandatory Report Scenario

Amir, an RP, learns that his employer, also an RP, is an alcoholic. Amir tries to help his employer get treatment, but the employer keeps relapsing. Yesterday the employer came back after lunch obviously impaired. Amir called his employer's wife to pick him up and take him home.

What concerned Amir most was that his employer treated three clients after lunch before Amir became aware of his condition. Amir is preparing his letter of resignation and consults a lawyer about what to do. The lawyer advises him that he must make a written report to the Registrar of the College, and explains that the report should include Amir's own name, the grounds for the report, and the names of the three clients seen after lunch on the day of the incident. Amir files the report.

► Offences – Mandatory Self-Report

Members must inform the college when they have been found guilty of an offence (i.e. finding by a court). All offences, including criminal offences, offences under federal drug or other legislation and provincial offences (e.g. highway traffic offences) must be reported to the college.

Only courts can make offence findings. Thus any findings by a body that is not a court, such as a tribunal, are not reportable under this provision. All findings are reportable regardless of whether or not they resulted in a conviction, for example, an absolute discharge order for assault, a conditional discharge order for theft or a conviction for public mischief.

Reports must be made to the Registrar of the College as soon as possible after the finding, and should contain the following information:

- name of the RP filing the report;
- nature of, and a description of the offence;
- date the RP was found guilty of the offence;
- name and location of the court that found the RP guilty of the offence; and
- the status of any appeal initiated respecting the finding of guilt.

Once a report is filed, it will be reviewed by the College and may result in an investigation. However, the report is not automatically placed on the public register. If there is an appeal that alters the information reported, an **updated report must be made**.

Offence Mandatory Report Scenario

Keri, an RP, is found guilty of careless driving under the Highway Traffic Act. On the College's annual renewal form she sees a question asking if she has been found guilty of any offence. She cannot believe that this question is meant to include her careless driving charge. She calls the College for clarification.

Keri is told that the RHPA requires all offences to be reported. The intent of requiring such reports is to prevent Members from determining whether the findings are relevant or not. That decision is made by the College. In fact, Keri should have reported the finding when it occurred and not waited six months for the annual renewal form. Keri makes the report and a few weeks later she receives a letter from the College thanking her for her report, stating that the College does not believe that this finding is worth investigating further, and reminding her that in future such findings need to be reported right away.

► Professional Negligence – Mandatory Self-Report

RPs found by the courts to have engaged in professional negligence or malpractice must report themselves to the Registrar of the College.

Findings by a tribunal do not need to be reported. Moreover, settlements of claims for professional negligence need not be included if they did not result in a court finding.

Reports are to be made to the Registrar of the College as soon as possible after the finding and should contain the following information:

- name of the RP filing the report;
- nature of, and a description of the finding;

- date of the finding;
- name and location of the court that made the finding; and
- the status of any appeal initiated respecting the finding.

The report will be reviewed by the College and may result in an investigation. The report is automatically placed on the public register. (See Section 3, Public Register, p.57.) If there is an appeal that alters the information reported, an updated report must be made.

Professional Negligence Mandatory Report Scenario

Lenora, an RP, is sued in Small Claims Court by a client, Donovan. Donovan claims that he told Lenora about pain in his lower abdomen but that Lenora attributed those symptoms to stress. After an initial assessment and two weeks of supportive therapy for stress, despite increasing pain, Donovan went to the emergency department. He was rushed into surgery and stayed in the hospital for almost a week. He claims that Lenora should have referred him to another health care provider to rule out a physical condition before assessing and treating the symptoms as purely stress-related.

The Small Claims Court judge agreed and ordered Lenora to pay Donovan \$10,000 for malpractice. Lenora reports the finding to the College. The College places a note about the finding on the public register.

► Duty to Warn & Mandatory Reporting

A regulated health professional who has reasonable grounds to believe that someone is likely to cause severe bodily harm either to him/herself or another person must warn the appropriate authorities of the risk. It may also be necessary to warn the person who is the subject of the threat, unless it is impossible to do so. This duty applies whether the person threatening harm is a client, colleague, a professional regulated by another college, or any other person.

If a Member has reasonable grounds to believe that another RP is likely to cause harm (or has caused harm), the Member is obligated to report this to the College Registrar. The College has included an aspect of this duty to warn in provision 39 of its Professional Misconduct Regulation:

Failing to promptly report to the College an incident of unsafe practice by another member if the member believes on reasonable grounds that the other member has committed such an incident [may be grounds for professional misconduct].

This report must be made promptly to the College and may include the name of a client without his/her consent.

If a Member has reasonable grounds to believe that **a client** will harm him/herself or another person, the appropriate authorities must be alerted. This may include the police or emergency medical services, other relevant health care providers involved in the client's care, and possibly the person who is the subject of the threat. Members are not required to report such incidents to the College.

Duty to Warn Mandatory Report Scenario

Terry, an RP, learns from his client, Kathy, that another RP strongly recommended that Kathy undergo eye movement desensitization and reprocessing (EMDR) sessions to ease a recent spate of traumatic memories. The EMDR sessions caused some abreactions in Kathy, leaving her disoriented and dissociative for several hours after she left the sessions.

Terry mentioned this to the other RP who seemed to shrug off his concerns dismissively. The RP stated that those reactions sometimes happen, and that there was nothing to be concerned about. Kathy's distress seemed to continue, and she sought out Terry, expressing concerns about how she was being treated, and indicating that she would be uncomfortable telling the RP of her wish to discontinue the EMDR sessions.

Terry is concerned that EMDR may not be safe for Kathy at this time, certainly not the way it is being conducted. He is also concerned that the RP is not practising EMDR in a safe, effective, or clinically sensitive way. Terry calls the College to discuss the case on a no-names basis to see whether he should report the matter to the College.

Sample Question

Is a mandatory report required where a Member overhears another RP tell two male clients a sexually explicit joke that causes the clients to laugh loudly?

- i. No. Dirty jokes are not sexual abuse.
- ii. Yes. This is sexual harassment. The report should be made to the Human Rights Tribunal.
- iii. No. The clients liked the joke and would not have been harmed by it.
- iv. Yes. This constitutes sexual abuse.

The best answer is iv. Sexual abuse includes comments of a sexual nature to a client. Reporting sexual abuse is mandatory. While it is unlikely that punitive action will be taken by the College (perhaps a sensitivity course), it is still important that RPs learn that such conduct can be harmful to some clients. One never knows what experiences clients have had in their past that might make even a dirty joke harmful.

Answer i is incorrect because dirty jokes are considered sexual abuse as that term is defined in the RHPA.

Answer ii is not the best answer because there are no mandatory reporting requirements under the Human Rights Code. Also, the RHPA uses the term sexual abuse rather than sexual harassment and gives that term a unique meaning.

Answer iii is not the best answer because whether the client was a willing participant or not is irrelevant. The joke should not have been told. Also, one never knows what experiences clients have had in their past that might make even a dirty joke harmful. In addition, sexualizing the practice of the profession is inherently confusing to clients who assume that there is no sexual aspect to their relationship with RPs.

V. Public Register

The *RHPA* requires that the public is able to obtain certain information about Members of the college. This information helps the public (e.g. clients, employers) decide whether to choose a particular therapist, and helps to ensure that therapists practise only as they are permitted to. For example, if a therapist is suspended for three months, this information would be posted on the college's public register.

The register must include contact information for the therapist, the class of registration, and any terms, conditions and limitations on the registration. It must also include any referrals to the Discipline Committee for a discipline hearing, a summary of every finding of professional misconduct, incompetence or incapacity and any findings by a court of professional negligence. Every suspension and revocation of registration must be included in the register as well as any agreement to resign and any agreement to never reapply for registration.

There are only a few circumstances where the college can choose not to place such information on the register, or remove information from the register, such as the following:

- The information (e.g. contact information) would jeopardize the safety of a Member (e.g. if an RP is being stalked).
- The information is obsolete or no longer relevant (e.g. if a finding of professional misconduct relating to conduct that is now acceptable, such as advertising by telephone which is now allowed under certain conditions).
- The information is unnecessary (e.g. with respect to incapacity matters, if the information relates to the personal health of a Member).
- After six years, where there was only a reprimand, a fine or a finding of incapacity, and the Discipline Committee or Fitness to Practise Committee agrees that there is no public interest in keeping the information on the public register.

The information on the register is available to the public in a number of ways: on the college's website; at the college's office; or on paper, if a paper copy of information is requested. The college is also permitted to provide information available on the register over the telephone. Where there is an inquiry about a Member, the college must assist, and may provide any information that is available on the register.

Public Register Scenario

Janet, a therapist, has separated from her husband. He has physically assaulted Janet a number of times, and since the separation, has been following her. The police cannot seem to stop Janet's husband. Janet moves to another city and asks the Registrar not to put her business address or telephone number on the public register so her husband cannot find her. Janet provides documents from the police and the courts about her husband's behaviour. The Registrar removes Janet's contact information from the public register.

VI. Professional Corporations

A Member can choose to practise personally (i.e. in his/her own name), through a partnership or through a professional corporation. Therapists who already have a regular business corporation will need to change that corporation to a professional corporation once they become registered with the College.

Professional corporations have a number of conditions and restrictions. These include the following:

- only Members can hold shares;
- the officers and directors of the professional corporation must be shareholders;

- the name of the professional corporation must include the words “Professional Corporation;”
- the professional corporation cannot be a numbered company (e.g. 1234567 Ontario Inc.); and
- the professional corporation can only offer psychotherapy services, or provide related or ancillary services.

Members cannot avoid professional liability through the creation of a professional corporation. For example, injured clients can sue the RP personally even if they provide their services through a professional corporation. However, RPs working through a professional corporation have protection against trade creditors. For example, if suppliers or other creditors are not paid by the professional corporation, they cannot sue the RP personally.

A number of provisions exist to ensure that all Members meet their professional and ethical obligations, even if they practise through a professional corporation. The College has the same powers over the professional corporation as it has over the RP.

Professional Corporation Scenario

Fraser, an RP, has had a business corporation for many years before the College was created. His wife and children are shareholders. It is not a professional corporation. What are his options?

Fraser must do something. He cannot continue to operate a regular business corporation once he becomes registered because it does not follow the rules for professional corporations. Fraser must either convert his business corporation into a professional corporation, or give up the business corporation. Fraser’s wife and children cannot be shareholders of the professional corporation unless they are also registered with the College. If Fraser gives up the business corporation, he cannot practise the profession through it. Fraser should speak to his accountant or lawyer to get advice on what is best for him.

C. PSYCHOTHERAPY ACT, REGULATIONS, BY-LAWS

The *Psychotherapy Act* is the profession-specific statute of the College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario. It establishes the College, sets out the scope of practice and controlled act for Members, and authorizes the College to make a number of regulations. Several of these regulations are discussed below.

I. Registration Regulation

The Registration Regulation sets out requirements for obtaining and maintaining registration, or entry to practice, with the College. It establishes the following classes of members:

- *Registered Psychotherapist*, a class intended for individuals whose primary practice is psychotherapy;
- *Temporary*, a class intended for individuals registered elsewhere who wish to practice in Ontario for a specific, time-limited purpose (e.g. teaching a course);
- *Inactive*, a class intended for existing Members who are not practising the profession; and
- *Qualifying*, a class intended for individuals who have completed an education/ training program and have substantially completed their registration requirements, and who wish to practise under clinical supervision while completing the full requirements.

To become a registered Member of the College, therapists must complete an application form that includes information about their training, experience and past professional experience. Applicants must also pay the required fees and provide evidence of professional liability insurance coverage.

The applicant must be able to speak, read and write either English or French with reasonable fluency. Applicants cannot be incapacitated. They must report all criminal offences that resulted in court findings, as well as other details relating to their professional history, such as prior professional discipline findings. In addition, they must have completed an approved professional practice and jurisprudence learning module on basic health regulation and law.

Each class of registration has specific registration requirements. For the RP category, requirements include completion of an acceptable education and training program, and passing the registration examination, among others. For established therapists practising in Canada at the time of proclamation of the *Psychotherapy Act*, there was a time-limited alternative route to registration, known as *grandparenting*. **This registration route is now closed.**

An applicant for Inactive membership must first be registered as an RP and must promise not to engage in direct client work or supervise direct client work.

Ontario legislation also allows qualified applicants registered elsewhere in Canada to transfer to Ontario with recognition of their qualifications based on labour mobility provisions.

Members of each class of registration are assigned one of the titles, which they must use so the public can identify their registration status.

Once a therapist is registered with the College, s/he must continue to meet certain requirements of the College. For example, if a Member is found guilty of a criminal or other offence, or if a Member is disciplined by another professional regulator, the Member must inform the College. (See Section 3, *Mandatory Reports*, p.51.)

Registration Regulation Scenario

Marla applies for registration. When she was in university she got involved in a fight at a pub and was convicted of assault. A few years later she obtained a pardon. When applying for registration, she is asked if she has ever been found guilty of a criminal offence. She is uncertain whether she needs to report the pardoned offence.

College staff tell her she must do so because it would be dishonest to say she had never been found guilty of an offence. The pardon does not absolve her of the need to disclose the offence. Marla reports the offence, and the Registrar asks her for more details. The Registration Committee determines that the offence does not make her unsuitable to be a Member of the profession and registers her.

II. Professional Misconduct Regulation

The *RHPA* has identified a number of actions, including sexual abuse of a client and failing to cooperate with the quality assurance program, as professional misconduct for all regulated health professionals.

As well, this College's Professional Misconduct Regulation sets out additional examples of professional misconduct including:

- failing to meet standards of practice of the profession;
- inappropriate behaviour towards clients or the public, including physical or verbal abuse of clients, and rude or unbecoming behaviour towards clients, members of the public or other health professionals;
- failing to make and keep appropriate and adequate records;
- failing to obtain informed consent before assessing or treating a client;
- failing to properly delegate the controlled act of psychotherapy;

- failing to maintain confidentiality;
- engaging in conflict of interest;
- improper billing and fees;
- misrepresentation, dishonesty in one's dealings with clients, colleagues, third party payors or the College;
- improper use of names, title or designations;
- improper advertising;
- impolite or uncooperative conduct towards colleagues; and
- disregarding restrictions on one's certificate of registration (e.g. a Member who is required to practise with clinical supervision or other supervision must do so, in accordance with the restriction on his/her certificate).

► **Conduct towards the College**

Professional misconduct may also involve inappropriate conduct towards the College, including:

- publicly challenging the integrity of the College's role or actions;
- breaching an undertaking given to the College;
- failing to participate in the quality assurance program;
- failing to respond appropriately and promptly to correspondence from the College; and
- failing to report an RP to the College who has jeopardized the safety of a client.

In addition, the RHPA deems failing to co-operate in an investigation by the college, or obstructing an investigation by the college as professional misconduct. The document, Professional Practice Standards and Guidelines provides greater detail about professional conduct and is posted on the College website.

► **Catch-all Provisions**

Two general 'catch-all' provisions cover types of conduct not specifically dealt with elsewhere in the regulations. One prohibits conduct that would be reasonably regarded as "dishonourable, disgraceful or unprofessional." This provision assumes that there is a general consensus in the profession of conduct or behaviour that would be considered unacceptable. For example, there is no specific provision that says that the therapist cannot verbally abuse a client's mother during a visit; however, no one doubts that this conduct would be unprofessional.

The second catch-all provision makes it professional misconduct to engage in conduct "unbecoming" a Member of the profession. This provision refers to conduct in a therapist's private life that brings discredit to the profession. For example, a therapist who engages in fraud on the stock exchange could be disciplined for dishonesty.

Professional Misconduct Scenario

Evan, a psychotherapist, has recently been criticized by his colleague, Wendy, who works in the same clinic. She suggests that Evan is sometimes too loud with his clients. Wendy mentions that in speaking loudly he is disrupting others working in the office. Evan tells Wendy that he is sorry for disrupting her, and any of her clients, and that he will try to lower his voice out of respect for others. Wendy feels this is a serious problem and thinks that Evan should be reported to the College for professional misconduct. She wants the very best atmosphere created for her clients, and thinks loud talking is completely unprofessional. Is Wendy correct in saying this would be professional misconduct according to the regulations?

Probably not. Wendy holds a particular view about Evan's level of voice that may not be consistent with the rest of the profession. Unless the conduct persists and unless it is so loud that most neutral observers would agree that Evan is disrupting the rest of the office, it is not professional misconduct.

While it is courteous for Wendy to raise the issue with Evan so they can come to a reasonable resolution, professional misconduct is not meant to apply to uniquely personal views of unacceptable behaviour. Instead, it relates to conduct that is considered unacceptable by general consensus of the profession.

Sample Question

Which of the following is possible professional misconduct according to the Professional Misconduct Regulation?

- i. Failing to maintain client confidentiality.
- ii. Using verbal threats and insults in an email to a client because s/he did not show up for an appointment.
- iii. Charging a higher rate because a third party is paying for the service.
- iv. All of the above.

The best answer is iv. The regulation describes many types of professional misconduct. All of the situations described involve conduct that is specifically prohibited in the Professional Misconduct Regulation.

Answers i, ii, and iii are not the best answers because all the situations listed in the question are clear examples of professional misconduct.

III. Record-keeping

Good record-keeping is essential for good client care. The client record is intended to capture what was done and what was considered by the therapist. Records permit the monitoring of changes in a client's status and can assist other therapists who may also see the client. Records enable an RP to explain what s/he did for clients if questions arise later, and may help defend the RP if a client recalls things differently. Failure to make and keep adequate records can be a failure to maintain minimum professional standards and therefore may be considered professional misconduct.

► How records are kept

Records may be kept on paper or electronically on a computer. Computerized records should be printable and viewable and should have an audit trail of changes made. All records must be legible, and while information can be recorded in other languages, it must also be recorded in English or French. It should be clear who made each entry and when that entry was made. Importantly, any changes to the record should still permit the reader to read the original entry. This includes changes to the client record.

Therapists cannot falsify records, meaning that, if an error is made in a previous entry, it cannot be removed (e.g. “whited-out” or deleted). The original wording should be maintained with the correction noted. Usually this is done by adding a single line through the erroneous entry and writing in the correction, along with the date and initials of the person correcting the error.

► **How long to keep records**

Records need to be kept for 10 years from the last interaction with the client or the client’s 18th birthday, whichever is later. Financial records, appointment and attendance records need only be kept for five years.

When the time period for keeping the record has expired, the records should be destroyed in a secure manner that prevents anyone from accessing, discovering, or otherwise obtaining the information. If a therapist destroys any records, s/he should record the names of the destroyed files and the date they were destroyed.

► **Maintaining or transferring records upon leaving a practice or retiring**

In general, the entire original record should be kept by the Member (or the health information custodian) and only copies of the record should be supplied to others.

Even when an RP retires or leaves the practice, the original record should be kept for the 10 year retention period, unless it has been transferred to another therapist who will maintain the record. The client must be notified of the transfer.

The only exception arises when there is a legal requirement to provide the original record (e.g. in a police, Coroner’s or college investigation, or with a summons). In such a circumstance, the Member should keep a legible copy of the record.

When transferring from paper to electronic records, the electronic version of the document becomes the original.

► **Confidentiality and privacy issues**

Therapists should take reasonable steps to keep records safe and secure. In general, no one other than authorized health professionals in the client’s circle of care should be able to access the records. Privacy protections must be in place to ensure that records cannot be seen, altered or removed by others. Paper records should be kept under lock and key, and electronic records stored on a computer must be password protected. Computers used to store records must have firewall and virus protections, and must be backed up on a regular basis.

► **Client access to records**

Although the therapist may own the client record and be responsible for it, clients are authorized by *PHIPA* to access their record. An exception applies if access would significantly jeopardize the health or safety of the client or another person. Clients also have the right to correct any errors in their client record. If a client requests any relevant parts of the record, the RP should provide a copy and not the original.

Record-keeping Scenario No. 1

Stan, an RP, who has been practising for 45 years in the same practice, decides he is ready for retirement but wonders what he is supposed to do with his client records.

Ordinarily he would have to retain client records for 10 years from the last interaction with the client or the client’s 18th birthday, whichever is later. But, in this case, Stan may be transferring his practice to another therapist to take over the business and clients. If this is the case, he does not have to retain the records himself but needs to notify the clients of the transfer of their records. This can be done through a combination of telling clients on their next visit and placing a notice in the local newspaper.

General requirements for the content of the health record

- The record should always contain identifying information such as the name and date of birth of the client. Identifying information should be on each document in the record so that a particular document may be returned to the record if separated.
- The record should include all relevant subjective and objective information gathered regarding the client. This includes information provided by the client (or his/her authorized representative, or other health care providers involved in the client's care), regardless of the medium or format (e.g. communicated in person, on paper, email, fax, telephone, etc.). It also includes any records regarding observations (e.g. how the client walked into the office).
- Any results of testing done (including psychological testing, etc.) by the Member should be recorded. If a client discloses test results from another health professional, this should be noted in the record. However, a Member does not have to ask for copies of reports if they are not needed.
- The client's condition prior to therapy should be recorded. Following this, the actual assessment and/or therapy provided should be noted. The record should also include any progress notes on how the client progressed during therapy, any changes in the client's condition, any reassessments or any modifications to the plan for therapy. The notes should be clear to any RP reading the record.
- If the client was referred by another health care professional, the name of the person who made the referral and the reason for the referral should be recorded.
- Any consent that is obtained should be included in the record, such as copies of signed consent and any notations of consent, including verbal or implied.

Record-keeping Scenario No. 2

Stuart, a therapist, sees a couple together for five sessions, then invites their adult daughter to join them for two sessions. Following this, the mother has two sessions just with the daughter. The couple then continues therapy for three more sessions as a couple. Stuart is unsure as to whether he should maintain these records together, separately or a combination of both.

Generally, this issue is best discussed with the three clients at the beginning of their involvement. In the absence of prior client consent, Stuart should work on the assumption that he should keep a record for each client. Each client's record should include information gathered from sessions in which the client participated.

Stuart separates the record into three subfiles and in each subfile places all the notes for sessions where the client was present. This requires Stuart to make copies of the notes for the sessions where more than one client was present.

Sample Question

Which one of the following does not need to be recorded in the client's record?

- i. The client's birth date.
- ii. The name of the client's friend who recommended the therapist.
- iii. The client's health concerns.
- iv. The therapy plan for the client.

The best answer is ii. Only if the client was referred by a health care provider must there be a record of who recommended the client. If another client referred the person or the person found out about the practice through advertising, such information does not have to be recorded (although in some cases it would be helpful to record this information).

Answer i is not the best answer because RPs need to record the client's birth date. It is relevant to many treatment decisions.

Answer iii is not the best answer because RPs need to record the client's health concerns (sometimes called chief complaints). It is relevant to many treatment decisions.

Answer iv is not the best answer because RPs need to record the therapy plan for the client. It is relevant to following through with the therapy on future visits and for justifying one's actions should questions be raised later.

IV. Conflict of Interest

A conflict of interest arises where a Member does not take reasonable steps to separate his/her own personal interests from the interest of clients. For example, if an RP refers a client to a health store owned by the therapist's friend, to buy products, a reasonable person would question whether the RP recommended that product because the client needed it or in order to help his/her friend.

There is no need for proof of an actual conflict of interest. Instead, one looks to what a reasonable person might conclude from the circumstances regardless of what is actually going on in the mind of the therapist. A conflict of interest can be actual, potential or perceived. The therapist should always ask him/herself – might another objective and reasonable person think there is a conflict of interest, given this circumstance?

There are circumstances where taking certain safeguards could remove the concern regarding a potential conflict of interest. These include:

- disclosing the nature of the relationship in questions (e.g. "My friend owns the health food store I'm recommending");
- providing alternative options (e.g. "Here are three other places you could get the product I'm recommending"); and
- reassuring the client that choosing another store will not affect the client's care (e.g. "You're free to choose any of the places to get the product; you will still be welcome here as my client").

Members must provide the college with any documents, explanations or information regarding a suspected conflict of interest if requested to do so. This is to enable the college to assess whether a conflict of interest actually exists.

Common examples of conflict of interest

- Splitting fees with a person who has referred a client;
- receiving benefits from suppliers or persons receiving referrals from an RP;
- giving gifts or other inducements to clients who use the Member's services where the service is paid for by a third party (e.g. insurance);
- working for an unregistered person who can interfere with professional decisions (e.g. how much time is scheduled for each appointment);
- using or referring a client to a business in which one has a financial interest;
- selling a product to a client for a profit;
- having a dual relationship with a client in addition to the professional one, which would reasonably be seen as affecting the member's professional judgment or adversely affecting a client's confidence in the Member; and
- bartering services with a client, except for products or services of equal or lesser value, when a client cannot afford to pay, so long as the exchange would not reasonably be seen as affecting the Member's professional judgment or adversely affecting a client's confidence in the Member.

Conflict of Interest Scenario No. 1

Catherine, a psychotherapist, owns a practice down the street from a women's shelter. She has been practising there for less than a year. She is trying to build her practice and wants people to know she's new to the neighbourhood. Catherine offers to give the administrator of the women's shelter free dinner and theatre tickets in return for her referring well-to-do clients fleeing spousal abuse to Catherine's practice.

While this may seem like a good business decision, Catherine is in a conflict of interest. Catherine cannot give a free ticket to the administrator of the women's shelter in order to obtain referrals, as this would constitute a form of benefit or inducement. Clients should be referred to Catherine based on an honest view of the appropriateness of the referral by the administrator, not because the referring person is getting free dinner and theatre tickets.

Conflict of Interest Scenario No. 2

Ayawamat, an RP, recently began using new "Nature's Calm" relaxation tapes. Clients have responded quite well to them. Ayawamat calls the company to explain how helpful the tapes have been to his clients.

The company asks him if he would like to participate in a new magazine advertising campaign. They plan to run a picture of him in the advertisement, identify him by name and qualifications and include his support for the product. They say they cannot pay him because they are still a small company, and don't have the budget for it. Ayawamat agrees.

Unfortunately, this would likely be a conflict of interest and therefore would constitute professional misconduct. Ayawamat cannot use his professional status to promote a product commercially, even though he has not been paid for the endorsement. It can be assumed that he will benefit from the advertisement in some indirect manner (for example, he may have increased client influx from those people who see the advertisement).

Also, Members should not make blanket clinical recommendations, such as an advertising testimonial. Ayawamat can give advice on products and remedies, including recommending a tape to clients, provided it is within a client-therapist relationship, and is based on professional judgment regarding a client's individual needs based on a proper assessment.

V. Advertising

Therapists are permitted to advertise as long as it provides relevant information to the public enabling them to make informed choices regarding their health care needs.

Advertising should be factual, accurate, objectively verifiable, independent of personal opinion, and professionally appropriate. It should not include any information that misleads, either by leaving out relevant information, or including non-relevant, false, or unverifiable information. Therapists should also take reasonable steps to ensure that advertisements placed by others (e.g. employees, marketing consultants) meet these standards as well.

In particular, references to qualifications in the advertisement should be consistent with the college's Standards. For instance, the title the Member can use will depend on his/her class of registration. Fees or prices advertised should meet expectations for honesty and accuracy.

Advertisements are prohibited if they promote a demand for unnecessary services, pressure vulnerable clients, make a claim, or promise a result that cannot always be delivered, or draw comparisons to others (e.g. better or best, claims of superiority). Testimonials from a client, former client, or other person regarding the Member's practice are also not permitted.

Soliciting or permitting solicitation should only be done in accordance with the Professional Misconduct Regulation.

Advertising Scenario

Aashi, an RP, has just started using a newly acquired technique in psychotherapy with clients experiencing high levels of anxiety, and is seeing great results. To attract new clients, she places a weekly advertisement in the community newspaper with a description of the service. She makes sure the advertisement only describes the therapy and does not offer any guaranteed outcome. She does not compare this new therapy to other therapies or provide reasons why she might be a better choice because she performs this therapy.

However, with the consent of a few of her clients, she takes "before and after" photos of their smiles and publishes them in the local newspaper. She feels that people can decide for themselves based on the photos if they want to try the therapy.

Unfortunately in doing so, Aashi has violated the advertising standards for the profession. Before and after pictures are inherently misleading as they cannot be verified for authenticity, and involve comparisons in order to promote a specific therapy. Also, "before and after" pictures may be construed as suggesting an outcome, or a guarantee, that cannot always be expected.

Sample Question

Advertising needs to be:

- i. Accurate.
- ii. Verifiable.
- iii. Not contain personal opinions.
- iv. All of the above.

Answer iv is the best answer. All the qualities listed are required of advertising. Advertisements should also be factual, objective, comprehensible, and professionally appropriate.

Answers i, ii and iii are not the best answers because all the answers listed are correct.

D. THE COLLEGE

The *Regulated Health Professions Act* gives the duty to regulate the profession to a body called a college. The Act requires health regulatory colleges to create structures and safeguards designed to protect the public from harm.

I. Registration Process

To register with this College, applicants complete an application form and pay applicable fees. The College verifies the applicant's qualifications and issues a certificate of registration if the applicant meets all the requirements to become a Member of the College. (This process is described in more detail in the discussion of the Registration Regulation.)

If the applicant does not appear to meet the registration requirements (or if this is unclear), the Registrar refers the application to the Registration Committee. The applicant will be informed of any concerns and given an opportunity to provide a written response.

Following this process, if the Registration Committee concludes that the applicant meets the registration requirements, a certificate of registration will be issued. If the Registration Committee concludes that the applicant does not meet the requirements, it can make a number of decisions including:

- directing the applicant to complete further training or examinations;
- issuing a certificate of registration with terms, conditions or limitations applied; or
- refusing the application.

If a certificate is not granted by the Registration Committee, the applicant may appeal the decision to the Health Professions Appeal and Review Board (HPARB). HPARB is an independent body appointed by the government. HPARB can make any of several determinations. For example, it may determine that an applicant meets the registration requirements, or require the Registration Committee to obtain additional information and make a new decision. HPARB's decision may be appealed to the courts.

The Office of the Fairness Commissioner of Ontario audits and reviews all college's registration processes to ensure that they are transparent, objective, impartial and fair.

II. Complaints and Discipline Process

The complaints and discipline process is set out in the RHPA and is common to all health regulatory colleges. Colleges investigate concerns regarding members' professional conduct or competence. Where possible, colleges deal with professional misconduct and incompetence by requiring members to undertake additional education and training. Serious matters, however, may be referred for discipline.

In the case of incapacity (i.e. a member's health condition that prevents him/her from practising safely), colleges consider the health condition and determine whether the member should be referred for treatment. A term, condition or limitation may be placed on the member's certificate of registration imposing certain restrictions. This may allow the member to continue practising during treatment (if treatment is deemed necessary) and following treatment.

For all colleges, the Inquiries, Complaints and Reports Committee (ICRC) is the statutory committee that handles member-specific concerns regarding professional misconduct, incompetence and incapacity. It does not handle claims about professional negligence (i.e. civil lawsuits).

► Formal Complaints

The ICRC handles only formal complaints and Registrar's reports. (See below regarding Registrar's reports.) To be considered a formal complaint the following requirements must be met:

- the complaint must be in writing or recorded on tape, film, disk or other medium (as set out in the Health Professions Procedural Code);
- the complainant must be identified;
- the Member must be identifiable;
- the complaint must identify some conduct or action that is of concern (i.e. not just a vague complaint that a Member is unprofessional, incompetent or incapable, but must include some level of detail about the circumstance); and
- the complainant must intend the matter to be a complaint.

The Registrar must give the Member in question notice of a formal complaint within 14 days of receiving it.

On rare occasions, when a complaint is clearly frivolous or vexatious, is made in bad faith, or is otherwise an abuse of process, the ICRC may choose not to investigate it. For this to happen, it must be fairly obvious that there is little merit to the complaint and that processing the complaint would be unfair in the circumstances. For example, a complainant repeating a previous complaint regarding an RP without any new evidence would be frivolous and vexatious. Notice is given to the Member and complainant if the ICRC intends to take no action in such cases.

Investigations of an RP follow a number of steps. First, both the complainant and Member are usually asked to provide all documentation available to them. Next, additional information is gathered from a variety of sources, including College files, the RP's files, public databases (e.g. court files), other regulators, witnesses, and other RPs, until it is determined that it is likely that all reasonable and available evidence has been obtained.

After reviewing all relevant information and evidence, the ICRC makes a decision about the complaint and determines what further action, if any, needs to be taken. A complaint is to be addressed within 150 days of being filed with the College. If it cannot be addressed within this timeframe, the parties must be notified regularly about the progress of the complaint. If the college takes too long, the complainant or the Member can ask HPARB to take action.

► Investigations of Registrar's Reports

An investigation of an RP may be launched if a concern arises that the Registrar believes warrants investigation. In this case, the concern is brought to the ICRC by the Registrar with a request that the ICRC appoint an investigator. The Quality Assurance (QA) Committee may also bring a concern to the ICRC. However, because the quality assurance program of the college is fully separate from the ICRC process, the QA Committee may only share limited information with the ICRC. (See Section 3, *Quality Assurance Program*, p.79.) If the ICRC decides to appoint an investigator, the investigator makes a report to the Registrar, following which the Registrar makes a Registrar's Report to the ICRC.

There is no set deadline to complete an investigation of a Registrar's Report and render a decision. However, such investigations should be completed within a reasonable timeframe. Once the investigation is completed, the ICRC makes a decision, called a disposition.

► Possible Outcomes of the ICRC Process

The ICRC may do any of the following:

Request an undertaking	The Member promises to do certain things (or refrain from doing certain things) to address the concern. No further action is necessary because the undertaking addresses the concern.
Refer to discipline	A decision to refer a matter to discipline is intended for serious concerns (e.g. dishonesty, breach of trust, willful disregard of professional values, inability to practise competently). The ICRC must ensure there is reasonable evidence to support the concern before deciding to refer the complaint to discipline. The Discipline Committee may hold hearings, make findings of credibility, find wrongdoing, or impose disciplinary sanctions (i.e. a fine or suspension) as appropriate.
Refer for incapacity proceedings	In cases where the conduct may be due to an illness or health condition, the concern is referred to incapacity proceedings.
Caution the member	The Member may be required to appear before a panel of the ICRC for a caution about his/her conduct. This may include constructive feedback regarding the Member's conduct, and is usually accompanied by a warning that, if the circumstances do not change, the Member will face more formal action in the future.
Other actions	The ICRC may be creative in its decisions and solutions. For example it may require the Member to undergo a specified continuing education and remediation program (e.g. a record keeping course).
Take no action	If there is no basis for concern, the ICRC may close (or dismiss) the complaint. Reasons must be given for taking no action.

If the complainant wishes to withdraw his/her complaint, the ICRC may still decide to proceed with an investigation. The ICRC must decide whether to accept the withdrawal of a complaint.

Either the Member or the complainant may seek a HPARB review of an ICRC decision, unless the decision was referred to discipline proceedings or for incapacity proceedings. HPARB may confirm an ICRC decision or return the matter to the ICRC to make a new decision. HPARB may also make recommendations to the ICRC.

► Discipline Proceedings

If a concern is not resolved at the ICRC level and becomes a discipline matter, it is referred to the Discipline Committee by the ICRC. In very serious cases, the ICRC may make an interim order (for example, suspension of the Member's certificate of registration) to protect the public while awaiting a discipline hearing. This is used only when absolutely necessary to protect clients from harm.

The Discipline Committee holds a hearing to consider any allegations referred to it. Before a discipline hearing starts, the Member in question is notified of the hearing and any information that will be needed during the process. S/he is given a summary of allegations and the conclusions that have been drawn from it. The Chair of the Discipline Committee selects a panel from Members of the Committee, usually five people (two must be public Members and three are usually professional Members).

Pre-hearing conferences may be held prior to a discipline hearing; the purpose is to reach an agreement on as many issues as possible, and to plan the hearing. Discussions at pre-hearing conferences are off the record. If a resolution is agreed upon (e.g. an agreed statement of facts and/or joint submission on penalty), it is presented to the panel of the Discipline Committee for acceptance.

The procedure of a discipline hearing is formal and similar to a court case, in that the two sides present their arguments and evidence to the panel. The hearing is open to the public unless there is a compelling reason for privacy. Generally, rules of evidence that apply to civil court trials apply to discipline hearings. Decisions are based exclusively on the evidence admitted and cannot draw on any knowledge that was not presented as evidence. A record is kept compiling all the exhibits of evidence.

Once the Discipline Committee determines what a Member has done, it must then decide whether or not that behaviour constitutes professional misconduct or incompetence. If a Member is found to have engaged in professional misconduct, the Discipline Committee may make one or more of the following orders:

Revocation	Removal of the Member from the profession for at least a year. Following the revocation period, the Member must satisfy the Discipline Committee that s/he ought to be permitted back into the profession.
Suspension	Temporary removal of the Member from the profession. The duration of the suspension can be fixed or flexible, or depend on an event occurring (e.g. successful completion of a course).
Terms, conditions and/or limitations	Attaching terms, conditions and/or limitations to a Member's certificate of registration, either for a specified period (e.g. until the Member successfully completes certain remedial training) or for an indefinite period (e.g. until the member is free from alcohol consumption). The terms, conditions and/or limitations must be related to the finding made by the Discipline Committee.
Reprimand	A conversation between the Discipline Committee and the Member where the Committee tells the Member its views of his/her conduct and how to avoid similar problems in the future.
Fines & Costs	The Discipline Committee can impose a fine of up to \$35,000 and can require that a portion of the expenses associated with the hearing be covered by the Member.

Either party involved in a discipline hearing may appeal to the Divisional Court. The Court has the power to confirm, amend or reverse a decision of the Discipline Committee if it acted unreasonably or made an error of law.

A ruling of incompetence is different from professional misconduct as it generally does not involve unethical or dishonest conduct, but rather, the Member does not have the knowledge, skill or judgment to practise safely. A finding of incompetence is based on the care of one or more of the Member's clients.

A finding of incompetence may be either that the RP is unfit to continue to practise, or that the Member's practice should be restricted. In incompetence cases, the Discipline Committee may order revocation or suspension, or it may impose terms, conditions and/or limitations on the Member's certificate of registration, affecting how s/he practises.

Where there is a finding of sexual abuse, the Discipline Committee may require the Member to reimburse the college for any therapy required by the client. For cases involving frank sexual acts, there is a mandatory minimum order of both a reprimand and revocation. No reinstatement may be made for five years after revocation on these grounds.

Complaints and Discipline Scenario

A client sends a letter of complaint to the College saying that Leigh, an RP, was rude to her. The client says that Leigh became angry when the client expressed concern that the therapy wasn't working. The client says that Leigh "threw her out of the office."

The Registrar sends a letter notifying Leigh of the complaint and asking for a response. Leigh responds that the client was extremely challenging and after doing all that she could for her, the client became verbally abusive and Leigh had to terminate the professional relationship. Leigh's letter is sent to the client who replies that she was never verbally abusive to Leigh and that Leigh is making this up to defend herself.

The ICRC obtains statements from the client's husband, Leigh's receptionist and clients who were in the office at the time. It is difficult to reconcile the stories but it appears that there was a verbal confrontation in which both parties may have used intemperate language.

The ICRC decides that this is not a case for discipline, particularly since there have been no previous complaints about Leigh. However, the ICRC sends Leigh a letter of caution reminding her of the need to be professional in her dealing with clients even in challenging circumstances.

III. Incapacity Process

Under the *RHPA*, incapacity has a particular definition in relation to a regulated health professional. Incapacity refers to a physical or mental condition which may warrant some restriction on a Member's registration. This section focuses on what happens when incapacity becomes a concern.

The goal of the incapacity process is to ensure that the Member receives appropriate treatment and is supervised and monitored sufficiently so that s/he may continue to practise without undue risk to the public. Only in rare circumstances will the Member's certificate of registration be suspended or revoked.

When incapacity becomes an issue, the concern is brought to the ICRC. Information about possible incapacity may come from a variety of sources, including a law enforcement agency, a mandatory report by an employer, or an expression of concern by a Member of the college, a member of another regulated health profession, or the public.

Once an ICRC panel is selected, notice is given to the Member that the panel intends to consider whether the Member may be incapacitated. The panel is an investigative body that gathers information, reviews relevant

information, takes statements and holds interviews, as needed. The ICRC may also order a specialist examination of the Member, and may access relevant medical records.

The ICRC must prepare a report of its inquiries and send a copy to the Member for comment. It then determines whether the matter should be referred to the Fitness to Practise Committee for a hearing.

The matter is referred for a hearing only when the Member's problem is serious. The decision to do so is not taken lightly; there must be sufficient evidence of, and a reasonable prospect of finding incapacity. This usually occurs when there is concern that the Member's condition will, now or in the future, affect his/her professional practice negatively. Typically, it involves a lack of insight by the RP into the extent of his/her condition.

In serious situations, the ICRC may order the Registrar to suspend the Member's certificate of registration, or to impose terms, conditions, or limitations on the Member's registration temporarily, until the Fitness to Practise Committee addresses the matter.

► **Hearings Before the Fitness to Practise Committee**

Hearings before the Fitness to Practise Committee share many similarities with the hearings before the Discipline Committee. A panel is selected by the Chair of the Fitness to Practise Committee, consisting of at least three people, including at least one public Member of college Council and at least two other persons, usually Members of the college. All relevant information and evidence is collected. Incapacity hearings are closed unless the Member requests that the hearing be open to the public.

If the Fitness to Practise Committee finds the Member to be incapacitated, it must decide what restriction to place on the Member's certificate of registration. It may revoke the Member's certificate entirely, suspend the certificate, or impose terms, conditions and/or limitations on the Member's certificate. Usually terms, conditions or limitations on the certificate are ordered. For example, conditions may include an order for treatment followed by monitoring and supervision.

If circumstances change, the Committee may alter orders it made in the past. For instance, if an RP establishes that for a period of time his/her illness has been in remission (i.e. sobriety), there may be a loosening of restrictions on his/her certificate of registration.

► **Appeals**

Either party at the Fitness to Practise hearing may appeal to the Divisional Court. In this case, despite an appeal being made, any order by the Fitness to Practise Committee takes effect while the appeal is pending. Again, the Divisional Court may confirm, amend or reverse a decision of the Fitness to Practise Committee.

Fitness to Practise Scenario

Tony is an RP who is partners with John, another RP. John reports to the College that he is terminating his partnership with Tony because Tony's alcohol use is beginning to affect his work. John is tired of covering for Tony when he comes to the office two hours late and smelling of alcohol.

The Registrar makes some inquiries that tend to confirm John's report. Tony, however, denies he has a problem. The Registrar reports the matter to the ICRC which asks Tony for consent to obtain a copy of his medical records. Tony gives consent and the records indicate that Tony has been recently charged for impaired driving.

The ICRC directs that Tony undergo an assessment through a substance abuse program. The report from the program suggests that Tony's use of alcohol is clearly problematic. The ICRC refers Tony to the Fitness to Practise Committee for a hearing, and suspends Tony's certificate of registration until the hearing is completed. Tony enters and successfully completes a 30-day treatment program for substance abuse, and participates actively in the recommended after-care program.

At the Fitness to Practise hearing Tony's lawyer and the College's lawyer present a joint submission asking the Committee to find that Tony is incapacitated, as defined in the Act, and to order that Tony's certificate of registration be restored on the following conditions:

- *that he continue in regular treatment,*
- *that he work with another RP who will monitor Tony's performance at work, and*
- *that regular reports of Tony's progress be made to the College.*

The Committee accepts the joint submission. In its reasons, the Committee explains that incapacity, as defined in the Act, does not mean total incapacity. It has a special legal meaning for Fitness to Practise hearings, which refers to a condition or disorder that requires restrictions on a Member's registration. Tony is safe to practise so long as he remains in treatment and is appropriately monitored.

IV. Quality Assurance Program

Every college must have a Quality Assurance (QA) program. This program is intended to assist members to improve and enhance their practice by participating in professional development activities and receiving constructive feedback.

The QA program is not a form of discipline. Information collected through the QA program may not be used by a college to discipline a member or in any legal proceeding. The only exception arises in cases where the member makes a false statement to the college or fails to cooperate with the program. However, if the Quality Assurance (QA) Committee is of the opinion that the member may have committed an act of professional misconduct, or may be incompetent or incapacitated, the QA Committee may report the RP's name and the allegation to the ICRC, which may choose to investigate.

The QA program is administered by the QA Committee of the college. The program includes professional development and self, peer, and practice assessments. It also involves monitoring of Members' participation in, and compliance with, the program.

► Self-assessment and professional development

As part of the QA program, Members must participate in self-assessment and professional development activities. Professional development activities enable RPs to remain informed about changes and innovations in practice standards and techniques, and to develop skills and knowledge of inter-professional collaboration.

► Peer and practice assessment and remediation

Each year the QA Committee selects a subset of Members to participate in peer and practice assessments. Members may be randomly selected for a peer and practice assessment. They may also be selected if the college requests to review the Member's self-assessment and professional development records and finds that the records are incomplete or inadequate. The College may develop other criteria for selecting RPs for peer and practice assessments. Selection criteria will be published on the College's website.

Peer and practice assessments are conducted by independent practice assessors appointed by the QA Committee. Generally, assessors will be fellow RPs. A practice assessor may review a Member's education, professional development and self-assessment records. The assessor may also obtain information about a Member's practice by various methods, including visiting the Member's office.

Peer and practice assessments

During a peer and practice assessment, Members must cooperate with the assessment by:

- permitting the assessor to enter and inspect the premises where the Member practises. However, assessors may not enter a Member's home unless s/he also practises there;
- permitting the assessor to inspect the Member's client records, even though they are confidential;
- giving the assessor any information requested regarding the care of clients or the Member's confidential records, and
- meeting with the assessor upon request.

► Follow up Actions

Following a peer or practice assessment, the assessor prepares a report for the QA Committee. After reviewing the report, the Committee determines what action, if any, is needed.

Since the quality assurance program is educational and supportive in nature, it will be rare for the Committee to direct anything other than upgrading (e.g. course work, working with a mentor, remedial action) even in cases where there are significant gaps in the Member's knowledge, skill or judgment.

If the Committee is of the opinion that the Member's knowledge, skills or judgment is not satisfactory, the Committee may direct the Registrar to impose terms, conditions and/or limitations on his/her certificate of registration for a specified period of time. The Committee must consider any written submissions by the Member before taking this action. If the Committee believes the Member may have committed an act of professional misconduct, or may be incompetent or incapacitated, the Committee may disclose only the name of the Member and the allegations against the Member to the ICRC.

Quality Assurance Scenario No. 1

Kevin, a psychotherapist, is asked by the College to provide his record of professional development and self-assessment activities. Kevin has not kept any record of these activities. A practice assessor is appointed and meets with Kevin to review his professional development and self-assessment activities. The assessor then prepares a report for the QA Committee that describes the professional development activities Kevin participated in. The Committee may decide that there is no reason to take action because Kevin has learned from this experience about the importance of keeping records of professional development activities.

Quality Assurance Scenario No. 2

Kim, an RP, is randomly selected for a peer and practice assessment and a practice assessor is appointed. Kim cooperates with the assessor's review of her records and inspection of her office. The practice assessor provides a report to the QA Committee, which indicates that Kim has not been keeping adequate clinical records. The Committee gives Kim an opportunity to respond in writing. After reviewing Kim's response, the Committee decides that Kim must take a record-keeping course. The Committee also directs that Kim's practice be reassessed in one year's time to see if there has been any improvement.

Sample Question

If a Member is selected for a peer and practice assessment, the Member should:

- i. Cooperate with the practice assessor's review, including permitting the assessor to inspect his/her office, and upon request, provide any requested records.
- ii. Permit the practice assessor to inspect his/her home.
- iii. Give the assessor all records except those that are confidential.
- iv. Complete all required professional development records and fill in gaps in client records before sending them to the practice assessor.

The best answer is i. Members have a duty to cooperate with peer and practice assessments.

Answer ii is the not best answer because practice assessors are not permitted to enter private homes unless the Member's office is located there.

Answer iii is not the best answer because the practice assessor's right to access premises and records overrides client confidentiality.

Answer iv is not the best answer because, while a practice assessment is a good opportunity to improve record-keeping and other practices, a Member should always update client records immediately so they are accurate. Members should never wait until they are selected for an assessment to update their records. Additionally, if records are falsified, the Committee may report the Member's name and this allegation to the ICRC.

E. OTHER LAWS

I. Personal Health Information Protection Act (PHIPA)

Members have a legal and professional duty to protect the privacy of clients' personal health information. The *Personal Health Information Protection Act (PHIPA)* governs therapists' use of personal health information, including its collection, use, disclosure, and access. *PHIPA* helps guide the general duty of confidentiality described above.

Personal Health Information refers to almost anything that would be in an RP's client files. Information is covered by *PHIPA* if it:

- relates to the person's physical or mental health, including the person's family health history;
- relates to the providing of health care to the person, including the identification of a person as someone who provided health care to the person;
- is a plan of service within the meaning of the *Home Care and Community Services Act, 1994* for the person;
- relates to the person's payments or eligibility for health care, or eligibility for coverage for health care;
- relates to the donation by the individual of any body part or bodily substance of the person or is derived from the testing or examination of any such body part or bodily substance;
- is the person's provincial health insurance number; or
- identifies a person's substitute decision-maker.

Privacy policies are the responsibility of the Health Information Custodian ("Custodian"). The Custodian is a person or organization responsible for health records. If an RP is working outside a supervised practice setting, or working in independent or solo practice, s/he is the Custodian of any health information collected during the course of practice. If an RP works for a health organization such as a community health centre or mental health agency, the organization is usually the Custodian of health records. The Custodian develops privacy policies for his/her organization, which must meet the requirements of *PHIPA* and should explain how health information will be protected. The privacy policy should clearly explain how and when personal health information will be collected, used and disclosed.

Two or more RPs who work together could decide to act as a single organization for the purposes of *PHIPA*, and could create a single privacy policy. This would allow for consistent record keeping practices, in which case the RPs would have shared responsibility for complying with *PHIPA*.

PHIPA requires every RP and health organization to appoint a contact person (often called a Privacy Officer) who ensures compliance with the privacy policy and requirements of *PHIPA*. The Officer's duties include reviewing the organization's privacy practices, providing training, and monitoring compliance. The Privacy Officer is also the contact person for requests for information from the public. An RP working outside a supervised practice setting, or working in independent or solo practice, usually acts as the Privacy Officer. A health organization may appoint a person within the organization, or may hire a person outside the organization to be its Officer.

PHIPA Scenario

Three RPs work together in an office. They decide they will act as an organization for privacy purposes. Their organization is the Health Information Custodian. The RPs create a privacy policy together and decide to appoint the most senior RP, Jackie, as Privacy Officer. Jackie creates a procedure to protect personal information, develops a privacy complaints procedure, and ensures that the RPs comply with the privacy policy.

► Protecting Personal Health Information

Custodians must establish practices to protect personal health information under their control. Practitioners and organizations must adhere to these practices and take appropriate measures to protect personal health information from unauthorized access, disclosure, use or tampering. Such safeguards must include physical measures (e.g. restricted access areas, locked filing cabinets), organizational measures (e.g. need-to-know and other employee policies, security clearances), and technological measures (e.g. passwords, encryption, virus protection, firewalls).

Custodians need to systematically review all the places where they may temporarily or permanently hold personal health information, assess the adequacy of the safeguards, and implement changes as necessary.

► Collection, use and disclosure of personal health information

An RP or organization may collect, use or disclose a person's personal information only if the person consents or if the collection, use or disclosure is otherwise permitted or required by law. A Member should collect, use or disclose no more information than is reasonably required in the circumstances.

Under *PHIPA*, collection, use and disclosure of personal health information is permitted without consent in the following limited circumstances:

Circle of Care

A Member may share information within a client's circle of care, which includes other health professionals who provide care to the same client, other health care providers within a multidisciplinary setting, and other health care providers where the client is referred by the Member.

An RP may assume that s/he has a client's implied consent to disclose personal health information to other health providers in the client's circle of care, unless the client instructs otherwise.

In some cases, the circle of care may also include other health care providers not mentioned here. For example, in circumstances where it is necessary to provide care to an individual, but not reasonably possible to obtain consent in a timely manner, the client's health information may be shared with other providers. However, to avoid misunderstandings, many practitioners do not share information with others in the circle of care without the client's explicit consent, except in emergencies. Caution is particularly important where the information is sensitive.

Family and Friends

While Members may commonly understand the circle of care to include supportive family and friends of the client, in this context, the circle of care has a specific meaning, referring only to health care professionals, as noted above.

Generally speaking, consent should be obtained before sharing personal health information with members of a client's family. However, personal health information may be disclosed for the purpose of contacting family members, friends, or other persons who may be potential substitute decision-makers, if the individual is injured, incapacitated, or ill, and not able to provide consent. This may be particularly relevant for Members working in acute care settings.

Disclosure related to risk

A Member may disclose a client’s personal health information if the RP believes on reasonable grounds that disclosure is necessary to eliminate or reduce a significant risk of serious bodily harm to the person or anyone else.

Other Laws

PHIPA allows disclosure of personal health information that is permitted or required by many other Acts. For example, the *RHPA* permits disclosure of personal health information to the ICRC or Quality Assurance Committee, if this information is required.

Despite the circumstances in which sharing a client’s personal health information is permitted (explained above), when a client or client’s substitute decision-maker says that s/he does not want information to be shared, the information must then be put in a “lock box” and cannot be shared unless another provision in *PHIPA* permits it.

Disclosure of personal health information is permitted or required by many other Acts, including the following:

- the *HCCA* or Substitute Decisions Act for the purposes of determining, assessing or confirming capacity;
- disclosure to a college in accordance with the *RHPA*; and
- disclosure to an investigator or inspector authorized by a warrant, or by any provincial or federal law, for the purpose of complying with the warrant or facilitating the investigation or inspection.

Additionally, as discussed in the Mandatory Reports section, there are some circumstances in which disclosure of personal health information is required.

Circle of Care Scenario

Hanna, a therapist, receives a telephone call from a registered nurse at a local psychiatric hospital. The nurse advises Hanna that her client has just been admitted to the hospital. The nurse reports that she has been unable to contact the client’s substitute decision-maker (SDM). The nurse wants to know what treatment Hanna has been providing to the client. Hanna tells the nurse in very general terms about the therapy she has been providing and discloses contact information she has for the SDM. In this case, the “circle of care” principle allows Hanna to disclose her client’s personal health information without express consent, and it would be inappropriate to insist on a signed consent before making any disclosure.

► Access to Personal Health Information

Every client has a right to access his/her own personal health information. One important exception is when granting access would likely result in a risk of serious harm to the client’s treatment or recovery, or a risk of serious bodily harm to the client or another person. It should be noted that *bodily harm* is interpreted to include mental or emotional harm.

If a person makes a request to access his/her personal health information, the Custodian must either:

- permit the person to see the record and provide a copy at the person’s request;
- determine, after a reasonable search, that the record is unavailable, and notify the person of this in writing, as well as his/her right to complain to the Information and Privacy Commissioner; or

- determine that the person does not have a right of access because of the risk of serious harm, and notify the person of this as well as his/her right to complain to the Information and Privacy Commissioner.

The Information and Privacy Commissioner may review the Custodian's refusal to provide a record, and may overrule the Custodian's decision. If law does not permit disclosure for any reason, the Member should black out (on a copy, not the original) those parts that should not be disclosed if it is reasonable to do so, so that the client may access the rest of the record.

► **Correction of Personal Health information**

Individuals generally have a right to request corrections to their own personal health information. An RP or other Custodian who receives a written request must respond by either granting or refusing the request within 30 days. It is also a good idea to respond to verbal requests as soon as possible. If the request cannot be fulfilled within 30 days, the person should be advised of this in writing.

Corrections to records must always be made in a way that allows the original record to be traced. The original record should never be destroyed, deleted, or blacked out. If the record cannot be corrected on its face, it should be possible for another person accessing the record to be informed of the correction and where to find the correct information. The person should also be notified of how the correction was made.

At the person's request, the RP should notify anyone to whom the RP has disclosed the incorrect information, of the correction. The exception to this is if the correction will not impact the person's health care or otherwise benefit the person.

The RP (or Custodian) may refuse the request if s/he believes the request to be frivolous or vexatious; if s/he did not create the record and does not have the knowledge, expertise and authority to correct it; or if the information consists of a professional opinion made in good faith. In other words, corrections are limited to factual information, not professional opinions.

An RP who refuses to make a correction must notify the person in writing, with reasons, and advise the person that s/he may:

- prepare a concise statement of disagreement that sets out the correction that the RP refused to make;
- require the Member to attach the statement of disagreement to his/her clinical records, and disclose the statement of disagreement whenever the RP discloses related information;
- require the RP to make all reasonable efforts to disclose the statement of disagreement to anyone to whom the Member has previously disclosed the record; or
- make a complaint about the refusal to the Information and Privacy Commissioner.

► **Complaints**

Every Health Information Custodian must have a system in place to deal with complaints regarding personal health information. Clients should also be aware of their right to complain to the college and/or to the Information and Privacy Commissioner.

Sample Question

Which of the following best describes a client's right to look at his/her personal health information contained in an RP's records?

- i. A client has an unrestricted right to access his/her personal health information.
- ii. A client generally has a right to access his/her health information, and has a right to complain to the Information and Privacy Commissioner if access is refused for any reason.
- iii. A client has a right to access his/her health information unless the RP believes it is not in the client's best interests to see the information.
- iv. A client may request a copy of a record containing his/her personal health information, but an RP does not have to provide it.

The best answer is answer ii. A client's right to access his/her health information is broad but has some legal limits. However, even if access is refused for an appropriate reason, the client is entitled to bring a complaint to the Information and Privacy Commissioner.

Answer i is not the best answer because the right to access personal health information may be restricted in some circumstances (e.g. where there is a serious risk of significant bodily harm).

Answer iii is not the best answer because an RP's opinion about whether it is good for the client to see the record is irrelevant. Only if the RP believes on reasonable grounds that viewing the information would seriously harm the client's treatment, may access be refused.

Answer iv is not the best answer because an RP does not have a general right to refuse a person access to personal health information.

II. Personal Information Protection and Electronic Documents Act (PIPEDA)

Another privacy law that Members should be aware of is the *Personal Information Protection and Electronic Documents Act (PIPEDA)*. *PIPEDA* is a federal law that governs the collection, use, and disclosure of personal information in relation to commercial activity, such as the sale of products at Member's offices and the offering of educational sessions. *PHIPA* and *PIPEDA* are based on the same principles. *PHIPA* simply provides more detail about how to achieve those principles in the health care context.

The following ten privacy principles apply to a Member's commercial activities:

Accountability

An organization must have a privacy officer who is accountable for the collection, use, and disclosure of personal information; develops privacy policies and procedures, and ensures that staff receive privacy training.

Identifying purposes

An organization must identify the purposes for which personal information will be used at the time the information is collected.

Consent

Informed consent is required to collect, use, and disclose personal information except in limited circumstances.

Limiting collection	An organization must collect only information needed for identified purposes.
Limiting use, disclosure and retention	An organization must use, disclose and retain only personal information that is necessary for the identified purposes, and is obtained with consent. It should be retained no longer than necessary.
Accuracy	Personal information must be as accurate, complete, and up-to-date as is necessary for the purposes for which it is to be used.
Safeguards	An organization must protect personal information with appropriate safeguards in order to protect against loss, theft, unauthorized access, disclosure, copying, use, or modification.
Openness	An organization must make its privacy policies readily available.
Individual access	Upon request, an individual must be informed of the existence, use, and disclosure of his/her personal information, and be given access to it. An individual may request corrections to the information. Access may be prohibited in limited circumstances.
Challenging compliance	An organization must have a complaints procedure relating to personal information and must investigate all complaints.

III. Health Care Consent Act

As discussed in Section 2, the *Health Care Consent Act (HCCA)* sets out rules about consent to treatment, which for RPs includes all assessments and therapies, especially where there is concern about the capacity of the client to consent to treatment. In general, except in cases of emergency, informed consent for any assessment or therapy must be obtained from the client. If the client is incapable, informed consent must be obtained from the client's substitute decision-maker.

Where there is a dispute about the care of an incapable client, the therapist, client, or substitute decision-maker may apply to the Consent and Capacity Board (CCB) to render a decision regarding the client's consent or capacity. The CCB may agree with the therapist's determination that a client is incapacitated, or may find that the client is capable with respect to the treatment. If the CCB overrules the therapist, s/he may not administer the treatment unless the client consents.

The CCB may provide direction to a substitute decision-maker with respect to an incapable person's wishes (e.g. whether the wish applies to the circumstances, or whether the client's wish was expressed when the person was capable). The CCB may also consider a request from a substitute decision-maker to depart from a person's wish that was expressed while the person was capable.

The CCB may review decisions regarding a person's capacity to consent to treatment, admission to a care facility, or use of a personal assistive service. The CCB may appoint a substitute decision-maker to:

- make decisions for an incapable person with respect to treatment, admission to a care facility or use of a personal assistance service;
- amend or terminate the appointment of a representative;
- review a decision to admit an incapable person to a hospital, psychiatric facility, nursing home or home for the aged for the purpose of treatment; and
- review a substitute decision-maker's compliance with the rules for substitute decision-making.

A client may challenge a decision of the CCB by appealing to the courts.

HCCA Scenario

David, an RP, works in a prison. David has proposed a therapy to be carried out with a client, but has been met with the client's adamant and unexplained refusal. David thinks this therapy is warranted and that it will help the client's rehabilitation. David does not think the client will make the gains he needs without the therapy. He also does not believe the client's refusal is rationally based, and proposes to go ahead with the therapy anyway, deciding that the client lacks the capacity to consent to, or withhold consent for, treatment.

The client does not agree with this decision, and decides to challenge it at the CCB. The CCB holds a hearing. It receives testimony from both David and the client, and concludes that the client is capable of withholding consent for the treatment. The client reaffirms to David that he is refusing to consent to the therapy.

In this situation, David cannot initiate the therapy, even if he believes it is in the client's best interest.

IV. Mental Health Act

Health care providers in psychiatric facilities who are treating clients pursuant to community treatment orders (CTOs) are subject to the Ontario Mental Health Act (MHA). The Act provides authority for admission to psychiatric facilities and authority for detention, psychiatric assessment, and treatment of clients in these facilities. It also provides authority for the implementation of CTOs.

► Types of Admission to a psychiatric facility

A person may go to a psychiatric facility voluntarily, and may be admitted upon the recommendation of a physician. A voluntary client may leave a psychiatric facility at any time, and s/he has the right to refuse treatment if s/he is capable of making treatment decisions.

The *MHA* does not authorize any person to detain or restrain a voluntary client. However, there is a common law exception that applies to emergency situations where there is a risk of serious bodily harm to the client or another person.

An informal client is a person whose substitute decision-maker has consented to his/her admission to a psychiatric facility. If the client is 16 years of age or over and objects to admission, consent may only be given on the client's behalf in limited circumstances.

An informal client has the same rights as a voluntary client, except that the client's substitute decision-maker may be responsible for making certain decisions for the client, including a decision to leave the psychiatric facility.

A person becomes an involuntary client upon the completion by a physician of a Certificate of Involuntary Admission (Form 3). An involuntary client does not have the right to leave a psychiatric facility as long as a valid Certificate of Involuntary Admission (Form 3) or Certificate of Renewal (Form 4) is in effect. Through the *HCCA*, an involuntary client does have the right to refuse treatment if s/he is capable of making treatment decisions.

A person may be brought involuntarily to a psychiatric facility for assessment, which may result in the client being admitted as a voluntary, informal, or involuntary client. A voluntary client may become an involuntary client if a physician completes a Certificate of Involuntary Admission (Form 3).

The test for involuntary admission is that the physician, upon examining the client, is of the opinion that (a) the client is suffering from a mental disorder of a nature or quality that will likely result in serious bodily harm to the client or to another person, or serious physical impairment of the client unless the client remains in the custody of a psychiatric facility; and (b) the client is not suitable for admission or continuation as an informal or voluntary client.

A Certificate of Involuntary Admission is valid for up to two weeks. A person may be detained for more than two weeks if a Certificate of Renewal is signed. A first Certificate of Renewal is valid for up to one month; a second for up to two months; and a third for up to three months. Upon the expiry of a Certificate of Involuntary Admission or a Certificate of Renewal, the client automatically becomes a voluntary client unless a new Certificate of Renewal has been signed.

An involuntary client has the right to obtain legal advice, to speak to a rights advisor, and to seek review of the decision before the CCB regarding any decision to issue a Certificate of Involuntary Admission or Certificate of Renewal.

► Use of restraints

Restraints may be used only for involuntary clients. There is a common law exception that permits the use of restraints on voluntary or informal clients in emergency situations, where there is a risk of serious harm.

Any use of a physical or chemical restraint must be clearly documented in a client's record, including a description of the means of restraint and behaviour that required the use or continued use of the restraint. In the case of a chemical restraint, the entry must include a statement of the chemical employed, method of administration and dosage.

It is an offence to violate any provision of the *MHA*, including the provisions regarding use of restraints. If found guilty, a person may have to pay a fine of up to \$25,000.

► Application for Psychiatric Assessment (Form 1)

A physician who believes a person meets the legal test for a psychiatric assessment under the *MHA* can complete a Form 1 application for a psychiatric assessment. Only a physician is authorized to complete a Form 1 and can do so only if s/he has examined the person within the past seven days. Once signed, a Form 1 authorizes any person to bring the person named in the application to a psychiatric facility for assessment within seven days of the date the application is signed. Form 1 authorizes the involuntarily detention of the named person for up to 72 hours for the purposes of psychiatric assessment.

Following the psychiatric assessment, the client is either discharged or admitted as a voluntary, informal or involuntary client.

Form 1 Criteria

A physician may complete a Form 1 (Application for Psychiatric Assessment) in the two situations described below.

Situation 1

The physician has examined the person in the past seven days and concludes that the person meets the following tests:

- a. the physician has reasonable cause to believe that the person:
 - has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself; or
 - has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or
 - has shown or is showing a lack of competence to care for himself or herself.

And,

- b. the physician has examined the person in the past seven days and is of the opinion that the person is apparently suffering from a mental disorder of a nature or quality that likely will result in serious bodily harm to the person or another person, or serious physical impairment of himself or herself.

Situation 2

If the physician has previously successfully treated a person for an ongoing or recurring mental disorder that if left untreated would result in serious harm, and if the physician is of the opinion that the person:

- a. is apparently suffering from the same or a similar mental disorder; and
- b. the mental disorder will likely result in serious bodily harm to the person or another person, or serious physical impairment of himself or herself; and
- c. is incapable of consenting to treatment in a psychiatric facility and the consent of his/her substitute decision-maker has been obtained.

MHA Scenario No. 1

Marsha, an RP, has a new client named Paul. Based on Paul's reports, Marsha is concerned that Paul is at risk of harming himself. Marsha persuades Paul to see his family physician, who assesses Paul later that day and concludes that Paul meets the test for a Form 1. Paul is transported to the local psychiatric facility where he is detained for the purposes of a psychiatric assessment. Following his assessment, Paul is admitted as a voluntary patient. Paul will reside at the psychiatric facility but may leave at any time unless his status is changed to informal or involuntary.

MHA Scenario No. 2

Ivy, a Member working at a psychiatric facility, meets a voluntary client, Paula, and observes that Paula shows signs of self-harming behaviour. Ivy is aware that a voluntary client cannot be detained or restrained, and is concerned that Paula may try to harm herself. Ivy consults with the physician in charge of Paula's care. The physician assesses Paula and issues a Certificate of Involuntary Admission. Paula is entitled to speak to a Rights Advisor about the decision to involuntarily detain her, and she is entitled to a review of this decision before the CCB.

► Community Treatment Plans

A physician may issue a CTO, which permits a client to receive psychiatric care and treatment in the community rather than in a psychiatric facility. A CTO is generally made where a client follows a pattern of being successfully treated in a psychiatric facility, but destabilizes upon release into the community and must be readmitted.

The client must consent to a community treatment plan. The physician who signs the CTO is responsible for the general supervision and management of the CTO. S/he may consult with other health care providers to determine whether or not to issue or renew a CTO.

In addition to the physician signing the CTO, a health care provider, including an RP, may be named in a community treatment plan. The health care provider must agree with the plan and is responsible for providing the treatment and care or supervision in accordance with the plan. S/he may share the client's personal health information with the physician who signed the CTO or any other person named in the plan for the purposes of providing the treatment, care, and supervision set out in the plan. This authority to share information prevails over all other law including *PHIPA* and the *HCCA*.

If a person subject to a CTO does not comply with its terms, the physician who issued the order may, in some circumstances, issue an order for examination of the person. The examination may result in a Form 1, a new CTO, or release into the community without a CTO. As well, a person may withdraw consent to a CTO, in which case the physician who issued the CTO must review the client's condition to determine whether the client can live in the community without the CTO. Unless it is renewed or terminated early, a CTO expires after six months.

MHA Scenario No. 3

Maria, an RP, is asked by her client, Hugo, to be a part of his community treatment plan. Maria agrees to be involved in Hugo's care in the community. Hugo's physician contacts Maria to discuss her involvement, and signs a CTO. Hugo subsequently meets with Maria and it appears that he has destabilized. He tells Maria he has stopped taking his medication. Maria consults the treatment plan and confirms that Hugo is required to take medication as a term of the CTO. Maria shares this information with the physician who issued the CTO.

Sample Question

If a voluntary client in a psychiatric facility reports to an RP that he is having suicidal thoughts and is planning to immediately leave the facility, the RP should:

- i. Restrain the client and call security.
- ii. Provide counselling, immediately notify the person responsible for the administration and management of the psychiatric facility or his/her delegate (i.e. the officer in charge), and document the incident.
- iii. Affirm to the client that he is free to leave, and help him pack his belongings.
- iv. Provide counselling and document the incident.

The best answer is ii. While a voluntary client can leave a psychiatric facility at any time, it is possible that the client's circumstances have changed and the client now meets the test for a Form 1. A physician may assess the client before he leaves, and depending on the results of the assessment, this may result in the client's status changing to involuntary.

Answer i is not the best answer because there is no legal authority to restrain a voluntary client, unless it is clear in the circumstances that immediate action is necessary to prevent serious bodily harm. If it is clearly necessary to restrain the client, the RP must be sure to document the method of restraint and reasons in detail.

Answer iii is not the best answer because, if there is a risk of suicide, encouraging the client to leave would not be appropriate, and may potentially result in accountability for the RP if the client subsequently commits suicide.

Answer iv is not the best answer because it is possible that the client's circumstances have changed and the client now meets the test for a Form 1. A physician may assess the client before he leaves, and depending on the results of the assessment, this may result in the client's status changing to involuntary.

Sample Question

An RP named in a CTO discovers that the client has violated the terms of the CTO by failing to take prescribed medication. The RP advises the client that she is going to share this information with the physician responsible for the CTO. The client believes this is a violation of his confidentiality and says he is going to complain to the College. The RP should:

- i. Acknowledge the breach of confidentiality.
- ii. Advise the client that he has a right to make a complaint, but remind the client that such communications between Members of the treatment team are permitted.
- iii. Remind the client of his obligations under the community treatment plan and insist that the client continue to take his medication.
- iv. Tell the client that if he does not cooperate, he may end up in a psychiatric facility.

The best answer is ii. Any client has the right to complain to the College at any time. Upon agreeing to be part of the community treatment plan, the RP should ensure that the client understands the terms of the plan and the ability of a named RP to share information. If possible, the RP should obtain the client's consent prior to communicating with the physician.

Answer i is not the best answer because an RP has the right to share this information and has a duty under the MHA to act in the client's best interests.

Answer iii is not the best answer because it does not address the violation of confidentiality concern. A discussion of the terms of the CTO may be an additional part of the conversation, if done appropriately.

Answer iv is not the best answer because it may be perceived as an improper threat of retaliation for making a complaint to the College. If the client is not complying with the CTO, the physician in charge may order an examination of the client. Additionally, a client may withdraw consent to a CTO at any time, in which case the physician who issued the CTO may, upon review of client's condition, conclude that the client can live in the community without the CTO.

V. Child and Family Services Act

A Member who suspects that any child is in need of protection must report this to a Children's Aid Society (CAS). This duty overrides all privacy and confidentiality duties and laws, including PHIPA. No legal action may be taken against a Member for making a report, unless the report is made maliciously or without reasonable grounds. The college cannot discipline a Member for making such a report in good faith and with reasonable grounds.

As a result of a report, a CAS worker may investigate further, and where action is needed, in many cases, CAS will offer family services such as counselling and parental support.

A therapist has a duty to report with respect to any child under the age of 16 (or who is 16 or 17 years old and under a child protection order). This includes all children, including the child of a client, or a child who is a client, or any other child. However, a Member has a special responsibility to report information about a child who is a client, or about a client if the information was obtained while providing treatment or services to the child. A Member may be fined up to \$1000 for failing to make a report in such a circumstance. The duty to report is ongoing (for new information) even if a previous report has been made respecting a child. The report must be made personally.

A Member must make a report if s/he has reasonable grounds to suspect any of the following:

A child has been or is at risk of harm

A report is required if a child has been, or is likely, at risk of being physically harmed by a person in charge of the child (e.g. a parent or guardian), either directly or as a result of neglect or a pattern of neglect. A report is also required if a child has been, or is at risk of being sexually molested or sexually exploited, by a person in charge of the child. A report is also required if the person in charge of the child knows or should know of this risk and fails to protect the child.

Failure to provide or consent to services or treatment

There are numerous circumstances where the person in charge of a child does not (or cannot) provide services or treatment to a child, or where the person in charge does not (or cannot) consent to services or treatment for a child. A report is required where a child is not receiving services or treatment, and:

- a. the child requires medical treatment to cure, prevent or alleviate physical harm or suffering;
- b. the child has suffered or is likely at risk of suffering emotional harm, demonstrated by serious anxiety, depression, withdrawal, self-destructive or aggressive behaviour, or delayed development believed to be caused by action or inaction of the person in charge of the child;
- c. the child has a mental, emotional or developmental condition that, if not remedied, could seriously impair the child's development; or if
- d. the child is under the age of 12, has killed or seriously injured another person or has caused serious damage to another person's property, and services or treatment are needed to prevent a recurrence.

Abandonment

A report is required if a child has been abandoned by a parent or guardian, or is otherwise left without a caregiver. This includes the death of the child's parents.

Failure to supervise a child

A report is required if a child has injured another person or damaged another person's property more than once because a person in charge of the child encouraged the child to do so. A report is also required if a child has injured another person or damaged another person's property more than once because a person in charge of a child has not or is not able to supervise a child adequately.

Mandatory Reporting Scenario 1

Lea, an RP, has a client who discloses that she has physically harmed her son. Lea has a duty to make a report to a Children's Aid Society, even if the client reported this in confidence or in the course of assessment or therapy. If two months later the client says something that makes Lea suspect the client has physically harmed her son again, Lea has a duty to make another report.

Mandatory Reporting Scenario 2

Julian, a therapist, has an 11 year old client who has been displaying signs of erratic and violent behaviour, and reports that he assaulted his friend last week to the point where the friend had to be taken to the emergency department. Julian believes that specialized health care services are necessary to prevent the client from causing serious injury again, and recommends a referral to another health care provider. The client's parents do not believe that their 11 year old son would really hurt anybody, suggesting that the seriousness of the incident was exaggerated by the victim's overreaction. The client's parents refuse to consent to further therapy. In this case, Julian has a duty to make a report to the Children's Aid Society. This duty to report exists even if the child does not want anyone to know about the incident and the parents refuse to believe the matter is serious and are angry at the RP.

VI. Long-Term Care Homes Act

The *Long-Term Care Homes Act* regulates long-term care homes in Ontario, which are facilities that provide 24-hour nursing care and supervision for persons in need of this level of care.

The *Long-Term Care Homes Act* sets out a Residents Bill of Rights requiring long-term care homes to ensure residents are treated fairly and with dignity and respect. This includes the right to participate in decision-making about the resident's care, the right to privacy in treatment and care, and the right to receive care and assistance aimed at maximizing the resident's independence as much as possible.

A long-term care home must have a zero-tolerance policy with respect to abuse (physical, sexual, emotional, verbal or financial) and neglect of residents.

Members have a duty to report abuse and neglect of residents and certain other types of conduct to the Ministry of Health and Long-Term Care. A report is required if a therapist (or any other person) suspects on reasonable grounds that any of the following has occurred:

- improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident;
- abuse of a resident by anyone;
- neglect of a resident by staff, including management, that resulted in harm or a risk of harm to the resident;
- unlawful conduct that resulted in harm or a risk of harm to a resident;
- misuse or misappropriation of a resident's money; or
- misuse or misappropriation of funding provided to a long-term care home.

It is an offence for a Member to fail to make a report in any of the above circumstances if the therapist provides care or services in a long-term care home. A Member may be fined up to \$25,000 for failing to make such a report.

Complaints and reports about the care of a resident or the operation of a long-term care home must be investigated by the Ministry of Health and Long-Term Care if they involve certain matters, including abuse of a

resident by anyone, and neglect of a resident by staff. Every person including an RP is protected from retaliation for making a report or for cooperating with an investigation. This includes protection from being fired, disciplined or suspended.

Sample Question

A Member is not required to report the following:

- i. A resident's son frequently yells and swears at the resident.
- ii. A staff Member is borrowing money from a resident with memory difficulties.
- iii. A nurse has not been monitoring a resident over the past several shifts.
- iv. A resident's daughter has stopped visiting the resident.

The best answer is iv. All of the above except iv must be both reported and investigated. While a resident's family member may neglect that person, this does not have to be investigated unless the neglect is to the point of emotional abuse.

Answer i is not the best answer because this may constitute emotional abuse, and emotional abuse by any person must be reported and investigated.

Answer ii is not the best answer because this may be considered financial abuse, and any person who financially abuses a resident must be reported and investigated.

Answer iii is not the best answer because a nurse who has not been monitoring a resident may be neglecting that client. Neglect of a client by a staff member must be reported.

VII. Human Rights and Accessibility Legislation

Laws and concepts relating to human rights and accessibility are described below.

► Human Rights Code

Every person is entitled to access and receive health care services in a manner that respects his/her human rights. The *Ontario Human Rights Code* requires every Member to treat clients, potential clients, employees, and others equally, regardless of the person's race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity or expression, age, marital status, family status or disability.

If a person feels that a therapist or organization has violated the *Human Rights Code*, the person may complain to the Human Rights Tribunal of Ontario. If the Tribunal finds that a therapist has violated the *Human Rights Code*, it may order the therapist or organization to pay damages and require the therapist or organization to take action, such as taking training or implementing a human rights policy.

Since the Human Rights Tribunal does not have the power to suspend or revoke a Member's certificate of registration, a person who believes his/her human rights have been violated may also bring a complaint to the college.

In order to meet the obligations of the college and to avoid a misunderstanding that could lead to a human rights complaint, Members should always clearly communicate their reasons for making clinical decisions, including assessments, therapies and referrals, among others. Members should always make decisions to refuse or end a

therapeutic relationship in good faith. For example, a therapist may refer a client whose presenting concerns are outside his/her area of competence to another professional; however, false claims of lack of training or expertise to work with a particular client, and refusal to provide services to the client based on such false claims, could be considered a form of discrimination.

Duty not to discriminate

A Member must not discriminate against any person on any prohibited ground. Examples of discrimination may include the following:

- refusing to accept or continue to treat a new client for a prohibited reason, such as race, colour, sexual orientation;
- making a treatment decision for a prohibited reason;
- insulting a client in relation to a prohibited reason;
- refusing to allow a client with a disability to attend an appointment with a support person, assistive device or service animal; and
- making assumptions, not based on clinical observation or professional knowledge and experience, about a person's health or abilities because of his/her age or another prohibited reason.

It is not discrimination to make clinical decisions or to accept or refuse to continue seeing a client for reasons other than prohibited grounds. For example, if an RP does not have the competency to treat or continue to treat a person, or if the assessment or therapy required is not within the Member's scope of practice, a Member should not initiate or continue therapy with a client.

RPs are similarly entitled to rely on professional knowledge, judgment and experience to comment upon clinically relevant matters that relate, for example, to a person's age, gender, or cultural background.

► Duty to Accommodate

The *Human Rights Code* requires that persons with disabilities be accommodated, unless the accommodation would result in undue hardship (e.g. because of a real risk to health or safety or because of undue cost). The duty to accommodate also applies to other prohibited grounds of discrimination.

To accommodate persons with disabilities, accommodation must be individualized. Individual accommodations should be discussed with the person where possible, and must be provided in a manner that respects the person's dignity and autonomy. However, a Member is not required to provide the exact accommodation that a person requests if another form of accommodation is reasonable and acceptable.

Examples of accommodation may include the following:

- permitting a client who uses a wheelchair to reschedule an appointment with less than 24 hours notice if the elevator in the RP's office is temporarily out of service;
- offering an extended appointment time to a client with an intellectual, learning, or mental health disability who may need a longer time to explain his/her concerns;
- permitting a person with a disability to enter your premises with a support person, service animal, or assistive device; and
- communicating in writing if a person with hearing impairment or other disability requests this.

Human Rights Code Scenario No. 1

Nancy, a psychotherapist, determines that she is not competent to continue to treat her client because the client's mental health condition has become increasingly more complex. The client is unhappy about Nancy's decision, and believes that Nancy has always had a problem with him because of his race and religion. Nancy should carefully communicate her reasons for terminating the client-therapist relationship, so the client is not left with a misunderstanding that the decision was made because of the client's race or religion. Nancy must continue to provide support for the client until an appropriate referral is made.

Human Rights Code Scenario 2

Simon, an RP, has a new client named Jennifer who has an intellectual disability, and he finds it difficult to communicate with her. Simon should ask Jennifer what he can do to better communicate with her. If Jennifer has a support person who sometimes provides assistance, she may ask to bring that person to Simon's office.

Simon is required by law to permit a support person to accompany a client. However, Simon should not assume the client needs a support person and should discuss the matter with the client if possible. Additionally, if the client does not have the capacity to make decisions regarding therapy, the client may need a substitute decision-maker. In any of these circumstances, Simon cannot refuse to accept the client because of his/her disability, even if the visits will take longer.

Human Rights Code Scenario 3

Evelyn, an RP, has a client who has been diagnosed with a mental illness. Evelyn has been having increasing difficulty interacting with her client. The client has also been rude towards Evelyn and staff. While no client has a right to be abusive, Evelyn may consider whether the behaviour is caused or exacerbated by the person's illness. Evelyn cannot stop providing services because of the client's mental illness, unless Evelyn concludes she is not competent to continue treating the client, or unless there are health and safety concerns for Evelyn or her staff.

If Evelyn believes a referral to another health care provider with the appropriate competencies to manage the client's health care needs is necessary, Evelyn should clearly explain the reasons for the decision. Evelyn also should consider whether any accommodations are possible. For example, a client who is uncomfortable in a crowded waiting room because of a mental illness might be offered an alternative space to wait. There may be other practical measures the client may be able to suggest that will help the client manage his/her disability-related symptoms.

► Accessibility for Ontarians with Disabilities Act

The *Accessibility for Ontarians with Disabilities Act (AODA)* provides standards for accessible customer service, information and communications, transportation, employment, and built environment (i.e. physical facilities). The intention of the standards is to achieve accessibility for Ontarians with disabilities by 2025. An RP or organization the therapist works for may be fined for not complying with the *AODA*.

The standards currently apply only to persons and organizations with at least one employee in Ontario. Different standards apply depending on the number of employees an organization has. Neither a sole proprietor nor a group of persons in a partnership are considered employees, therefore the *AODA* standards currently do not apply in these situations. However, if a therapist has incorporated as a business, s/he may be considered an employee of the corporation along with any other employees the RP has.

Accessibility standards are found in regulations and have the status of law. A breach of an AODA standard is not necessarily a breach of the *Human Rights Code*. However, it is possible that the AODA standards will be used as a reference point in Human Rights Tribunal hearings.

Relevant Accessibility Standards are listed below:

Customer Service Standard

Therapists with at least one employee in Ontario must comply with the accessible customer service standard as of January 2012. For organizations with fewer than 20 employees, the AODA requires therapists to:

- implement policies, practices and procedures regarding the provision of goods and services to persons with disabilities, that are consistent with the principles of dignity, independence, integration, and equal opportunity, and that deal with the use of assistive devices and the availability of any measures that make services accessible (e.g. TTY, elevator);
- permit service animals and support persons in public areas of premises;
- provide reasonable notice of any temporary disruptions to any accessibility features or services, including the reason for the disruption, the anticipated duration, and a description of any alternate services;
- provide training to all employees and anyone else who deals with members of the public or third parties, which must include the following:
 - a. review of purposes of AODA and requirements of Customer Service standard;
 - b. how to interact with persons with disabilities who use assistive devices, use a service animal, or are assisted by a support person;
 - c. how to use available accessibility equipment and devices on premises or that are otherwise provided to the public; and
 - d. what to do if someone with a particular type of disability is having difficulty accessing the providers' goods or services; and
- establish a process for receiving and responding to feedback about accessibility and make information about the process readily available to the public. This process must permit people to provide feedback in person, by telephone, in writing, or electronically, and the process must specify actions that will be taken if a complaint is received.

For organizations with 20 or more employees, there are additional requirements, including putting any policies, practices and procedures in writing and making them available upon request, filing publicly-available accessibility reports, and keeping records of the training that has been provided.

Integrated Standard

The Integrated Standard includes standards on information and communications, transportation, and employment. For organizations with fewer than 50 employees, the general requirements under this standard include the creation and implementation of policies, practices and procedures regarding how the organization will meet the Integrated Standard. It includes requirements for training of all employees, volunteers, and others on the Integrated Standard and the *Human Rights Code*.

Information and Communication Standard

The Information and Communication Standard requires organizations to ensure that information available to the public and the organization's communications with the public are accessible, or may be made accessible. This standard will be phased in and will apply to organizations with fewer than 50 employees in 2017.

This includes making any feedback system accessible upon request, ensuring that any emergency or public safety information available to the public is made accessible upon request, and providing accessible information formats and communication supports upon request.

For example, this standard may require therapists with at least one employee to provide intake forms, charts, and other health information in accessible format (e.g. large print, audio, or Braille). It may also require therapists to provide sign language interpretation. The therapist must consult with the person making the request regarding an accessible format or communication support, and then must provide an accessible format or communication support in a timely manner, without increasing the cost to the client.

For organizations with 50 or more employees, additional steps will be required, including ensuring that websites are compliant with web accessibility standards, and filing accessibility reports.

Employment Standard

The employment standard requires employers to provide an accessible workplace. This includes the following:

- providing public notice regarding accessibility practices in hiring employees;
- providing accessible workplace information; and
- providing, on request, any individualized emergency response information to employees who require this individualized information because of a disability.

For organizations with fewer than 50 employees, the employment standard will generally come into force on January 1, 2017. The deadline for providing individualized workplace emergency response information is January 1, 2012.

Built Environment Standard

The standard on built environment has not yet been developed. However, it will apply to the construction of new buildings and to major renovations.

AODA Scenario

Samir, an RP, has an office with one employee who provides administrative support. Under the Accessibility for Ontarians with Disabilities Act's customer service standard, Samir must create an accessibility plan for providing accessible customer service and accessible information and communications.

Samir is not required to put his policies, practices and procedures in writing, but must ensure that they are followed, including by his employee. Samir is also responsible for ensuring that training is provided to the employee regarding the accessibility standards (e.g. that support persons, animals or devices are allowed on the premises). Samir should also be aware of how the information and communications and employment standards will apply to his/her practice. He may wish to consider documenting any policies, practices and procedures in writing and make a record of any training provided to employees.

VIII. Municipal Licensing

In some circumstances, Members may require a municipal license. A municipal license, such as a business license, is granted and regulated by the municipality, and not by the provincial government or the college. A municipal license does not give a therapist the right to be registered with the College.

Municipal licensing applies to all business operators, not just RPs. Generally speaking, the purpose of municipal licensing is to set conditions for the premises in which a business operates, as well as to address public health matters such as sanitation. For example, a municipal inspector may inspect an RP's office to ensure that protocols are in place to avoid the spread of disease. A municipal licensing body is generally not focused on professional qualifications or professional conduct.

It is the Member's obligation to ensure s/he is meeting the licensing requirements and standards of their municipality. If the college requires a higher standard or different standard than the municipality does, the college's standard must always be followed, as the *RHPA* is a provincial statute which takes priority over a municipal by-law.

Municipal Licensing Scenario

Laurie has a municipal business license allowing her to operate an office in her city, and pays a fee every year to renew her license. Laurie now wishes to register with the College. She inquires whether the College will accept her municipal license as meeting all of the registration requirements for the College. She assumes that this is what is meant by 'grandparenting.' The College advises Laurie that she is misinformed and must meet all registration requirements of the College, including conditions for grandparenting, in order to become a Member. Laurie's business license has no bearing on her eligibility for registration with the College.

CONCLUSION

When legal issues arise, Members are encouraged to discuss them with colleagues and with their professional association, and to check with the College about its expectations. The College cannot provide legal advice, nor can one's colleagues or professional association, unless they have legal/ethical consultation services in-house, as some do. Thus, on many issues a Member may need to consult with his/her own lawyer to address specific concerns.