

Disclosing Information to Prevent Harm DRAFT Professional Practice Guideline

Introduction

Registered Psychotherapists have an obligation to maintain client confidentiality. In some circumstances, however, disclosure of client information is permitted or required by law. The *Personal Health Information Protection Act, 2004*¹ (PHIPA) allows health information custodians to disclose personal health information about an individual, without that individual's consent,

if the custodian believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.²

This guideline document explores when and how a member of the College can disclose information under this provision.

The question of whether to disclose confidential information to prevent harm is multifaceted, involving aspects of law, ethics, and professional practice standards. The College advises members that they may be held accountable for failing to take steps to prevent harm. Members have lost their employment, been the subject of complaints or reports to the College, and can be sued in court, for failing to respond appropriately to situations involving risks to clients or third parties.

The expectation that a professional disclose confidential information to prevent harm is sometimes referred to as the 'duty to warn'. This exception to confidentiality is *in addition* to other reporting obligations, for example reporting to a Children's Aid Society about a child in need of protection. Members should review the College's *Professional Practice and Jurisprudence* manual, and *Professional Practice Standards*, for an understanding of these obligations.

¹ SO 2004, c 3, Sch A.

² *Ibid.*, s. 40(1).

Interpretation

The following are brief explanations of key concepts quoted above:

<i>Reasonable grounds</i>	A concern that is based on more than suspicion, rumour or speculation.
<i>Necessary</i>	There is no other reasonable way (such as continuing therapy with the client) to prevent the risk of harm to the client or others. If disclosure is necessary, as little information as possible is disclosed to eliminate or reduce the risk of harm; that is, extraneous information is not shared.
<i>Significant risk</i>	Requires a case-by-case evaluation of both the likelihood and magnitude of harm. "Significant risk" falls in between the extremes of low risk and certainty.
<i>Serious bodily harm</i>	Death or "any hurt or injury, whether physical or psychological, that interferes in a substantial way with the integrity, health or well-being of a victim." ³
<i>Person or group of persons</i>	The victim(s) are identifiable or their characteristics are described specifically.

Professional Judgment, Consultation and Documentation

Each situation involving a potential risk of harm is different. The member is responsible for using professional judgment to determine whether and how to disclose information appropriately.

Part of developing and applying professional judgment is knowing when to seek consultation. Consulting with supervisors and colleagues allows multiple perspectives and options to be presented, allowing the member to make an informed decision. Consultation is especially important in complex situations, or where a member is accountable as part of a team or organization. A member should consult early, as potential risks begin to emerge, and not wait until harm is imminent. As the law regarding disclosure of confidential information to prevent harm is complex and evolving, members may find it helpful to consult with their legal advisor.

Deciding whether to make a report requires serious consideration. Members should recognize that the therapeutic relationship may be compromised as a result of disclosing information without the consent of the client. Concern about maintaining the therapeutic relationship, however, should not prevent a member from disclosing information where doing so is needed.

Members should document their actions, including consultations made and action taken.

Working with Clients at Risk

When working with clients who are at risk of harm, it is strongly recommended that members consider ways of facilitating their own self-care and strengthening resilience. They may do this by engaging in education, supervision, personal therapy or other personal care activities, e.g. meditation, connecting with personal supports, taking a break, etc. While this should be ongoing, it may be particularly important after dealing with more challenging clinical issues or in the unfortunate event that a client has been injured or dies as a result of suicide or homicide.

Example Situations

This section covers types of situations a member could encounter. Actual situations are likely to be nuanced and involve elements of uncertainty. The examples given here are simplified for basic learning purposes.

³ *R. v. McCraw*, 1991 CanLII 29 (SCC), [1991] 3 SCR 72, at p. 88.

Client self-harm or suicide

Members are expected to have competence in risk assessment. Minimally they should know when and how to conduct a risk assessment (during intake, the initial session, and/or at some point during the course of therapy). There are various methods for conducting a risk assessment, which may include having the client completing a written form, orally asking the client a series of standard questions, or some combination of the two. Risk may need to be re-assessed based on new information presented by the client or after following up with the client at a later session.

It is important to explain the limitations to confidentiality at the outset of therapy, to request that clients provide an emergency contact person, and to maintain up-to-date contact information of the client. The member should have the client's address in case the member learns in between sessions that the client is at risk and needs to contact emergency services.

Members should be familiar with the safety planning process, including helping the client identify internal and external resources and strengths, and with treatment and referral options for suicidal ideation or other self-harming behaviours. Members should be alert to distinguish between 'passive' suicidal ideation (where there is no intention to take action), and active planning. Depending on the situation, it may be appropriate to offer to escort the client to hospital, get in touch with the client's emergency contact person, call the client's other known healthcare providers, contact police or dial 911.

Example: The client regularly discusses end of life decision-making in session, including the option of suicide. To date the idea of suicide has been hypothetical in nature with no indication of active planning. In between sessions, the client emails the therapist indicating that they plan to take their own life in the next several days. The therapist replies that they will need to report this to police and the client's family physician, and does so.

Example: An individual calls a community mental health agency threatening suicide. Agency staff phones the police. The police inform the agency that the individual in question is known to police for making false reports of suicidality, and tell the agency that they do not need to contact the police if the individual calls again. The individual calls again stating that they will take their own life. Notwithstanding the advice from police, agency staff contacts the police again about the individual.

Client knowledge of a third party at risk, e.g. of suicide

Sometimes a client will share that someone they know is at risk, for example planning to die by suicide. Where disclosure is warranted, the client can be involved in the process if this can be of therapeutic benefit. Therapists should be cautious in assuming the client will make a report about a third party at risk. Relying on the client to report may be appropriate if the risk is not imminent and the therapist believes it is likely the client will follow through; however, once the therapist is aware of an imminent risk, the therapist may have a responsibility to disclose information themselves to prevent harm.

Example: The client tells the therapist about their friend's social media posting that they plan to take their own life shortly. The therapist explains their duty to report, and offers to phone the police together with the client. The client agrees and they do so.

Risk of harm to the client by a third party, e.g. intimate partner violence

In some situations, the client may be at risk of serious injury or death from another person. The client may be reluctant to share this information with anyone else. This can put the therapist in a very difficult position for deciding whether or not to disclose information. Members must respect the client's autonomy in deciding whether or not a report should be made. In addition, reporting a client's partner to police can potentially increase risk and re-traumatize the client. A thorough history and risk assessment is required.

Example: The client discloses to the therapist concern for their safety and that they may be at risk of harm by their partner. The therapist assesses risk and lethality and in establishing a safety plan with the client, explores a variety of options (e.g. accessing a shelter, supportive resources in the client's life, the client's calling police).

Related, members should view threats of self-harm by a third party communicated to the client as potentially *both* an attempt to exercise control over the client, as well as a legitimate risk to the third party.

Risk to a third party by the client

The client may disclose in session their intention to harm a specific person or group. The therapist should assess the level of risk on an ongoing basis, by considering factors such as specificity of planning, history of violence and access to weapons. If the risk is significant, contacting police will generally be sufficient to fulfill one's responsibility. There is debate about whether warning the intended victim of a threat is necessary in addition to advising police (assuming it is reasonably possible to obtain contact information of the intended victim). In contemplating this step, a member needs to weigh the severity of the risk to the intended victim against the negative impact disclosure may have on the intended victim. That is, the greater the risk of harm, the more important it may be to alert the intended victim, if it is possible to do so.

Once information is disclosed, members should consider whether it is reasonable in the circumstances to follow up with the recipient of the information, in particular if circumstances change. Expect that police may not be able to provide updates about their investigation.

Example: The client confides in the therapist that he plans to kill his former spouse. After the session, the therapist immediately contacts police. In addition, the therapist's records include the former partner's name and workplace, and the therapist provides this to the police as well.

The issue of a client's disease status, particularly HIV, can raise questions about the need to disclose information to prevent harm. A client's HIV status is confidential personal health information. Improvements in treatment are drastically reducing the risk of sexual transmission of the virus. This will form part of the analysis of whether the client's conduct constitutes a "significant risk" of serious bodily harm.

Example: The client discloses to the therapist that they are having unprotected sex with partners who are unaware of the client's disease status. Because this is a specific and evolving area of law and medicine, the therapist consults clinical literature, as well as individuals and organizations with specialized knowledge.⁴

Risk to the therapist by the client

Clients expressions of anger or hostility 'toward' a therapist are often part of the therapeutic process and can most often be worked out through therapeutic conversation. However, there may be situations where it is most therapeutic to refer the client elsewhere or terminate the therapeutic relationship altogether. In rare circumstances, a client may pose a risk of harm to a therapist, and it may be necessary to contact police in order to ensure the safety of the member.

Example: A client becomes angered by the outcome of therapy, which very quickly escalates into resentment and clear threats of physical violence. The therapist terminates the therapeutic relationship and provides referral options to community resources. The therapist then contacts police to discuss safety planning and available legal measures.

⁴ See e.g. HIV & AIDS Legal Clinic Ontario, online: <http://www.halco.org/>; Canadian HIV/AIDS Legal Network, online: <http://www.aidslaw.ca/>.

See Also

[Professional Practice Standards for Registered Psychotherapists](#), standards 1.3: Reporting Unsafe Practices, and 3.1: Confidentiality.

[Professional Practice & Jurisprudence for Registered Psychotherapists](#), pages 51-56 and 83-87.

[CRPO web page: Reports about Members](#)

[Mandatory Reporting Obligations for Registered Psychotherapists](#)

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