

Professional Practice Standards

For Registered Psychotherapists

Approved by Council January 15, 2014

Revised November 24, 2016

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INTRODUCTION

As part of its mandate under the *Regulated Health Professions Act, 1991*, (RHPA) every health regulatory college is required to develop and establish Professional Practice Standards for its members.

Colleges often start with a basic set of standards, which typically evolve over time. Initially, practice standards focus mainly on professional conduct and items rooted in legislation and regulations, such as confidentiality, consent, record-keeping, business practices and the like. Over time, limited ‘clinical’ standards may be developed, often the result of a perceived need when a particular therapeutic approach or assessment method proves problematic for members. These concerns may be identified through the College’s Quality Assurance Program, or may come to light through the complaints process.

This initial set of *Professional Practice Standards for Registered Psychotherapists* is based largely on the Professional Misconduct Regulation developed by CRPO’s Council under the *Psychotherapy Act, 2007* and subsequently approved by the Ministry of Health and Long-Term Care and the Government of Ontario. Provisions of the Professional Misconduct Regulation have been incorporated into the standards and are re-stated in plain language, with detail added to help our members understand what is expected in the practice environment.

Standards have the force of law when based directly on the statutory regulations of the College, and are distinct from guidelines. Guidelines, which the College may develop in the future as the need arises, provide more detailed information on how to apply standards in particular circumstances. Guidelines are less directly enforceable and are provided to assist members in their thinking and decision-making when considering issues that may arise in their daily practice. In addition, Council has developed a Code of Ethics, which also is not directly enforceable, but establishes a level of conduct that members should strive to uphold.

These Standards were developed by members of the profession drawn from a wide range of specialties and modalities, and by members of Council who are not members of the profession. The standards were laboured over for many months and are the product of extensive research, discussion, debate, and ultimately, the need to arrive at consensus. As a final step in their development, these Professional Practice Standards were circulated for stakeholder comment, and revisions were made based on stakeholder input.

As members of a regulated profession, Registered Psychotherapists (RPs) have particular duties to clients, colleagues, the College, and the general public. CRPO Professional Practice Standards describe the minimum acceptable professional standards expected of members; they are not intended as best practices. Members are expected to practise in accordance with these standards and to apply them consistently in their practice environments. In addition, they should ensure that their employees abide by these standards and do not act on behalf of members in a manner that falls below expected levels of professionalism. Similarly, members must take care not to enter into employment or business relationships that would impede their ability to meet professional standards.

This document is divided into six sections:

1. Professional Conduct
2. Competence
3. Client-Therapist Relationship
4. Clinical Supervision
5. Record-keeping and Documentation
6. Business Practices

Each section includes an introduction and several standards. Each standard provides background and context, states the standard concisely, and provides advice to assist members on how they may demonstrate the standard. At the end of each section, the reader is referred to related standards.

These Professional Practice Standards were approved by Council on January 15, 2014. They will be reviewed and updated periodically.

SECTION 1 PROFESSIONAL CONDUCT

Members of self-regulated professions are held to standards of professional conduct in their practice and, to a certain extent, in their personal lives. Professional conduct encompasses interactions with the College, clients, colleagues, other professionals and the public.

As the governing body of the profession, the College's ability to fulfil its public protection mandate depends on the cooperation of members in various aspects of College activities. Key to this is members' acceptance of the regulatory authority of the College based in legislation – in this case, the *Regulated Health Professions Act, 1991* and the *Psychotherapy Act, 2007*. Together, these two statutes constitute the legislative framework of the College.

Professional conduct, among other things, comprises the proper use of titles, including one's regulated title and any specialty titles a member may have earned. Members must comply with any terms, conditions or limitations placed on their Certificate of Registration, and must participate in the College's Quality Assurance Program. In addition, they must comply with any orders made by a panel of their peers, i.e. other members of the College, fulfill any undertakings (agreements) entered into with the College, and co-operate with College investigations. Failure to do so could lead to disciplinary action against the member.

Members have a duty to report unsafe practices of colleagues and other regulated health professionals, and to report knowledge or suspicion of sexual abuse by a colleague, client or other health professional. In addition, members strive to avoid dual relationships with clients; they respect boundaries and refrain from influencing clients unduly, especially in legal and financial matters; and they do not engage in sexual activity with clients. The latter is an extremely serious form of professional misconduct that can result in loss of registration and/or other mandatory penalties.

Members are required to take steps to avoid conflicts-of-interest in their professional lives and to deal appropriately with conflict situations. They can be disciplined for "disgraceful, dishonourable, or unprofessional conduct" related to their practice, and for "conduct unbecoming a member of the profession" in their private lives, if such a finding is made by a panel of peers following a complaint to the College.

Members practise only in areas in which they have the necessary knowledge, skill and judgment, and perform only controlled acts they are legally authorized to perform. They understand there are situations when a client should be referred to another health care provider with different expertise, and they appreciate the role of supervision and/or consultation in their own continuing professional growth as a therapist.

All of these aspects of professional conduct, among others, are described in greater detail in this section. Members and prospective members should familiarize themselves with the College's standards of professional conduct, and the obligations of registration.

1.1 Accepting the Regulatory Authority of the College

BACKGROUND

The College's authority

In accepting a Certificate of Registration from the College, members obtain privileges, such as use of the title Registered Psychotherapist or RP. At the same time, members take on obligations, such as recognizing the authority of the College. By accepting the College's authority, members help maintain public confidence in the College and in the profession itself.

Complying with the terms of a Certificate of Registration

When the College issues a Certificate of Registration to a member, s/he must adhere to all terms, conditions and limitations (TCLs) associated with the certificate. Members should ensure that clients and colleagues are aware of any TCLs. A breach of TCLs could result in disciplinary action by the College.

Some TCLs are imposed by regulation, such as the requirement to practise only in areas of the profession in which the member has knowledge, skill and judgment. TCLs may also be imposed by a College committee. Some TCLs, such as requiring a member to practise with clinical supervision, allow a member to grow professionally and expand his/her professional competency.

Responding to the College

When formally contacted in writing by the College, including by email, members must provide an appropriate response within 30 days. A response is appropriate if it is complete (providing all the information requested), accurate, and made in writing.

Complying with panel orders

Panels are sub-groups of College committees. Several committees of the College have the ability to issue orders that are binding on members. These committees include: the Inquiries, Complaints and Reports Committee (ICRC, Discipline Committee, and Quality Assurance Committee. If a member fails to comply with an order of a panel of the College, s/he is openly challenging the authority of the College.

Appearing for a caution

In response to a complaint or report, the member may be ordered by the ICRC to attend a private meeting, called a "caution". Attendance at this meeting is mandatory, and members must respond to a notification from the ICRC. During the meeting, the member may be advised of a concern and given an advisory and educational warning about his/her conduct. A caution is not disciplinary in nature.

Fulfilling an undertaking

An undertaking is a promise made by a member to the College. An example of an undertaking would be a requirement to complete a course to upgrade a skill. Members often enter into undertakings as an alternative to formal disciplinary action. It is considered an act of professional misconduct if a member does not complete or abide by an undertaking.

Complying with a suspension

The College has sole authority to suspend a member's Certificate of Registration. The suspension may result from non-payment of fees, or from the decision of a committee (e.g. the Discipline Committee). Members under suspension must refrain from practising psychotherapy, and must not receive any benefit or income, either directly or indirectly, from their professional status while suspended. Members should retain appropriate financial and other records to show that they have not benefitted from their professional status while suspended. During a suspension, a member may transfer the operation of his/her practice. As part of contingency planning, members should consider who will manage their practice in the event that they are suspended. Failure to comply with requirements relating to suspension may result in disciplinary action.

In certain circumstances, the Executive Committee may occasionally grant an exemption to allow a member to receive income indirectly from the practice of the profession (e.g. it would be unfair, if the member's spouse is also registered with the College, to prohibit the spouse from practising during the suspension because the family will receive income from the spouse's work). This is determined on a case-by-case basis. In applying for an exemption, the member must make full disclosure to the College regarding the circumstances and nature of the benefit. Approval must be granted prior to receiving the benefit.

Participation in Quality Assurance

Promoting the continuing competence and quality improvement of members is an important part of the College's role. Members must participate fully in all mandatory aspects of the College's Quality Assurance Program. This includes complying with a request for disclosure of a member's self-assessment and professional development information, and participating in a peer & practice assessment, when requested to do so.

Cooperating with College investigations

A member is obligated to fully cooperate with the College during an investigation of the member or another member. It is expected that the member will cooperate in a timely manner, including providing access to facilities, records, or equipment relevant to the investigation. The member must also exhibit appropriate behaviour during the investigation and not subject the investigator to rude, threatening or obstructionist behaviour. Similarly, once evidence of the appointment of a formal investigator by another college is made known to the member, s/he is obligated to cooperate with that investigator. This responsibility reinforces the member's obligation to assist that college in protecting the public by investigating any complaint or report.

STANDARD: Accepting the Regulatory Authority of the College

A member of the College accepts and complies with the regulatory authority of the College, College committees and their sub-groups – known as panels.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- practising in compliance with the terms, conditions and limitations attached to his/her Certificate of Registration;
- refraining from practising the profession of psychotherapy while suspended, and ensuring that no benefit or income is received from the practice of psychotherapy;
- when formally contacted by the College, communicating with the College in a timely and appropriate manner;
- cooperating with College investigations/investigators;
- appearing before a panel as required, e.g. attending a caution;
- adhering to any undertaking made with the College;
- complying with orders of a committee or panel;
- participating fully in all mandatory aspects of the College's Quality Assurance Program.

See also:

- Standard 1.2 Use of Terms, Titles and Designations
- Section 4 Clinical Supervision
- Professional Misconduct Regulation, provisions 44, 45, 46, 47, 48, 49, 50
- Standard 6.4 Closing, Selling, or Relocating a Practice

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

1.2 Use of Terms, Titles and Designations

BACKGROUND

The *Psychotherapy Act, 2007* restricts the use of the titles “Psychotherapist”, “Registered Psychotherapist”, and “Registered Mental Health Therapist”,¹ as well as any variations and abbreviations of these titles. The College has the authority to determine who may use these titles and the manner in which they may be used. The College also determines the circumstances in which its members may use other terms, titles and designations, including educational credentials, job titles, and specialty designations.

It is a provincial offence for an unauthorized person to use a restricted title or hold him/herself out as qualified to practise psychotherapy in Ontario. The College has the ability to prosecute unauthorized persons in provincial court. The College also has the ability to bring a restraining order (an injunction) directing any person to comply with the *Psychotherapy Act, 2007*.

Requirement to use regulated title

Members are required to use the title conferred by the College when acting in a professional capacity, e.g. in all advertising, professional publications, and on business cards and invoices. This includes all such uses via electronic media. The following are the titles that members of this College must use in accordance with their class of registration:

Registered Psychotherapist

The title associated with this class should be used in the following manner:

- Registered Psychotherapist or
- RP
- Psychothérapeute autorisé(e) or
- PA

Qualifying

The title associated with this class should be used in the following manner:

- Registered Psychotherapist (Qualifying) or
- RP (Qualifying)
- Psychothérapeute autorisé(e) (stagiaire) or
- PA (stagiaire)**Temporary**

The title associated with this class should be used in the following manner:

- Registered Psychotherapist (Temporary) or
- RP (Temporary)
- Psychothérapeute autorisé(e) (temporaire) or
- PA (temporaire)

¹ At the present time, the College has deferred use of the title “Registered Mental Health Therapist”. However, it is still one of the restricted titles set out in the *Psychotherapy Act, 2007*.

Inactive

The title associated with this class should be used in the following manner:

- Registered Psychotherapist (Inactive) or
- RP (Inactive)
- Psychothérapeute autorisé (inactif) or
- Psychothérapeute autorisée (inactive) or
- PA (inactif) or PA (inactive)

Education/training credentials

When acting in a professional capacity, members should display only education/training credentials related to the practice of the profession, specifically, the highest credential earned that is related to the practice of the profession.

Job titles

Members may identify themselves by using a job title in addition to their professional title. The job title should not replace the professional title. For example, a person may hold a position as manager of a clinic, and also be a Registered Psychotherapist.

Use of specialty designations

At this time, the College has not established a program to formally recognize and confer specialty designations. However, members may use a term, title or designation conferred by a third party, provided it meets all the following conditions:

1. The term, title or designation is earned. “Earned” means that the term, title or designation is not honorary and was not awarded purely through attendance, but that the member demonstrated development of the knowledge and/or competence associated with the term, title or designation. Note: This is not intended as an exhaustive definition.
2. It is conferred by a recognized credentialing body. “Recognized credentialing body” means one that is broadly recognized within the profession as legitimate.
3. It meets established standards. “Established standards” mean standards that are broadly recognized within the profession as legitimate. And
4. Prominence is given to the member’s regulated title.

These conditions enable members to use terms, titles and designations that are meaningful and generally recognized by the profession, while maintaining the distinction between the regulated title and additional qualifications. In considering whether a term, title or designation meets the conditions listed above, the test is whether a panel of one’s peers would view it in this way.

Examples

The following are examples of acceptable presentations of one’s respective titles:

Anna Persaud, M.Ed., RP, (C) OACCPP
Manager, Northwestern Psychotherapy Clinic

Jean-Michel Chénier, M.Sc.
Psychothérapeute Autorisé, RMFT

Sandra Smith, M.A., Registered Psychotherapist
Canadian Certified Counsellor (or CCC)

Note: By placing one's regulated title immediately after one's name and educational credential, a member meets the requirement to give the regulated title prominence.

The doctor title

Use of the title "Doctor" or "Dr." is protected in the *RHPA*. Members of this College are not permitted to use this title in a clinical setting. If a person is not from one of the health professions entitled to use the doctor title (chiropractic, optometry, medicine, psychology, dentistry) or a social worker with an earned doctorate degree in social work, s/he cannot use the title "Doctor" or "Dr." in a clinical setting. This is the case even if the person has an earned doctoral degree (e.g. the person holds a Ph.D). Under this provision, the title "Doctor" can be used in other settings, socially or in a purely academic setting, where no clients are present.

Note: The above does not prevent a member from displaying a Ph.D or other doctoral degree in his/her promotional material, if the degree is their highest credential earned and is related to the practice of the profession.

Misuse or misleading use of titles

It is also important to use only appropriate titles. The use of false or misleading titles or designations, including their use in advertising is considered professional misconduct, and may lead to disciplinary action. For example, it would be professional misconduct for a member to refer to an educational degree that has not been earned.

Practice description

Members may describe their field of practice as long as it does not suggest that a specialty designation has been earned when in fact it has not, e.g. "practice in family and couples therapy" would be acceptable.

STANDARD: Use of Terms, Titles and Designations

A member uses the title conferred by the College when acting in his/her capacity as a member of the profession, giving prominence to this title above any other qualification, designation or title. A member uses a term, title or designation implying a specialization appropriately and only if it is earned, conferred by a recognized credentialing body, meets established standards and prominence is given to the member's regulated title.

Demonstrating the Standard

Member demonstrates compliance with the standard by, for example:

- ensuring that his/her title is displayed on promotional material, and on other relevant material (such as letterhead, business cards), including electronic media, that is shared with clients;
- displaying the title in his/her office setting;
- ensuring that the member's regulated title is displayed in a manner that is more prominent than any other title(s);
- ensuring that the title used is appropriate for the member's class of registration;
- using the regulated title with clients and with students in a teaching setting;
- ensuring that the Doctor title is not used in a clinical practice setting, even if the member holds a Ph.D.;
- using other titles, such as educational credentials and specialty designations, in accordance with the rules described above.

See also:

- Standard 6.2 Advertising and Representing Yourself and Your Services
- Professional Misconduct Regulation, provisions 33, 34

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

1.3 Reporting Unsafe Practices**BACKGROUND**

Members have a legal obligation to report to the College another member's unsafe practice or behaviour. The reporting member need not have witnessed the incident of unsafe practice but need only have reasonable grounds to believe that an incident of unsafe practice has occurred. Reasonable grounds include apparently reliable information about an incident from another person (including a client). Members use their own judgment in deciding what to report. They should consider, for example, whether someone has suffered, or will suffer, serious harm as a result of the member's unsafe practice.

Duty to report – not investigate

Members are obligated to report, not to investigate. A client's identity must not be submitted in the report unless his/her consent is given or otherwise permitted by law (such as when there is risk of ongoing and serious harm).

Frivolous or vexatious complaints

While members have an obligation to report unsafe practice, as well as other forms of professional misconduct, incompetence, or incapacity to the College, they should not use the complaints process for ulterior purposes. A complaint made in good faith to protect vulnerable parties and/or the general public is appropriate. A vexatious complaint made for ulterior motives (e.g. to further a civil or domestic dispute) and made knowing it likely has no validity, is not appropriate. Repetitious complaints on the same matter may be considered vexatious. Abusing the complaints process is unprofessional, unfair to the other member and a waste of regulatory resources.

Mandatory reporting of sexual abuse

Under the *RHPA*, if a member has reasonable grounds to believe that another regulated health professional has sexually abused a patient/client, the member is legally obligated to make a report to that professional's regulatory college. If the regulated health professional is the member's own psychotherapy client, additional reporting obligations apply. Specifically, the member must report an opinion, if s/he is able to form one, as to whether the member's client is likely to sexually abuse their clients in the future. An additional report is required where the member ceases to provide psychotherapy to the regulated health professional.²

Members should also be aware of other reporting obligations, such as the duty to make a report under the *Child and Family Services Act, 1990*, where a member has reasonable grounds to suspect that a child is in need of protection due to physical harm, neglect or sexual abuse by a person having charge of the child.

STANDARD: Reporting Unsafe Practices

Members promptly report to the College another member's unsafe practice where there are reasonable grounds to believe that the other member has engaged in such practice. Members keep the identity of any client confidential unless the client has given consent, or disclosure is legally permitted or required. Members refrain from making frivolous or vexatious complaints.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- reporting promptly to the College the unsafe practice of another member where there are reasonable grounds to believe that unsafe practice has taken place;
- maintaining the confidentiality of any client involved unless the client has consented to disclosure or disclosure is permitted or required by law;
- refraining from making frivolous or vexatious complaints;
- reporting sexual abuse involving another regulated health professional.

See also:

- Professional Misconduct Regulation, provisions 39, 40

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

² See *Regulated Health Professions Act, 1991*, sections 85.1, 85.3, and 85.4.

1.4 Controlled Acts Note: This version of Standard 1.4 is out-of-date. Standard 1.4 was revised on November 21, 2019. For the current version, visit <https://www.crpo.ca/standard-1-4/>

BACKGROUND

As part of their scope of practice, regulated health professionals may be authorized to perform some of the 13 controlled acts set out in the *RHPA*. The controlled acts are health care procedures associated with a risk of harm.

Members of this College currently aren't authorized to perform any controlled acts; however, once the controlled act of psychotherapy is proclaimed, members of this, and five other regulated professions, will be authorized by the *RHPA* and their respective acts to perform the controlled act of psychotherapy. They are: nurses, occupational therapists, physicians, psychologists/ psychological associates and social workers/ social service workers. These professionals are regulated by their respective colleges.

Proclamation of Controlled Act of Psychotherapy Postponed

In 2007, the Ontario legislature enacted the controlled act of psychotherapy. However, this controlled act is not yet in force so is not yet restricted to members of regulated professions. The wording of the proposed controlled act of psychotherapy is 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.

General exceptions

The *RHPA* creates a number of exceptions permitting anyone to perform controlled acts in certain circumstances, including:

- helping someone in an emergency;
- helping someone with activities of daily living;
- treating by prayer or spiritual means according to the tenets of one's religion; and
- when administering a substance or communicating a diagnosis to a member of one's household (e.g. telling one's child that she has a cold).

Receiving authority through delegation

On their own initiative, members are not legally authorized to perform any controlled act.

However, another legally authorized regulated healthcare practitioner, working within his/her scope of practice and following the protocols established by his/her regulatory college, may delegate a controlled act to another person, including an RP.

The person delegating the act is responsible for the actions of the person receiving the delegation; the actions of the person receiving delegation may also be restricted by the regulations or professional standards set by his/her own college.

STANDARD: Controlled Acts

Members refrain from performing any of the 13 controlled acts listed in the *RHPA*, unless authorized by delegation or through an exemption.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- declining to perform a controlled act, even under delegation, if it is beyond the member's competence, or when doing so would, in his/her professional judgment, be counter-therapeutic;
- declining to perform a controlled act under delegation if the delegating practitioner is not providing supervision.

See also:

- Standard 4.1 Providing Clinical Supervision
- Standard 2.1 Consultation, Clinical Supervision and Referral
- Professional Misconduct Regulation, provisions 10, 12

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

1.5 General Conduct**BACKGROUND****Disgraceful, dishonourable or unprofessional conduct**

Instances may arise where a member, in the course of practising the profession, engages in disgraceful, dishonourable or unprofessional conduct that has not been foreseen by specific definitions of professional misconduct articulated by the College. Such behaviour goes beyond legitimate professional discretion, or errors in judgment, and constitutes misconduct as defined by the profession – as opposed to the public. This standard reassures the public that members of the College share a vision of respect for clients, and a commitment to practising with integrity and professionalism.

Impairment

It is professional misconduct to practise the profession while the member's ability to do so is impaired by any condition or dysfunction or substance which the member knows or ought to know impairs his/her ability to practise.

Conduct unbecoming a member of the profession

Members rely on one another to conduct themselves privately and in the community in a manner consistent with the values, beliefs and standards to which they adhere professionally. The Professional Practice Standards are generally concerned with conduct in the course of professional practice. Actions outside the practice of psychotherapy may be regarded as unbecoming a member of the profession, reflecting poorly on the member's integrity and the profession as a whole. Generally this type of misconduct involves dishonesty (e.g. fraud) or a serious breach of trust (e.g. child abuse).

Illegal conduct

Illegal behaviour may also be considered professional misconduct. Members may be held accountable by the College if they contravene the *Psychotherapy Act, 2007*, the Regulated Health Professions Act, 1991, or any Canadian law, if the purpose of the law is to protect or promote public health (broadly defined), or if the contravention is relevant to the member's suitability to practise.

If members are uncertain about whether particular actions or conduct are appropriate for an RP, they should consult with colleagues and/or the College.

STANDARD: General Conduct

Members refrain from illegal conduct related to the practice of the profession, as well as from knowingly practising while the member's ability to do so is impaired by any condition or substance. In addition, members at all times refrain from conduct that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional, or unbecoming a member of the profession.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- practising the profession with integrity and professionalism;
- considering the impact of his/her actions on the profession as a whole;
- assessing his/her actions from the perspective of a panel of professional peers;
- consulting another member or the College if the member finds him/herself in questionable circumstances.

See also:

- Professional Misconduct Regulation, provisions 41, 42, 43, 52, 53

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

1.6 Conflict-of-interest**BACKGROUND**

A conflict-of-interest exists when a member is in any arrangement or relationship where a reasonable person could conclude that the exercise of the member's professional expertise or judgment may be compromised by, or be influenced inappropriately by, the arrangement or relationship. A conflict-of-interest may be actual, potential or perceived.

Recognizing and preventing conflicts-of-interest

RPs are expected to be alert to any circumstance where a conflict-of-interest may develop or may be perceived by others, and respond by taking appropriate action. Most conflicts of interest are preventable if the situation is avoided at the outset.

Managing conflict-of-interest

Not all conflicts-of-interest are of equal concern. Some situations may be very serious and must be avoided entirely. There are other situations where a conflict-of-interest may develop, but is unavoidable, or not in the best interest of the client to avoid. These situations must be managed carefully.

An example of the latter could include working in a small or isolated community where a member may be the only person who can provide psychotherapy services to local residents. As a result, the member may provide psychotherapy to someone who is also his/her mechanic, hairdresser, lawyer, doctor, etc.

The following are some examples of situations that place a member in a conflict-of-interest:

1. Accepting a benefit for referring a client to any other person

A benefit is any advantage or gain, whether direct or indirect, and whether or not it is monetary in nature. A conflict may exist even if the benefit is not to the member directly, but to a related person or related corporation. A related person is someone connected with the member by blood, marriage, common-law, or adoption. A related corporation is a corporation that the member or a related person wholly or substantially owns.

A member should refer a client to another service provider only if the client requires or requests the service. The member should choose the place of referral solely on the basis of merit and benefit to the client, and not because the member hopes to receive a benefit as a result of that referral.

2. Offering a benefit for receiving a referral

This situation is the inverse of the previous one. Referral recommendations must be made solely for the benefit of the client. Referrals for the benefit of the member can promote unnecessary services.

3. Offering a benefit to a client where the member's services are being paid for by a third party

Where a third party pays for the service (e.g. an insurance company), it is inappropriate to give the client expensive gifts to encourage him/her to continue therapy. Inducing a client to come in for a service paid for by a third party through gift-giving promotes unnecessary treatment and could involve fraud. The giving of a small, health-promoting product is acceptable (e.g. a free stress ball).

4. Accepting materials or equipment

A member should not accept a benefit in the form of materials or equipment in return for using or recommending a supplier's product or service. The member's choice of product or service should be based solely on quality for the client. This does not preclude acceptance of nominal gifts (e.g. a small number of free sample stress balls).

5. Using premises or equipment without reasonable payment

This example is given to prevent members from placing themselves in a conflict-of-interest with a landlord or supplier (e.g. obtaining the use of a free or low cost office from someone who could benefit from a member's recommendations to clients).

Members pay for all premises and equipment at a reasonable, market rate. Otherwise, there is at least an appearance that the member will favour the landlord or supplier in the member's recommendations.

6. Entering into an agreement or arrangement that interferes with the member's ability to properly exercise his/her professional judgment

A member may not enter into an agreement or arrangement, or coerce another member into an agreement or arrangement, which prevents the member from placing the needs of clients first. For example, an agreement that a member will provide a certain treatment to all clients is improper because decisions must be based on an assessment of each client's individual needs. Avoiding this type of conflict reassures the public that, despite any contractual obligations, the member will always place the needs of his/her clients first. Members may describe this rule when negotiating agreements with other parties.

7. Engaging in any form of revenue sharing except in specific circumstances as set out below

In some practice arrangements, a member might not receive the entire fee paid by the client or a third party for providing professional services, but may share it with others within the organization or practice. In order to avoid a conflict-of-interest, members may share revenue only with one or more of the following:

- i. another member of the College;
- ii. a member of another regulated health profession;
- iii. a health professional corporation;
- iv. a social worker or social service worker or a professional corporation for a social worker or a social service worker; or
- v. any other person if there is a written contract with the person stating that the member will have control over, and be responsible for, his/her own professional decisions, and for maintaining professional standards.

8. Selling a product to a client or recommending a product that is sold in any premises associated with the member, without first advising the client that s/he may purchase the product elsewhere without affecting the client-practitioner relationship

A member may not pressure the client into purchasing products from the member's practice or the member's landlord. Avoiding this type of conduct assures the public that any sale or recommendation made by the member is in the client's interest only. It also gives the client the opportunity to obtain products elsewhere, perhaps at a lower price or at a more convenient location.

If recommending a product to a client that is sold in any premises associated with the member, the member also issues a written description of the product. In addition, the member advises the client that s/he may purchase the product elsewhere without affecting the client-practitioner relationship.

STANDARD: Conflict-of-interest

Members remain alert to potential, actual or perceived conflicts-of-interest, and take measures to prevent these situations from arising. Members take action to effectively manage and mitigate any conflicts-of-interest that may arise.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- being aware of, and avoiding, situations that may place the member in a conflict-of-interest;
- carefully managing conflicts-of-interest by appropriately disclosing the conflict, and ensuring that suitable safeguards are established and documented;
- seeking advice from peers or the College, when in doubt.

See also:

- Standard 1.7 Dual or Multiple Relationships
- Standard 1.8 Undue Influence and Abuse
- Standard 1.9 Referral
- Professional Misconduct Regulation, provision 16

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

1.7 Dual or Multiple Relationships**BACKGROUND**

Whenever possible, members should avoid dual or multiple relationships with clients in addition to their professional one (e.g. relative, friend, student, employee). In remote areas with few other psychotherapists, it may be impossible not to have some other relationship with a client (if only as a member of the same small community). In those circumstances, the member must use his/her professional judgment, and ensure that safeguards are in place, e.g. appropriate supervision, ensuring that any conflict-of-interest concerns are addressed, etc.

Multiple relationships are prone to cause confusion for both the member and the client. For example, the therapist or client may not know in which relationship certain information is being provided.

If the member is in a position of authority over the client (e.g. as employer), the client may feel the need to acquiesce to a request from the member as a therapist. Dual or multiple relationships may also affect the member's professional judgment (e.g. the member might say things to a client who is also a friend that s/he would not otherwise say to a client).

Note: Students in some psychotherapy training programs undertake personal psychotherapy as part of program requirements. In this instance, teachers in the program may engage with students in therapy. An important safeguard would be to ensure that a member engaged in such therapy does not also evaluate the students' academic or other performance in the program.

Relationships with former clients

The College urges members in the strongest possible terms to avoid romantic or sexual relationships with former clients. In most cases, relationships with former clients are inappropriate, inadvisable, and potentially damaging to the parties concerned.

Despite this proscription, the experience of some regulatory colleges is that an outright prohibition of such relationships is unworkable, especially where a relationship may develop many years later, and the original client-therapist relationship was relatively brief.

Members must, therefore, carefully consider the following factors before entering into such a relationship with a former client:

- the nature and length of the former client-therapist relationship;
- the issues presented by the client in therapy;
- the length of time since the client-therapist relationship ended; and
- the vulnerability of the client.

Members should understand that it may never be appropriate to enter into a romantic or sexual relationship with a former client, e.g. where the therapeutic relationship was long or intense, or if a power imbalance continues to exist between the member and the former client.

Ultimately, a member may be called upon to defend his/her actions before a panel of peers, if a complaint is made against the member.

Romantic relationships with current clients are totally unacceptable. Any sexual relationship with a client is considered sexual abuse and can lead to revocation of a member's Certificate of Registration.

STANDARD: Dual or Multiple Relationships

Except in extenuating circumstances where relevant circumstances have been considered, members avoid dual or multiple relationships with clients.

Demonstrating the Standard

A member demonstrates compliance with the standard, for example, by:

- avoiding entering into a therapeutic relationship with a family member, colleague, or friend unless there is no other option available for providing the required service, and doing so only after informing the client about the potential boundary and conflict-of-interest issues involved;
- avoiding the creation of dual relationships with clients, as well as behaviours that may lead to the creation of dual relationships (e.g. inappropriate or non-therapeutic self-disclosure, gift giving, meeting outside the clinical setting);
- always avoiding romantic and/or sexual relationships with clients;
- in most instances, avoiding personal, romantic or sexual relationships with former clients.

See also:

- Standard 1.6 Conflict-of-interest
- Standard 1.8 Undue Influence and Abuse

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

1.8 Undue Influence and Abuse**BACKGROUND**

Clients and/or their representatives may be emotionally and otherwise vulnerable. At the same time, clients may be particularly influenced by the views or suggestions of their psychotherapist. It is important therefore to ensure that clients feel safe with their therapist, and that they are not subjected to inappropriate influence or abuse. Upholding this standard includes apologizing for minor lapses in courtesy or use of inappropriate language, and consulting colleagues and/or the College if a member is unsure how to behave in particular situations. In addition, members sometimes work with clients who are dealing with life-changing events and end-of-life decisions (for example, when clients are executing a will or power of attorney). Members must guard against influencing the autonomy of clients in these decisions.

The College's Professional Misconduct Regulation requires that members not inflict any form of verbal, physical, psychological and/or emotional abuse on clients. Sexual abuse is an extremely serious form of professional misconduct, and is dealt with directly in the *Regulated Health Professions Act, 1991*. It is so serious, in fact, that the RHPA prescribes specific penalties; sexual intercourse with a client, for example, carries a mandatory revocation of registration for a minimum of five years. Other forms of sexual abuse may result in equally severe disciplinary action. The College's Client Relations Program is primarily devoted to preventing and dealing with sexual abuse of clients.

The RHPA³ defines sexual abuse as:

- a. sexual intercourse or other forms of physical sexual relations between the member and the patient;
- b. touching, of a sexual nature, of the patient by the member; or
- c. behaviour or remarks of a sexual nature by the member towards the patient.

The *RHPA* also states that the term “sexual nature” does not include: “touching, behaviour or remarks of a clinical nature appropriate to the service provided”. Therefore, the *RHPA* does not prevent members from taking a sexual history relevant to the services provided, discussing sexual issues in therapy, or even, referring a client to a sexual surrogate. In the latter instance, however, the surrogate shall not be an employee of the member or an associate supervised by the member. In addition, there is an onus on the member to try to ensure that the surrogate is appropriately trained/certified, and that s/he adheres to accepted norms and standards for sex surrogacy. While some forms of touch or bio-energetic work may form a legitimate part of psychotherapy practice, it is clear that any form of disrobing or sexual touching of clients is inappropriate conduct on the part of members.

STANDARD: Undue Influence and Abuse

Members are respectful of clients and their representatives. They refrain from verbal, physical, psychological, emotional and sexual abuse, and do not influence clients or their representatives unduly, particularly with regard to financial decisions such as those relating to wills, power of attorney and other testamentary instruments.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- practising the profession with integrity and professionalism;
- refraining from any form of verbal, physical, emotional, psychological or sexual abuse;
- being cognizant of the individual vulnerabilities of clients and/or representatives;
- being respectful of the best interests of clients;
- apologizing for minor lapses in courtesy or inappropriate language;
- ensuring that the member’s influence does not affect the personal decision-making of a client, particularly in financial matters and end-of life decision-making;
- consulting another member or the College if the member finds him/herself in questionable circumstances.

See also:

- Standard 1.9 Referral
- Professional Misconduct Regulation, provisions 2, 32

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

³ At schedule 2, s. 1(3).

1.9 Referral

BACKGROUND

Members refer clients to other professionals in various circumstances: due to temporary unavailability of the member; a full client load; supplementing the care of a client; or where the member is unable to provide the kind of care required. Members are professionally obligated to refer a client to another professional when the member lacks the knowledge, skills or judgment to offer needed services (see Standard 2.1 Consultation, Clinical Supervision and Referral).

When referring clients to other professionals, members inform clients of the reasons for and implications of referral, and obtain the client's informed consent before making the referral. Members should also take reasonable steps to ensure that the other professional is appropriately trained and/or certified; that they adhere to accepted standards of their profession; and that any information provided by the member about the other professional is accurate. Whenever possible, it is advisable to provide the names of more than one professional when making a referral.

Self-referral

Self-referral occurs when an RP working in one professional setting refers clients to him/herself in another professional setting. For instance, a member working in an agency or Employee Assistance Program may refer a client to his/her own private practice.

Members are not prohibited from making self-referrals, so long as the following safeguards are followed:

1. the conflict is disclosed to the client (e.g. the member stands to gain by making the self-referral);
2. options are provided (e.g. whenever possible, a list is offered of three similar service providers); and
3. the client is reassured that if s/he chooses to obtain the service elsewhere, the existing relationship and service will not be affected.

Technically, a referral to a related person or corporation places the member in a conflict-of-interest. However, there will be situations where this is appropriate. As long as the member adheres to the safeguards outlined above, and s/he documents the conversation occurring around the self-referral, s/he will not be creating a prohibited conflict-of-interest.

STANDARD: Referral

Members adequately inform clients about any referral they propose to make; obtain the client's informed consent; and take reasonable steps to assure themselves of the competence and character of the professional to whom the client is being referred. Members avoid self-referral unless the benefit to the member is disclosed to the client, alternative options are provided, and the client is reassured that the existing relationship will not be affected by the client's decision.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- informing clients of the reason a referral is being proposed;
- taking steps to ensure that the other professional is qualified and competent;
- disclosing to the client any actual or perceived conflict-of-interest in proposing a self-referral;
- when proposing self-referral, providing the client with the option of seeking alternative services, and reassuring the client that the existing relationship will not be affected;
- documenting any disclosure relating to self-referral.

See also:

- Standard 3.2 Consent
- Standard 2.1 Consultation, Clinical Supervision and Referral
- Standard 1.6 Conflict-of-interest
- Standard 1.7 Dual or Multiple Relationships
- Professional Misconduct Regulation, provisions 3, 4, 8, 9, 16

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

SECTION 2 COMPETENCE

The overriding responsibility of Registered Psychotherapists is to hold the best interests of their clients paramount. In fulfilling this professional obligation, Registered Psychotherapists must possess a sound understanding of their professional capabilities, their areas of competence, and their professional limitations.

Another way of stating this is to say that individual ‘self-regulation’ is an important aspect of self-regulation of the profession as a whole. Members must continually assess their knowledge, skill and judgment, i.e. their competence, to determine whether they are equipped to work with particular clients, especially when a client presents with an unfamiliar issue or one the member does not have the expertise to deal with.

Knowing when to seek clinical supervision or consultation, and when to refer a client to another professional is integral to a member’s professional obligations as a regulated practitioner. Members must act in the best interests of clients and ensure that clients are not harmed by a member’s failure to acknowledge his/her own professional limitations.

As members progress through their careers, it is understood that some entry-to-practice competencies will fade as they develop greater competence in particular areas or modalities of practice. Many members will develop specialized skills. Others will require upgrading, clinical supervision or consultation if they intend to change their area(s) of practice. All members are required to participate in the College’s Quality Assurance Program, the purpose of which is to ensure that members engage in ongoing self-assessment and professional development.

At the time of initial registration, members will have achieved entry-to-practice competencies. An Entry-to-Practice Competency Profile has been developed by CRPO, working with a broad range of stakeholders and future members. It underpins many College programs and standards, such as the Registration Exam and the process for reviewing and recognizing education and training programs. The Entry-to Practice Competency Profile is posted on the College website.

2.1 Consultation, Clinical Supervision and Referral

BACKGROUND

Members are expected to practise within their areas of competence. Indeed, an important aspect of professional accountability is a requirement to continually assess one’s knowledge, skills and judgment, i.e. competence – including one’s ability to work with particular clients and clinical issues within particular modalities.

As self-regulated professionals, members are expected to understand their professional limitations, as well as their capabilities. They should provide only those services that are within their areas of competence, based on training and experience.

When a member encounters a client with an issue the member is not familiar with or not equipped to work with, the member must exercise professional judgment. Specifically, s/he must promptly determine whether to: pursue relevant study; seek clinical supervision; consult with a colleague who has the required knowledge, skill and judgment; or refer the client to another practitioner who is able to provide the required care.

STANDARD: Consultation, Clinical Supervision and Referral

A member understands not only his/her professional capabilities but also his/her limitations. A member provides only services that are within the member's knowledge, skill, and judgment, i.e. competence, to provide. When a member encounters a client who has needs beyond the member's capabilities, s/he pursues relevant study, consults with a more experienced colleague or seeks clinical supervision. If this does not provide adequate safeguards, the member refers the client to another professional who is qualified to provide the required care.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- considering whether s/he has the knowledge, skill and judgment, i.e. competence, to work with a particular client, and doing so only when the member possesses the necessary competencies;
- pursuing relevant study;
- consulting with an experienced colleague or seeking clinical supervision when required;
- if pursuing relevant study, consulting with a colleague, or seeking clinical supervision are inadequate to provide necessary safeguards, the member refers the client to a qualified professional.

See also:

- Professional Misconduct Regulation, provisions 8, 9

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

SECTION 3 CLIENT-THERAPIST RELATIONSHIP

The client-therapist relationship is the foundation of psychotherapy. It is central to the provision of safe, effective and ethical care. Members are expected to conduct themselves professionally at all times, and to place client well-being at the forefront of the relationship.

Clients come to therapists with sensitive personal information, and must be able to trust their therapist with this information. It is the professional and legal responsibility of the member to ensure that client information is kept confidential, subject to the legal limits to confidentiality.

Members are required to obtain informed consent before working with a client, and to ensure that therapy is undertaken only if it is necessary or can be expected to benefit the client.

Clients sometimes look to their therapists to work in cooperation with their other health care providers. Members are expected to communicate with other health professionals who are treating and caring for their client, where the client consents to such sharing of information, and when such communication is necessary and is done in the client's best interests.

In addition, members must ensure that clients understand their right to make a complaint to the College regarding a member's professional conduct, and also, where to take such a complaint.

3.1 Confidentiality

BACKGROUND

Confidentiality is considered a cornerstone of the profession of psychotherapy and is embedded in its core values. Individuals come to therapists with sensitive, personal information, and confidentiality is required to build trust in the therapeutic relationship.

Confidentiality is also an important legal concept that applies to all regulated health professionals, including Registered Psychotherapists. The *Personal Health Information Protection Act, 2004 (PHIPA)* establishes the rules relating to confidentiality and privacy of personal health information in Ontario. *PHIPA* requires that personal health information be kept confidential and secure.

It is a fundamental responsibility of members to maintain client confidentiality at all times. In compliance with *PHIPA*, members must ensure that the professional relationship with the client and the client's personal information are kept confidential, within legal limitations. Members must explain to clients the principle of client confidentiality and the legal limits to confidentiality (see "Limits to confidentiality" below). Members are also responsible for maintaining client information in a secure manner, so that unauthorized individuals do not gain access to records (see Section 5, Record-keeping and Documentation).

Personal health information

Personal health information is identifying information about a client.⁴ It can be in verbal, written or in electronic format, and does not necessarily include the client's name. If a client can be recognized, the information is considered personal health information; it includes information in the client health record. Information that does not allow the client to be identified is not personal health information, and is not subject to *PHIPA*.

⁴ See *Personal Health Information Protection Act, SO 2004, c 3, Sch A, section 4*

Consent to the collection, use, and disclosure of personal health information

A member does not collect or use information about a client without the informed consent of the client or the client's authorized representative, nor does the member disclose information about a client to anyone without the written informed consent of the client or the client's authorized representative, except where disclosure is permitted or required by law.

Circle of care and 'lock box'

The terms "circle of care" and "lock box" are based on *PHIPA* and are defined by the Office of the Information and Privacy Commissioner, Ontario. The circle of care includes other health professionals who provide care to a client, other providers in a multidisciplinary setting, and other providers to whom the member has referred a client. *PHIPA* allows health providers to assume in certain circumstances that a client has provided implied consent to disclose his/her personal health information to another individual within the circle of care or to a specific health care provider. Despite this generality, however, a client may indicate that s/he does not want certain information (or any information) shared, even within that circle. In this circumstance, the practitioner must not share the information. This is called placing information in a "lock box".⁵ Despite *PHIPA* provisions, the College will require members to obtain explicit informed consent from clients for the disclosure of any client information (see below).

Release of client information by RPs

Due to the nature of the psychotherapeutic relationship, the sensitivity of information shared between client and therapist, and because of the particular weight placed on the duty of confidentiality by the psychotherapy profession, this College requires a higher standard of confidentiality than is set out in *PHIPA* regarding the circle of care. Specifically, the College requires members to obtain written consent before disclosing information to any other party, including other health professionals. This also applies to sharing information with individuals such as the client's spouse, or contacting any third party, such as third-party payors, insurance companies, or Employee Assistance Program for billing purposes.

This standard is not intended to prevent members from sharing client information within a care team such as those found in a hospital or agency settings, nor in an emergency situation. Members providing care as part of a team should enter into written agreements with clients explaining what information will be shared with other providers in the team context.

In all cases, professional discretion is employed, and only relevant and necessary personal health information may be disclosed.

In obtaining informed consent from a client to disclose his/her information to any third party, the member must explain what information will be disclosed, to whom, the reasons for the disclosure, and the time-frame within which disclosure is to be made. The member should report back to the client following the disclosure.

⁵ See *Personal Health Information Protection Act*, SO 2004, c 3, Sch A, sections 20(3), 40(1).

Limits to confidentiality

Normally, a member may only disclose personal health information with the consent of the client or his/her authorized representative. However, in law, there are a limited number of circumstances where disclosure of personal health information is required without consent. Notable limits to confidentiality include:

1. where the member believes on reasonable grounds that disclosure is necessary to eliminate or reduce significant, imminent risk of serious bodily harm (includes physical or psychological harm) to the client or anyone else, e.g. suicide, homicide;

Note: If the member believes a significant, imminent risk of serious bodily harm exists (this includes physical or psychological harm), there may be a professional and legal duty to warn the intended victim to contact relevant authorities, such as the police, or to inform a physician who is involved in the care of the client.⁶

2. where disclosure is required under the *Child and Family Services Act, 1990* for example, where the member has reasonable grounds to suspect that a child is in need of protection due to physical harm, neglect or sexual abuse by a person having charge of the child;
3. where necessary for particular legal proceedings (e.g. when the member is subpoenaed);
4. to facilitate an investigation or inspection if authorized by warrant or by any provincial or federal law (e.g. a criminal investigation against the member, his/her staff, or a client);
5. for the purpose of contacting a relative, friend or potential substitute decision-maker of the individual, if the individual is injured, incapacitated or ill and unable to give consent personally; and
6. to a college for the purpose of administration or enforcement of the *Regulated Health Professions Act, 1991* (e.g. providing information about your client to the College if a complaint has been made against you, assessment of the member's practice as part of the Quality Assurance Program; mandatory reporting where the member's client is a regulated health professional and the member has reasonable grounds to believe that the client has sexually abused a patient/client);

When compelled to disclose client information for a legal proceeding, members should exercise prudence, and are advised to consult their legal advisor to determine the best way to respond.

⁶ The law in Canada concerning the "duty to warn" is complex and evolving. Members are advised to consult their legal advisor if faced with a situation where this exception to the duty of confidentiality may apply.

STANDARD: Confidentiality

A member does not collect or use information about a client without the informed consent of the client or the client's authorized representative, nor does s/he disclose information about a client to anyone other than the client or the client's authorized representative without the written informed consent of the client or the client's authorized representative, except where the collection, use or disclosure is permitted or required by law.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- explaining to the client the duty of confidentiality and the limits to confidentiality;
- ensuring that the client has given informed consent for the collection, use or sharing of information with others;
- documenting informed consent in the client record regarding collection, use or disclosure of information, indicating the manner in which consent was given (verbally, by gesture, in writing);
- collecting, using or disclosing only information that is reasonably required in the circumstances;
- sharing information without informed consent only in the limited circumstances set out in *PHIPA* or for other authorized legal purposes;
- establishing processes to protect personal health information (hard copy and electronic files) from access by unauthorized persons while it is being maintained, transferred, or disposed of.

See also:

- Standard 3.2 Consent
- Section 4 Clinical Supervision
- Section 5 Record-keeping and Documentation
- Standard 1.6 Conflict-of-interest
- Standard 1.7 Dual or Multiple Relationships
- Professional Misconduct Regulation, provision 5

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3.2 Consent**BACKGROUND****Informed consent**

Informed consent is an important legal concept in health care and is set out in the Health Care Consent Act, 1996. In general, practitioners are required to obtain informed consent for any intervention of a therapeutic, diagnostic, preventive, palliative or other health-related purpose. Practitioners must ensure that clients receive relevant information, including information about possible risks or adverse effects and other treatment options, in order for consent to be considered informed.

Informed consent is required for all assessments and any therapy provided by a member. The principles of informed consent should be followed even when the intervention is not technically a “treatment” as defined in of the Health Care Consent Act, 1996. Members should apply the principles of informed consent, therefore, to anything done for a therapeutic, preventive, palliative, diagnostic or other health-related purpose.

Only in emergency situations may therapeutic interventions be undertaken without consent, e.g. when a client is suicidal.

Accuracy and specificity

The client must have received sufficient information to understand the nature of the therapy and potential risks and benefits, as well as information about other available therapeutic options and the implications of not proceeding with therapy. Information provided to clients must not misrepresent potential benefits or raise unrealistic expectations. If therapy is expected to probe troubling experiences or to cause emotional distress, this should be explained to the client and noted in the client record. If and when a therapist intends to alter his/her approach to therapy, or to use specific techniques, e.g. hypnotherapy or EMDR (eye movement desensitization and reprocessing), the technique should be explained in some detail, and noted in the clinical record. In such cases, it may be prudent to obtain written consent.

To be valid, a client’s consent must:

1. be informed
2. be voluntary
3. be specific, i.e. based on specific relevant information, not vague generalities, and
4. not involve misrepresentation or fraud.

Written consent

Health care professionals often use standardized forms to obtain written consent from clients. Members should understand that a signature on a form does not necessarily constitute informed consent. The elements of informed consent (see above) are usually obtained through discussion between the member and the client. Only following *discussion* can the client provide informed consent. The signature of the client is only partial evidence that s/he has provided informed consent.

Ongoing consent

Normally, psychotherapy is not a one-time intervention, but continues over a period of time or may be intermittent. Similarly, informed consent is not simply obtained at one point in time and never thought of again. Ongoing consent is implied by the continuing attendance of a client at therapy sessions. However, any change in the therapeutic approach or the techniques employed should be documented in the client record, along with a note about the client’s implied or verbal consent.

Implied consent

Consent may be written, verbal or implied. Generally, in the context of psychotherapy, consent is implied by the very attendance of a client at a therapy session. Attendance must be willing and voluntary, and the client should be informed about the process of therapy and the type of therapy or therapeutic approach normally employed by the therapist. In many instances, engaging in a dialogue with the therapist and discussing personal experiences and issues, will amount to implied consent for therapy.

Age of consent

There is no minimum age for consent. Clients under 18 years of age can, if they are capable of understanding and appreciating the consequences of their decision, give consent. For minors, consent must be considered on a case-by-case basis in light of the young person’s capacity and applicable laws.⁷

⁷ The College may develop detailed guidelines on working with minors, in the future.

Incapacity

As a general principle, informed consent requires that a client be capable of providing such consent. This means that the client must be cognitively capable, i.e. able to understand the information provided, and appreciate the consequences of his/her decision.

Generally, a therapist may assume that a client is capable, and is not required to conduct a capacity assessment unless there are reasonable grounds to believe the client may not be capable. The therapist assesses the capability of the client by discussing the proposed therapy or therapeutic process with the client. The purpose is to see whether s/he understands the information, and appreciates any possible risks or consequences, including the implications of not proceeding with therapy.

It is important to understand that a client may be incapable with respect to certain issues and capable with respect to others (e.g. a client may be capable of discussing personal matters but incapable of managing their finances).

When a client is found to be incapable, the therapist must identify a substitute decision-maker who can provide informed consent on behalf of the client. The substitute must be at least 16 years of age (unless s/he is the parent of a child), and must be a capable person who is willing and able to act. The substitute decision-maker is usually a spouse, parent, friend, or other relative. Potential substitutes are ranked in law, (see below for the ranking of substitutes). Normally, the person ranked highest is asked to serve as substitute decision-maker, if able and willing.

Withdrawal of consent

A client may withdraw consent at any time. Withdrawal of consent should be documented in the client record, and should include the reason for the change.

Documenting consent

It is important for members to document and date the consent process. This is done by making a note in the client record when consent was obtained orally or was implied, or by asking the client to sign a form, and by noting any specific therapeutic intervention or technique in the client record. A signed form in itself does not constitute informed consent but must also include a discussion and an understanding of the process by the client.

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-conjugal 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.

STANDARD: Consent

The member ensures that informed consent is obtained from the client or his/her authorized representative on an ongoing basis. Consent may be verbal, written or implied and is documented in the client record. The therapist provides sufficient relevant information so the client understands the process of therapy, possible benefits and risks or adverse outcomes, other therapeutic options and the implications of not proceeding with therapy. This ensures that the consent is informed. In addition, the therapist ensures that the consent is voluntary, specific and does not involve misrepresentation or fraud.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- providing, on an ongoing basis, relevant information to the client regarding the process of therapy, the therapist's usual approach to therapy, therapeutic methods and/or specific techniques to be employed, potential risks or adverse outcomes of therapy, and other therapeutic options;
- documenting informed consent in the client record on an ongoing basis, indicating the manner in which the client gave his/her consent (verbally, by gesture, in writing), and briefly describing the information provided by the therapist to inform the client, and other relevant details;
- if there is reason to believe the client is incapable, identifying a capable person who is able and willing to act as substitute decision-maker and provide informed consent on behalf of the client.

See also:

- Section 5 Record-keeping and Documentation
- Professional Misconduct Regulation, provision 3

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

3.3 Communicating Client Care**BACKGROUND****Interprofessional collaboration**

Registered Psychotherapists are expected to create and sustain positive working relationships with other professionals encountered in practice. Clients are entitled to have their care coordinated by their health care providers, when it is necessary and appropriate to do so and when the client explicitly authorizes such collaboration. In addition, regulatory colleges are required under the *RHPA* to take steps to enhance interprofessional collaboration.

Appropriate communication is a key component of successful interprofessional collaboration, and may help to reduce conflicting or inconsistent information or advice given to clients. Appropriate communication between providers contributes to enhanced safety for clients and better professional relationships.

Communication

In general, members can expect to communicate with other professionals in a client's circle of care, when the client has provided consent to do so. As stated previously, the circle of care includes: those who provide care to the same client, other healthcare providers within a multidisciplinary setting, and other healthcare providers where the client is referred by the member.

Good communication can be achieved in a number of ways, including written communication between health care providers, conference calls, team meetings, meetings requested by the client and family meetings. Such communication should be documented in the clinical record.

Members are expected to make reasonable efforts to communicate with other providers when the client consents to such communications and it is likely to have a positive effect therapeutically. A member cannot be held responsible, however, when another professional refuses to communicate or does not respond to the member's reasonable efforts to communicate about a client's care. Unsuccessful attempts to communicate should be noted in the clinical record.

Client instruction

It is important to understand that the client controls collaboration and communication in specific circumstances. If a client is uncomfortable with any aspect of this communication, s/he may direct the member not to share the information. Members should explain to clients the potential benefits of interprofessional collaboration, as well as the implications of not permitting the therapist to share information with other providers.

Release of information by RPs

See Standard 3.1 Confidentiality.

Cases of emergency

There are circumstances where obtaining prior consent to share information with other professionals is not possible. In such cases, for example, when a client is admitted to hospital, and disclosure is reasonably necessary for the provision of health care, and it is not possible to obtain the individual's consent in a timely manner, the member is permitted to disclose necessary information, as long as the client has not prohibited him/her from doing so.

STANDARD: Communicating Client Care

A member makes reasonable attempts to communicate with a client's circle of care, provided the client has given explicit written consent. A member may decide not to communicate with professionals in the circle of care in cases where the communication is unnecessary, or where it will have a negative impact from a therapeutic perspective.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- ensuring that the client agrees to the information sharing, and that s/he has the information needed to make an informed decision;
- documenting informed consent in the client record, including how consent was obtained and what information was provided;
- sharing client information only when necessary, and when doing so is likely to have a positive effect from a therapeutic perspective;
- not sharing information if the client requests that it not be shared.

See also:

- Standard 3.1 Confidentiality
- Standard 3.2 Consent
- Professional Misconduct Regulation, provisions 5, 54

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

3.4 Electronic Practice**BACKGROUND**

The growth of technology provides new ways of communicating with clients, and may enable members to work with clients who have limited mobility, or who live in isolated areas. It also poses new challenges.

Generally, rules that apply to the provision of professional services also apply to the provision of services by electronic means. For example, members must follow established professional practices, such as assessment, developing a plan of therapy, maintaining records and communicating appropriately with other providers. Confidentiality must be maintained no matter what medium is used.

When using electronic means of communication (e.g. telephone, Voice Over IP, e-mail, video conferencing, etc.), members do so ethically, and ensure they are not using the technology to circumvent safeguards that would otherwise apply.

Communication technologies and consent

A member may provide professional services using electronic communication technology only if the member receives consent from the client for use of such technology. In addition:

- before providing services via electronic communication technologies, a member enters into a contract with the client concerned. Note: This does not preclude using electronic communication technologies in developing the contract;
- members do not provide therapeutic services to anonymous clients; and
- members should employ extreme caution in providing advice, clinical assessment, or clinical information accessible to the general public on websites, blogs, forums, or other communication platforms.

Members must take reasonable steps to ensure that the electronic communication technology employed is secure, confidential and appropriate in the circumstances. If a member intends to use an electronic medium, clients should be made aware of any potential risks, particularly an inability to ensure security and confidentiality that could arise from the use of the technology. Social media outlets, such as Facebook or Twitter, should not be used for therapeutic purposes.

Professional liability insurance and e-practice

Members must ensure that services provided through electronic communication technologies are covered by their professional liability insurance. Insurance coverage varies, and may not cover all clients or clients in all locations. Members should consult their insurance provider.

STANDARD: Electronic Practice

A member obtains informed consent from clients regarding the use of electronic communication media in the provision of services; takes reasonable steps to ensure that the technology employed is secure, confidential and appropriate in the circumstances; and ensures that his/her professional liability insurance provides sufficient coverage for these services.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- ensuring that clients provide consent to receiving professional services via a specific electronic communication technology;
- ensuring that clients understand any potential risks associated with the technology;
- taking reasonable steps to ensure that the technology is secure, confidential and appropriate;
- ensuring that their professional liability insurance as required under CRPO by-laws, provides coverage for the services delivered through the medium;
- ensuring that all professional standards are maintained while using this technology.

See also:

- Standard 3.1 Confidentiality
- Standard 3.2 Consent
- Professional Misconduct Regulation, provision 55

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

3.5 Unnecessary Treatment

BACKGROUND

Effectiveness of therapy

It is important for members to ensure that any assessment or course of therapy offers a reasonable prospect of benefit to the client. Unnecessary therapy poses a risk of harm by raising false expectations and wasting the client's time and money. Ultimately, one of the important goals of therapy is to foster independence and autonomy from therapy. Similarly, members should be sensitive to the effect that particular labels or assessment findings may have on clients. Registered Psychotherapists should try to share such information in a way that is beneficial to the client.

Client's understanding of therapy

Members help ensure that clients make informed decisions about attending therapy. It is important that clients understand the purpose of therapy and the therapeutic approach employed, and are aware of potential risks of therapy.

Continuing therapy

If therapy is no longer indicated, proves to be ineffective or has ceased to be effective, the member must discuss the option of discontinuing therapy.

STANDARD: Unnecessary Treatment

A member provides therapy only where there is a reasonable prospect of benefit to the client, and continues therapy only when there is a reasonable expectation of continuing benefit.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- providing assessment/therapy that has a reasonable prospect of benefit to the client;
- continuing to provide therapy to a client only when it continues to be indicated, effective or beneficial;
- discussing the option of discontinuing therapy when the therapy is no longer indicated, effective, or beneficial;
- periodically reassessing, with the client, the goals and expected outcomes of the therapeutic relationship, and the likelihood of ongoing benefit.

See also:

- Standard 6.3 Discontinuing Services
- Professional Misconduct Regulation, provision 7

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

3.6 Complaints Process

BACKGROUND

Clients, authorized representatives and members of the public have a right to file a complaint with the College regarding a member's professional conduct. The member must advise the client/authorized representative/member of the public of such if asked. If a client asks whom they can complain to about the member's professional conduct, it is the member's responsibility to advise the client to contact the College. As the College is new, it is particularly important that members make their clients aware of the existence of the College and its role in regulating Registered Psychotherapists.

Members must facilitate the complaints process by providing contact information for the College. This information must be provided to clients, a client's authorized representative and to members of the public when requested.

Contact information for the College is as follows:

College of Registered Psychotherapists of Ontario
375 University Avenue, Suite 803
Toronto, ON M5G 2J5
Tel: 416-479-4330 or 1-844-712-1364
Fax: 416-639-2168
info@crpo.ca

STANDARD: Complaints Process

A member makes general information about the College available to clients, and if asked, informs clients of their right to file a complaint with the College. The member also provides the College's contact information to facilitate the filing of the complaint.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- providing general information about the College to clients;
- providing contact information for the College to clients, a client's authorized representative and to members of the public when requested;
- if asked by a client how to file a complaint, informing a client that s/he has a right to file a complaint and providing the College's contact information (address and telephone number).

See also:

- Professional Misconduct Regulation, provisions 14, 15

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

3.7 Affirming Sexual Orientation and Gender Identity

BACKGROUND

Introduction

The College affirms that there are a range of sexual orientations and gender identities.

Affirming Sexual Orientation and Gender Identity Act

In June 2015, the Ontario legislature passed Bill 77, the *Affirming Sexual Orientation and Gender Identity Act*. The Act applies to anyone who provides health care services in Ontario, and relates to efforts to change an individual's sexual orientation or gender identity (sometimes referred to as "conversion therapy" or "reparative therapy"). The Act amends the *Health Insurance Act and the Regulated Health Professions Act, 1991*.

New offence

It is now an offence in Ontario, and therefore professional misconduct, to provide any treatment that seeks to change the sexual orientation or gender identity of a person under 18 years of age who lacks the capacity to consent to the treatment. While the Act does not apply to adults or to minors who have the capacity to consent to treatment, the College strongly advises members to refrain from providing any such services. Seeking to change or direct a person's sexual orientation or gender identity are not 'therapy', are not supported by the profession and do not respect the diversity and dignity of all persons.

Valid services not affected

The prohibition is not intended to prevent services that provide acceptance, support or understanding of a person or the facilitation of a person's coping, social support or identity exploration or development, nor to any services related to gender affirming activities (e.g. living as one's gender identity, hormone treatment, surgery). Members providing services that focus on sexual orientation or gender identity issues ensure they have the competence (knowledge, skill and judgment) to do so.⁸

⁸ See for example, The World Professional Association for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, 7th ed. (WPATH, 2013), page 13 (Competency of Mental Health Professionals Working with Children or Adolescents with Gender Dysphoria), pages 22-3 (Competency of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria).

STANDARD: Affirming Sexual Orientation and Gender Identity

Members refrain from providing services such as conversion or reparative therapy, which seek to change or direct a person's sexual orientation or gender identity.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- obtaining informed consent to work with a client on issues relating to sexual orientation or gender identity;
- documenting discussions with clients about sexual orientation or gender identity, including client goals and progress;
- ensuring they have adequate training, experience and supervision to provide services relating to an individual's sexual orientation or gender identity.

See also:

- Standard 3.2 Consent
- Standard 1.10 Referral
- Standard 2.1 Consultation, Clinical Supervision and Referral
- Professional Misconduct Regulation, provisions 1, 3, 8, 9, 28, 42, 52
- *Regulated Health Professions Act, 1991*, section 29.1

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

SECTION 4 CLINICAL SUPERVISION

As the name suggests, clinical supervision is a specific kind of supervision, considered essential to the professional formation of the psychotherapist. For purposes of the College, clinical supervision means:

A contractual relationship in which a clinical supervisor engages with a supervisee to promote the professional growth of the supervisee; enhance the supervisee's safe and effective use of self in the therapeutic relationship, discuss the direction of therapy; and safeguard the well-being of the client.

Clinical supervision is distinct from general (or managerial) supervision by a supervisor or manager in the workplace, and distinct from the general supervision of students as provided for by the *Regulated Health Professions Act, 1991*. These distinctions do not mean that an employee cannot receive clinical supervision from a manager or team leader in the workplace, nor does it mean that students do not receive clinical supervision (indeed they do). However, clinical supervision is a particular kind of supervision that has specific characteristics:

- it is contractual;
- it is purposeful (intentional);
- records are kept;
- there are regular meetings; and
- there may be shared responsibility for the well-being of clients depending on circumstances and modality.

The purpose of clinical supervision is four-fold:

1. to promote the professional growth of the supervisee;
2. to enhance the supervisee's safe and effective use of self in the therapeutic relationship;
3. to discuss the direction of therapy; and
4. to safeguard the well-being of the client.

Just as clinical supervision is distinct from managerial supervision, clinical supervision is also distinct from consultation with colleagues or other professionals when seeking direction or advice regarding the way forward with a particular client or clinical issue. While sometimes less structured than clinical supervision, consultation is an important (often essential) professional activity that provides access to the experience and expertise of other practitioners. Unlike clinical supervision, the College has not established standards or guidelines on "consultation", but recognizes its value in the professional development of members and the well-being of clients.

4.1 Providing Clinical Supervision

BACKGROUND

The clinical supervisor

As mentioned above, clinical supervision refers to a contractual relationship between a clinical supervisor and a supervisee. The purpose of clinical supervision is: to discuss the direction of therapy and the therapeutic relationship; to promote the professional development of the supervisee; to enhance the supervisee's safe and effective use of self in the therapeutic relationship; and to safeguard client well-being. The clinical supervisor must be competent in the area of practice/ modality that s/he has agreed to supervise. Clinical supervision may be individual (one supervisor per supervisee), dyadic (one supervisor to two supervisees) or group (generally, up to eight supervisees). College registration policies provide more detail regarding when these different formats are appropriate. (See Registration Guide)

Requirements of clinical supervisors

Prior to proclamation, a clinical supervisor is a practitioner who has extensive clinical experience, generally five years or more, in the practice of psychotherapy.

In the first three years following proclamation, a clinical supervisor is a regulated practitioner in psychotherapy in good standing with her or his College⁹, who has extensive clinical experience, generally five years or more, in the practice of psychotherapy and who is competent in providing clinical supervision. Upon proclamation of the Psychotherapy Act, practitioners who are receiving supervision from an unregulated practitioner will have a grace period of one year to transition their supervision to a regulated practitioner who meets the above requirements.

Three years after proclamation, a clinical supervisor is a regulated practitioner of psychotherapy in good standing with her or his College, who has extensive clinical experience, generally five years or more, in the practice of psychotherapy, and who has demonstrated competence in providing clinical supervision.

Outside Ontario, a clinical supervisor is an experienced practitioner of psychotherapy qualified to provide clinical supervision in his/her jurisdiction.

When clinical supervision is required**Fulfilling registration requirements**

To qualify for registration as a Registered Psychotherapist, applicants are required to have completed 100 hours of clinical supervision in conjunction with 450 direct client contact hours. Typically, a portion of these hours will be completed as part of the applicant's education and training program. Frequently, however, individuals will graduate without having completed the required 100 hours of clinical supervision. In that case, they may be eligible for registration in the Qualifying category, until they have completed the full 100 hours, and possibly, other outstanding registration requirements.

Qualifying members are required to practise with clinical supervision. In addition, all Registered Psychotherapists are required to practise with clinical supervision until such time as they have completed 1000 direct client contact hours and 150 hours of clinical supervision, i.e. until they have completed an additional 550 client hours and 50 clinical supervision hours beyond those required for registration as an RP.

College-directed supervision

Supervision may also be imposed by the College when a College committee directs that a member must practise with clinical supervision or some other form of supervision. This may occur when a member wishes to resume practice after a period of non-practice, or to address gaps in knowledge, skill or judgment identified through the Quality Assurance Program or discipline process. A member's managed health issue could also result in a requirement to practise with supervision, thereby allowing the member to continue practising with monitoring and oversight.

In cases of College-directed supervision, supervisors need to know why supervision was imposed by the College, and must provide appropriate supervision as directed, particularly with respect to frequency of sessions, record-keeping and other conditions that may be stipulated.

Voluntary clinical supervision and consultation

Members may seek clinical supervision or consultation voluntarily, in order to discuss the direction of therapy regarding a particular client or clients, for reasons of professional growth, or to develop competence in a new area. This is strongly encouraged; indeed some psychotherapists engage in ongoing clinical supervision throughout their professional careers.

⁹ Includes College of Nurses of Ontario, College of Occupational Therapists of Ontario, College of Physicians and Surgeons of Ontario, College of Psychologists of Ontario, Ontario College of Social Workers and Social Service Workers

Supervising students

It is important to understand that the College does not regulate students. In fact, some psychotherapy students may plan to register with another regulatory college, or may already be registered with another college, e.g. Ontario College of Social Workers and Social Service Workers. However, practice standards set out in this section apply to members who provide clinical supervision to students. In addition, members may be responsible for other forms of student supervision related to their roles as teachers, professors, mentors, etc. In these situations, it is a regulatory requirement that members provide appropriate supervision to those whom they are responsible for supervising. The intensity of this oversight and level of direct involvement by the supervisor will depend on the experience and apparent competence of the student.

The clinical supervision agreement

Clinical supervision is characterized by a formal relationship between supervisor and supervisee(s). It is a requirement, therefore, that members providing and receiving clinical supervision have an agreement in place between or among the parties involved. Details of supervision agreements will depend on particular circumstances, including the therapeutic approach or model of supervision used. The agreement is to be documented in the records of all parties, and ideally will be in writing and signed.

The agreement could include the following:

1. the purpose of the supervision, plan for supervision and/or expectations of the relationship;
2. contract details, e.g. duration, frequency, etc.;
3. format (individual, dyadic, or group); modality (psychodynamic, cognitive behavioural, systemic, other); and method (self-report, videotape, live observation, thematic, other);
4. location or medium of meeting (face-to-face; electronic medium, etc.);
5. expectations of supervisor and supervisee(s);
6. expectations regarding the sharing of client information and informing clients about supervision;
7. provisions regarding the confidentiality of information shared between/among supervisor and supervisee(s);
8. process for providing evaluation and/or feedback;
9. process for resolving conflicts;
10. remuneration, if any;
11. process for renewing or terminating the agreement; and
12. making explicit what, if any, responsibility the supervisor will take for the well-being of the client in the therapy.

Record of supervision provided

Supervisors should keep a detailed record of clinical supervision provided. In particular, records should include the name of supervisee(s), dates of attendance, number of hours provided, and fees paid. It may also include issues discussed and any directions given.

STANDARD: Providing Clinical Supervision

A member appropriately supervises persons whom s/he is professionally obligated to supervise, or with whom s/he has entered into a clinical supervision agreement.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- entering into a supervision agreement that sets out the responsibilities of the supervisor and supervisee(s), and the expectations of both parties;
- documenting the supervision agreement and, ideally, having the agreement in writing and signed;
- clearly defining what client information is to be shared between/among the supervisor and supervisee(s), and documenting both parties' expectations with regard to informing clients about the supervision relationship;
- meeting regularly and documenting discussions between supervisor and supervisee(s), e.g. focus of the discussion, particular issues addressed, etc.;
- supporting the progress of the supervisee(s);
- undertaking supervisory responsibilities only when the member has the necessary knowledge, skill and judgment, i.e. competence, to provide the services to be supervised.

See also:

- Standard 4.2 Practising with Clinical Supervision
- Standard 2.1 Consultation, Clinical Supervision and Referral
- Registration Regulation
- Professional Misconduct Regulation, provision 11

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

4.2 Practising with Clinical Supervision

BACKGROUND

As discussed above, clinical supervision is essential to the professional formation of the psychotherapist. Qualifying members of the College and Registered Psychotherapists who have not yet completed 1000 direct client contact hours and 150 clinical supervision hours are required to practise with clinical supervision. In addition, members may practise with clinical supervision voluntarily, or may be required to do so by order of a College committee, e.g. Registration, Quality Assurance and Discipline Committees.

Clinical supervision

The College defines clinical supervision as a contractual relationship in which a clinical supervisor engages with a supervisee to discuss the direction of therapy and the therapeutic relationship; promote the professional growth of the supervisee; enhance the supervisee's safe and effective use of self in the therapeutic relationship; and safeguard the well-being of the client.

Responsibilities of supervisees

Members required to practise with clinical supervision participate meaningfully in such a way as to promote the purpose and effectiveness of clinical supervision.

Supervision hours should occur at regular intervals in relation to client contact hours. Determining "regular intervals" will depend on individual circumstances, as set out in the supervision agreement. It is not appropriate, however, to accumulate required clinical supervision hours over a short period of time, i.e. to clump them together; hours should be spaced out over time in relation to client contact hours. For example, unless clinical circumstances require more supervision, it is considered appropriate for Qualifying members to obtain one clinical supervision hour per four or five direct client contact hours.¹⁰ For RPs who are required to practise with clinical supervision, it is generally considered appropriate to obtain one clinical supervision hour per ten hours of direct client contact.¹¹ The suggested ratios are guidelines only.

When required clinical supervision hours have been completed, members continue to meet with their supervisor on a regular basis, until such time as they have been notified by the College that they have met all of the requirements for 'independent practice', i.e. practice without clinical supervision.

It is the responsibility of members to maintain a record of supervision received. The record could include:

- name and contact information of the clinical supervisor;
- the supervision agreement or a description of its terms;
- dates and number of hours of clinical supervision received; and
- format (individual, dyadic, or group).

It may also include issues discussed at meetings or in correspondence with the clinical supervisor.

Informed consent and confidentiality

As part of obtaining informed consent from clients, it is prudent for members practising with clinical supervision to inform clients about the supervision arrangement. Members should also inform the client as to whether s/he may contact the clinical supervisor directly to ask questions or express concerns about services provided by the supervisee. Where information identifying the client will be shared with the clinical supervisor, the supervisee *must* obtain the informed consent of the client. When a member communicates with his/her supervisor using electronic media, particular care must be taken to ensure that personal client information is safeguarded.

STANDARD: Practising with Clinical Supervision

¹⁰ This ratio is based on the requirement of Qualifying members to complete 450 direct client contact hours and 100 hours of clinical supervision in order to be registered as an RP.

¹¹ without clinical supervision, i.e. independently.

¹¹ This ratio is based generally on the requirement of RPs to have completed a total of 1000 direct client contact hours and 150 hours of clinical supervision, in order to be able to practise

Members required to practise with clinical supervision participate meaningfully in the supervisory relationship and process.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- developing, recording, and adhering to a clinical supervision agreement;
- keeping a record of clinical supervision received;
- informing clients of the supervisory arrangement, and including, if appropriate, the identity and contact information of the supervisor and the client's right to contact the supervisor;
- ensuring clients are informed that a supervisor has access to their identifying information, if this is the case;
- spacing clinical supervision hours appropriately in relation to direct client contact hours;
- participating in clinical supervision in such a way as to promote the purpose and effectiveness of clinical supervision.

See also:

- Standard 4.1 Providing Clinical Supervision
- Standard 2.1 Consultation, Clinical Supervision and Referral
- Professional Misconduct Regulation, provision 44

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

SECTION 5 RECORD-KEEPING AND DOCUMENTATION

Secure and appropriate record-keeping is essential for good client care. The client record enables the member to keep track of what was done and what was considered by the therapist. It may also provide information for other therapists and professionals who may provide services to the same client. It enables the member to track progress, note changes in a client's condition, and make adjustments to the therapy plan if needed. Records also allow a member to explain and defend what was done, if and when required.

Records are important for both clinical and operational aspects of practice.

Members should keep the following types of records which are all part of the client record:

- clinical records;
- appointment records; and
- financial records.

When preparing and maintaining records, Registered Psychotherapists are subject to the *Personal Health Information Protection Act, 2004*. *PHIPA* governs therapists' use of personal health information, including its collection, use, disclosure and access.

A health information custodian is the person or organization responsible for maintaining health records. If practising alone, the member is the health information custodian of his/her clients' records. If an RP is working in an employment situation, s/he is expected to follow the record management practices of his/her employer.¹² The organization may have an information officer to monitor compliance with *PHIPA*.

Under *PHIPA*, clients have a right to access their own health records and to correct errors in them. While records are not written primarily for clients to read, they should be legible and intelligible to readers, including the client, insofar as is reasonably possible.

Also, while the College acknowledges that therapeutic services may be provided in any number of languages (including sign language), the written record – for the purpose of record-keeping – is to be maintained in one of Canada's two official languages, English or French.

Clients not satisfied with the way their records have been maintained or shared have a right to make a complaint. Members should inform clients of their right to complain to the College and/or the Information and Privacy Commissioner. In addition, clients have the right to require that inaccuracies in their health record be corrected.

5.1 Record-keeping – Clinical Records

BACKGROUND

Registered Psychotherapists work in a variety of settings, including agencies, institutions, community service providers, and independent practice. Some may be associated with a group of professionals, including other therapists. In all cases, record-keeping is an important component of good client care.

The clinical record serves as an important reference document and should be complete and accurate. It helps the therapist recall his/her objective observations, and explain choices regarding the plan for, and progress of, therapy. It may also facilitate consultations among therapists or other members of a client's healthcare team, as well as discussions with the client's authorized representatives as appropriate.

¹² This assumes that the employer's record management practices comply with *PHIPA*. If this is not the case, the member must ensure that his/her clinical records comply with *PHIPA*.

Clinical records

Clinical records encompass a client profile (personal information provided by the client at the outset of the therapeutic relationship) and corresponding treatment records. They are kept on a client-by-client basis.

When more than one person (e.g. a couple or family) attends therapy, records may be maintained in one file as long as the couple or family attends the sessions in the same combination. However, when the couple or family attend in different combinations, the member should generally keep separate files or sub-files for each individual. For example, if one member of a couple attends for an individual session, a file for the individual session should be maintained separately from the file for the couple.

Similarly, in a group therapy setting, records for the group may be maintained in one file. If, however, a client in the group begins individual therapy with that member, the member creates and maintains a separate file for that client's individual therapy.

If maintaining a hard copy record, each sheet of paper should include the client's name or unique identifier,¹³ date of each entry, and signature of the member. Electronic records should similarly permit each entry to include the client's name or unique identifier, date and the member's signature or initials, i.e. evidence that the member in fact made the record.

The clinical record should also include where relevant:

- the date of every consultation the member receives from another healthcare provider, or the member provides to another healthcare provider, regarding service provided to the client;
- specific information related to any referral made by the member regarding the client;
- notes, forms and other material, regardless of the medium or format (i.e. email, fax, telephone, etc.) in which relevant information has been received from, or provided to, the client or his/her authorized representatives or other professionals involved in the client's care;
- a list of all reports sent or received respecting the client;
- a record of any therapeutic assessment, including assessment method(s) used, outcomes/results, conclusions, problem formulation or other professional opinion regarding client status; and
- a record of conclusion or termination of the therapeutic relationship, including reasons and an explanatory note such as a summary of outcomes attained, a record of referrals, or follow-up recommendations.

Maintaining separate records

RPs may maintain additional notes and documentation, (e.g. progress notes containing particularly sensitive client information), separately from other parts of the clinical record; however, reference to the existence of these notes must be made in the clinical record.

It is important to note that the entire record must be managed in accordance with legal and College requirements. The record, including any separately maintained notes and documentation, must be made available to the client upon request in accordance with *PHIPA*. In addition, disclosure of the entire record to a third party may be legally compelled, and members should exercise caution when considering what information to include in the record.

Client profile

The client profile includes the client's full name, address, telephone numbers, date of birth, and unique identifier (if applicable and/or necessary to distinguish the client from other clients). It also contains relevant information regarding the client's legally authorized representatives (as applicable and as described in the *Health Care Consent Act, 1996*), as well as the full name and contact information of any professional who referred the client, along with the reason for the referral. If the client was self-referred, this should be noted as well.

¹³ A unique identifier is a code (e.g. a number) that allows the member to identify that client without using the client's name or other direct personal information. If using unique identifiers, members must securely maintain a key linking each client to their unique identifier.

Plan for therapy

The plan for therapy will depend on particular circumstances including the therapeutic approach or model used. The record should minimally indicate the plan or direction that the therapy is intended to take and should log the client's initial and subsequent consent(s) as necessary. It will also include any reports on tests administered to the client. As the therapeutic relationship continues, changes in the therapy plan will also form part of the record. The initial plan establishes the direction of therapy and helps guide future sessions and evaluate change. The therapy plan may be updated, and will include both subjective and objective information. Subjective information is relevant information provided by the client. Objective information is relevant information observed by the member.

Client contact

The record includes a notation of all in-session and out-of-session contacts with a client, including any advice or directives given. Examples of out-of-session contacts with clients include letters, emails, texts, telephone calls and videoconferencing.

Incident report

When a major, unexpected negative outcome occurs, it is important to document the incident in the clinical record as well as any action and/or follow-up undertaken. The documentation should provide a clear record of the incident, which can be used to explain the event and relevant details surrounding it.

Mandatory reports

There are certain circumstances where federal or provincial laws require the member to advise a person or organization of a serious concern (e.g. child abuse or sexual abuse of a client by a regulated health professional). Members keep a record of all such mandatory reports they make. If the report was not made in writing, members maintain details of the report in their records.

Amending records

Every entry into the clinical record indicates who made the entry and when. If an amendment to a record is needed, the amendment should indicate what change was made, when, by whom, and why, making sure that the original entry is still legible.

Accessibility of records

Records are prepared and maintained in a timely and systematic manner. Regardless of how the information is structured or stored, it is important that client records are easily accessible.

Retention

Where the RP is the custodian of the clinical record, s/he retains the record for at least 10 years from the date of the last interaction with the client, or for 10 years from the client's 18th birthday, whichever is later. For example, if a child is age 7 at the time of the last interaction, the record would be kept until s/he is 28 years of age.

STANDARD: Record-keeping – Clinical Records

Members keep an accurate and complete clinical record for each client. Members provide access to legible client records, when requested to do so by a client, authorized representative or another legal authorization.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- including a complete client profile in the clinical record;
- including in the clinical record a plan for therapy that is reflective of the modality used;
- ensuring a record of client communications is included in the clinical record;
- including a record of any therapeutic assessments, including methods used, outcomes and results/conclusions;
- including a record of conclusion or termination of the therapeutic relationship, reasons and explanatory notes and a record of referrals and/or follow-up recommendations in the clinical record;
- completing incident and mandatory reports as warranted;
- ensuring the clinical record is accessible, maintained in a timely manner, legible, written in plain language, and written in English or French; and
- ensuring that records are accurate, and that amendments show changes and original entries;
- ensuring that, if progress notes are maintained separately from the main clinical record, the clinical record includes a notation to that effect.

See also:

- Professional Misconduct Regulation, provisions 25, 26, 27

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

5.2 Failing to Provide Reports

BACKGROUND

One of the reasons members maintain effective record-keeping systems is for the purpose of issuing timely reports when requested to do so by a client or client's authorized representative. In addition to a designated family member or friend, an authorized representative may be a lawyer or an insurance company. In many cases, the information or document requested is required for legal proceedings or employment and insurance matters. Delays (or refusal) to satisfy the request could seriously disadvantage a client. Effective record-keeping facilitates the timely generation of reports and also serves to track the turn-around time to dispatch the report.

Reasonable causes for a delay in providing a report might include the unavailability of a critical piece of information or illness of the member rendering him/her unable to practise. Inability of the client to pay for the report is not, however, a valid reason for declining to provide or release the requested document. A client's dispute with a member is not a valid reason to withhold a report.

STANDARD: Failing to Provide Reports

Where a request from a client or the client's authorized representative has been received, members must provide a report or certificate relating to the treatment performed.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- responding appropriately to a request for a report or certificate from a client or the client's authorized representative. An appropriate response is one that is delivered in writing and responds fully and completely to the request, in so far as the member is able to do so, within his/her scope of practice as an RP;
- delivering the response within 30 days of receiving the request;
- alerting the party initiating the request when a delay is unavoidable;
- sharing the reason for the delay if the delay is unavoidable;
- providing a firm date by which the request will be met if there is a delay.

See also:

- Professional Misconduct Regulation, provision 37

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

5.3 Issuing Accurate Documents

BACKGROUND

Clients and third parties rely on the integrity of members' statements and the appropriateness of the information and documentation they provide. The credibility or honesty of a member may be questioned if s/he is found to have signed a document or record containing incorrect or false information.

Members must provide clients with accurate records and other documents, including invoices, bills and receipts. It is not appropriate, for example, to issue a bill listing an earlier date for a service, in order to enable the client to make an insurance claim. It is also inappropriate to issue an invoice for services that were not provided, other than for an established fee for a cancelled appointment.

STANDARD: Issuing Accurate Documents

Members ensure that documents they sign or transmit in a professional capacity contain accurate and complete information. This includes (but is not limited to) letters and/or reports sent to employers, lawyers and third-party payors.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- exercising care to ensure the accuracy of information presented in documents prepared for their signature and transmittal. This includes documents they themselves prepare, and those prepared by others;
- considering how the reader will interpret the information upon receipt and using clear language that cannot be misconstrued;
- not signing or sending documents containing misleading or false information;
- issuing invoices, bills and receipts that are accurate. This includes listing the correct fee, date and time of services provided.

See also:

- Professional Misconduct Regulation, provisions 17, 26, 27

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

5.4 Record-keeping – Appointment Records

BACKGROUND

Appointment records support accountability in the therapeutic relationship. Records of appointments and attendance details (e.g. appointment, cancellation, no-show, etc.) should be maintained. Appointment records are to be maintained for five years.

STANDARD: Record-keeping – Appointment Records

Members create an appointment and attendance record for each client.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- documenting the date, time, and duration of each professional encounter with the client, and (depending on practice setting) documenting cancelled or missed appointments. Duration of the appointment may be recorded in the clinical record, through a billing system or by other means;
- maintaining appointment records for five years.

See also:

- Professional Misconduct Regulation, provisions 25, 26, 27

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

5.5 Record-keeping – Financial Records

BACKGROUND

Records documenting financial transactions for the reimbursement of therapeutic services form part of the accountability framework governing the therapeutic relationship, and are useful in resolving payment disputes should they arise.

Retention

Financial records are retained for five years from the last interaction with the client or until the client's 18th birthday – whichever is later. They may be kept separately from clinical records but should be maintained with due regard for security. They should be easily retrievable, along with clinical and appointment records, to form a unified client record as needed.

STANDARD: Record-keeping – Financial Records

Members ensure that a financial record is kept for every client to whom a fee is charged for therapeutic services. Financial records are retained for five years from the last interaction with the client or until the client's 18th birthday – whichever is later.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- ensuring financial records include a clear identification of the person(s) providing the service and his/her title, and a clear identification of the client to whom the service was provided – client's full name and address, and unique identifier (if applicable);
- identifying or describing the service provided, the cost of the service and the date and method of payment received;
- identifying fees charged for services provided by supervised personnel;
- indicating the reason or reasons why a fee may have been reduced or waived;
- ensuring that if fees were charged to a third party, the full name and address of that party is included in the record;
- indicating any balance due or owing; and
- including (if applicable) information documenting the retention of an agency for the collection of any outstanding balance.

See also:

- Professional Misconduct Regulation, provisions 25, 26, 27

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

5.6 Record-keeping – Storage, Security and Retrieval

BACKGROUND

Regardless of the type of storage system (electronic or paper-based), it is important to observe best practices regarding the safety and security of client (and related) records.

Members are expected to make all reasonable efforts to ensure that the privacy of the client record is protected during the transmission or disclosure of information.

Whether recording or maintaining client information electronically or on paper, the record-keeping system should provide the ability to view or print client data in a manner that supports chronology. Similarly, to enable the reader to see when a modification was made, and by whom, modifications to the record are to be dated and signed/initialled (whether by hand or electronically). The original entry must not be overridden or erased.

When placing information in a central filing or record system, members must take steps to ensure the information is not misused by those authorized to access the system, and must take reasonable measures to ensure that unauthorized persons do not gain access to the files.

Electronic record-keeping systems

Electronic record-keeping systems must provide protection against unauthorized access. The system must have user ID and password protection with mechanisms to prevent unauthorized alterations to documents (e.g. locking of documents, read-only access, firewalls, encryption). The system must also automatically back up files at reasonable intervals and must allow for recovery of backed-up files. The system must be reliable and provide reasonable protection against information loss, damage to information and inaccessibility. As well, an alternate process for record-keeping must be ready in case the electronic system is unavailable.

Electronic systems should enable the member to:

- record date and time of entries for each client;
- show the identity of the author of each entry;
- capture changes to the record, including who made the change and the reason the change was made;
- preserve the original information in the record when the record is changed or updated; and
- record when data is exchanged with other systems.

STANDARD: Record-keeping – Storage, Security, and Retrieval

Members make all reasonable efforts to ensure that client records are securely stored and protected from loss, tampering or unauthorized use or access. Similarly, they make reasonable efforts to ensure that the privacy of the client record is protected during any authorized transmission or disclosure of information.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- ensuring the original record is retained by the member or the organization where the member works;
- providing only copies to others unless legally compelled to provide the original record. If the transfer of the original record is required, the member shall make all reasonable efforts to retain a legible copy;
- organizing records in a logical and systematic fashion to facilitate retrieval and use of the information;
- completing documentation in a timely manner appropriate to the setting;
- ensuring that every page of the record has a reference identifying the client (e.g. full name and date of birth, or unique identifier), as required; and ensuring that every entry in the record is dated and attested to, and the identity of the person who made the entry is recorded;
- maintaining records in such a way as to support an audit trail;
- where client information is held separately from the client's main clinical record, placing a notation in the record indicating the nature and location of the separate information;
- ensuring that modifications in the completed record are dated and signed/initialled by the member who originally entered them without obscuring the original entry;
- using addenda to modify or correct the clinical record, as necessary, without removing or obscuring the original information, and sending copies of any addendum to recipients of the original document.

See also:

- Professional Misconduct Regulation, provision 25

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

SECTION 6 BUSINESS PRACTICES

Members are expected to conduct themselves professionally, not only in their clinical work, but also in their business relationships with clients and members of the public.

Clients expect their therapists to provide a suitable practice environment, and to conduct themselves in a professional manner. In operating a practice, members are required to comply with College standards governing advertising and representation of themselves and their services. Clients are entitled to receive accurate and verifiable information from members about their professional qualifications and experience, and members are expected to be transparent and reasonable in their fees and billing practices.

When discontinuing client services or when relocating, transferring or closing a practice, members must consider the best interests of their clients. In these circumstances, members are responsible for notifying clients of changes to their practice, and referring clients to other qualified practitioners.

6.1 Fees

BACKGROUND

The College does not set the fees that members may charge for services. However, a member may not charge or accept a fee that is excessive or unreasonable in relation to the service provided. Members also may not offer a discount or rebate to a client for prompt payment of fees, nor charge more than the member's usual fee for a service where a third party is paying for the service. Members may accept payment on a sliding scale, i.e. variable fee depending on ability to pay. Members must ensure that clients are aware of their fee schedule before commencing services, and are required to provide an itemized account of services, upon request.

Free consultations and service agreements

Members may provide free initial consultations without further obligation, and must provide the service promised, and as advertised.

If a member chooses to increase his/her fees, s/he should provide reasonable notice to clients and should not discontinue therapy because a client cannot afford the higher fee.

Non-payment of fees

If a client fails to pay a member in accordance with agreed-upon terms, this is not grounds for immediately discontinuing services. While the member is entitled to be paid for his/her services, the member must place the needs of the client first. Before discontinuing services for non-payment, the member should advise the client of alternative services/service providers that are accessible to the client. At the start of the relationship, the member should make sure the client understands that s/he is required to pay for services, and that services will be discontinued if payment is not received.

Forms of payment

Ordinarily, payment for service is made through monetary exchange, whether this takes place directly or indirectly via a third-party payor or employer.

A member is permitted to barter his/her services with a client who cannot afford to pay, if certain conditions are respected:

- the services provided by the member are of equal or greater value than the item or service being exchanged;
- the bartering arrangement would not be seen to affect the member's judgment;
- the arrangement would not adversely affect the client's confidence in the member; and
- the arrangement is clearly spelled out and agreed to before therapy commences or continues.

Members should be aware that bartering could trigger tax consequences, and should consult with their tax professional to ensure they are in compliance with all provincial and federal laws.

Members may also charge a block fee (a flat fee for a predetermined set of services), as long as the following aspects of the agreement are established in writing beforehand:

- services covered by the fee;
- amount of the fee;
- arrangements for paying the fee; and
- the rights and obligations of the member and the client if the relationship between them is terminated before all the services are provided.

Fulfilling agreements with clients

If a member agrees, either verbally or in writing, to provide a course of therapy for a regular set fee or a negotiated fee, the member must fulfil this commitment to the client. This does not preclude a member from raising fees with proper notice, as mentioned above.

Use of collection agencies and selling client debts

While members are permitted to use the services of a debt collection agency in order to recover unpaid fees, they are prohibited from selling or assigning client debts. This does not prohibit members from accepting payment by credit card.

STANDARD: Fees

Members inform clients of their fee schedule prior to providing services; charge fees that are reasonable in relation to services provided; fulfill the terms of agreements established with clients; and provide itemized accounts upon request.

Demonstrating the standard

A member demonstrates compliance with the standard by, for example:

- setting reasonable fees, informing clients about fees up front, and adhering to the agreed-upon fee schedule;
- not offering a discount or rebate to a client for prompt payment of fees;
- entering into a barter arrangement only where the client's interests are protected;
- not selling or assigning client debt;
- advising clients of alternative services accessible to the client, before discontinuing services for non-payment.

See also:

- Standard 6.3 Discontinuing Services
- Standard 1.6 Conflict-of-interest
- Standard 5.5 Record-keeping – Financial Records
- Professional Misconduct Regulation, provisions 18, 19, 20, 21, 22, 23, 24, 51

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

6.2 Advertising and Representing Yourself and Your Services

BACKGROUND

Clients rely on members to provide accurate and verifiable information about their qualifications and experience, and to be transparent in the way they represent themselves and their services.

Advertising

An advertisement is any message communicated in a public medium intended to influence an individual's choice, opinion or behaviour, including business names associated with a member's practice.

Members may advertise their professional services, as long as the information provided is relevant, and assists prospective clients or members of the public in making an informed choice regarding health care services. Advertising should be truthful, factual, clear, and easily understood. It should include only information that is objective and verifiable.

Members must ensure that advertising does not convey information that misleads clients or confuses the public. This includes omitting relevant information, or including non-relevant, false, or unverifiable information that may be misleading. Members should take reasonable steps to ensure that advertising placed by their associates (e.g. employers, employees, marketing consultants) meets these same objectives.

In advertising, members do not:

- promise a result that cannot necessarily be delivered (e.g. “you’ll get the job you always wanted”);
- use comparisons to others, use superlatives, or suggest that their practice is unique (e.g. “the best therapy available” or “the most caring treatment”); or
- appeal to a person's fears (“avoid being alone, come in for therapy”).

In advertising, members may:

- list education and qualifications;
- describe areas of practice and/or specialization and populations served, but must not suggest that they are recognized by the College as qualified in a specialty area;
- outline a philosophy or approach to practice; and
- identify membership in the College.

Testimonials

Testimonials from clients, former clients, or other persons regarding a member's practice are not permitted in advertising. A testimonial is a statement from another person about the quality of the member's services. Testimonials are subjective and may be unreliable. They may also be misleading, as each client is unique and each situation is different; a technique that works well for one client may not work for another. A client's plan of therapy should be based on the individual client's needs, not on the experiences of others. Testimonials may also lead to concerns that clients have been pressured into providing them, which is not in the best interest of the client or the therapist.

This rule does not prevent clients or others from writing reviews about members (e.g. on third party Internet sites for rating professionals), provided the member does not request them to do so, and provided the member does not influence which reviews are published.

Soliciting

Soliciting individuals in a way that pressures them to engage the member's services, is not acceptable. Members are permitted to solicit individuals only in accordance with the Professional Misconduct Regulation, as follows:

- i. The person who is the recipient of the solicitation must be advised, at the earliest possible time during the communication, that,**
 - a. The purpose of the communication is to solicit use of the member's professional services, and
 - b. The person may elect to end the communication immediately or at any time during the communication if he or she wishes to do so, and
- ii. The communication must end immediately if the person who is the subject of the solicitation so elects.**

These rules are not intended to prevent members from contacting clients to provide reminders about appointments and follow-up services.

Providing information to clients about member's services

Members are required to reply appropriately to a reasonable request by a client or a client's authorized representative for information about a service or product provided or recommended by a member.

Claims about therapy

Members offering information, advice or comment to clients or others take reasonable measures to ensure that their statements are accurate and supportable, based on reasonable professional opinion, and consistent with professional standards and ethics. Unsubstantiated claims can lead to ineffective or even harmful treatment choices. They can also erode the public's confidence in the profession.

Member's name

Clients are entitled to know the name of the member with whom they are dealing, and to verify the registration status of any member. In addition, the College must be able to identify and locate a member in the event that it receives a complaint or report about the member. In his/her professional role, a member must identify him/herself using the name recorded in the Public Register of the College.

Members may use nicknames or other variations of their name with clients, as long as these names are registered with the College along with the member's legal name. The member's legal name (along with any alternate name) should be indicated on official documents such as invoices and when identifying him/herself to clients, e.g. on business cards and pamphlets.

Members may also create and use business names, (e.g. Riverside Therapy Services), as long as they use their own name as set out in the College Register on official documents and when identifying themselves to clients.

Permitting misrepresentation

Only members may represent themselves as Registered Psychotherapists or RPs. They must not permit, counsel or assist a person who is not a member to misrepresent him/herself as a member. This rule applies in settings where the member can prevent the conduct from occurring, such as within the member's office or clinic.

If a member is aware that an unregistered person is holding him/herself out, i.e. presenting him/herself as an RP, the onus is on the member to intervene. The member may speak with the individual and/or inform the College of the misrepresentation if it persists. In particular, members should report misrepresentation or false claims to the College if they are grievous and/or persistent.

STANDARD: Advertising and Representing Yourself and Your Services

Members provide truthful and accurate information to clients and the public, and are transparent in representing themselves and their services.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- advertising services to the public only if the information provided is factual, accurate, objective and verifiable;
- avoiding misleading or subjective claims in advertising;
- refraining from pressuring individuals into engaging the member's services;
- expressing reasonable professional opinion when discussing therapeutic techniques or procedures;
- intervening where a person who is not a member represents him/herself as a member, if the person is not authorized to do so;
- identifying him/herself to clients using the name (or nickname) that appears on the Public Register of the College.

See also:

- Standard 3.5 Unnecessary Treatment
- Standard 1.6 Conflict-of-interest
- Standard 1.2 Use of Terms, Titles and Designations
- Standard 1.2

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

6.3 Discontinuing Services

BACKGROUND

It is the member's professional obligation to ensure that s/he acts in the best interests of clients at all times, including when discontinuing services. Once a member begins working with a client, the relationship should continue as long as the client is benefiting from therapy and/or wishes to continue receiving services. Members should not unilaterally discontinue services to clients without good reason. There are several legitimate reasons for discontinuing services to clients, including:

- the member lacks the necessary competence to continue working with a client;
- the member believes the client will not benefit from continued therapy;
- the member would be at risk of serious harm if s/he were to continue working with the client, e.g. the client threatens or assaults the member;
- the member is closing his/her practice;
- when by prior agreement a fixed number of sessions is to be provided; and
- when the client has not met his/her obligation to pay fees as agreed (see Standard 6.1, Fees).

In all cases, the member makes reasonable efforts to inform the client of the reason for discontinuing services, and refers the client to another service provider, as appropriate. The member also documents the reason for discontinuing services.

Discrimination and the duty to accommodate

Members shall not decline to provide services, or discontinue services for personal reasons if, for example, the therapist does not like a client, or does not agree with the client's political views. These are not acceptable grounds to discontinue therapy. Ontario's *Human Rights Code* also prohibits the denial of services on the grounds of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

Members must not refuse to work with a client or discontinue therapy because of a client's disability. The Human Rights Code requires that persons with disabilities be accommodated, unless this would cause undue hardship for the therapist. Members are required to make reasonable efforts to accommodate the needs of persons with disabilities. A decision to end therapy should always be made in good faith. For example, a therapist must not tell a client that s/he is ending the therapeutic relationship because the therapist lacks the competence to work with the client, when the real reason lies elsewhere. To avoid confusion and concerns about discrimination, the therapist should always clearly communicate the reasons for ending the therapeutic relationship, and document the discussion in the client's file.

STANDARD: Discontinuing Services

A member discontinues professional services only when doing so would be reasonably regarded as appropriate, having regard to:

- the member's reasons for discontinuing services;
- the condition of the client;
- the availability of alternate services; and
- the opportunity given to the client to make alternate arrangements before services are discontinued.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- discontinuing services only when the decision to do so is made in good faith;
- clearly communicating to the client the reason for discontinuing services and referring the client to other services if needed;
- recording the reasons for discontinuing services;
- not discontinuing services on a discriminatory basis.

See also:

- Standard 6.1 Fees
- Standard 6.4 Closing, Selling, or Relocating a Practice
- Professional Misconduct Regulation, provision 6

Note: College publications containing practice standards, guidelines or directives should be considered by all members in the care of their clients and in the practice of the profession. College publications are developed in consultation with the profession and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

6.4 Closing, Selling, or Relocating a Practice

BACKGROUND

Members are obliged to advise their clients if they intend to close, sell or relocate their practice. Notice should be given well in advance, or as soon as is reasonably possible. The purpose is to provide time for clients to seek alternate services. Direct notice is best (in person at a scheduled appointment, by letter, or by telephone). If this is not possible, multiple forms of indirect notice should be used, such as posting a notice at your office, in a newspaper, on one's website, or providing a recorded voice message.

Where possible, the member should assist the client in identifying alternative services.

Members must ensure that client records are transferred to the member's successor (if there is one) or to another member if the client requests this. Client records that are not transferred should be retained or disposed of in a secure manner in accordance with the *Personal Health Information Protection Act, 2004* and the College's record-keeping and documentation standards.

Contingency planning

Members should have in place a plan to address unforeseen interruptions to their practice, such as unplanned leave, illness or death and even natural disaster. These plans should promote continuity of client care and allow others to manage, transfer, or close a practice in the event that a member is unable to do so. The plan should include back-up and storage of contact lists and where possible, client records, directions for contacting clients or their authorized representatives and contact information for alternative service providers. If individuals (such as clients or colleagues) become aware of an abandoned or interrupted practice, they should contact the College.

STANDARD: Closing, Selling, or Relocating a Practice

A member provides adequate notice to clients when closing, selling, or relocating a practice, and complies with the *Personal Health Information Protection Act, 2004*, as well as College regulations and policies.

Demonstrating the Standard

A member demonstrates compliance with the standard by, for example:

- when closing, selling, or relocating a practice, ensuring that notice is given well in advance or as soon as is reasonably possible;
- providing information to clients about alternative services;
- ensuring that the client's records are transferred to the member's successor or to another member, if the client so requests, or ensuring that each client's records are retained or disposed of in a secure manner;
- having in place a contingency plan to promote continuity of care in the event of an unexpected interruption to one's practice.

See also:

- Section 5 Record-keeping and Documentation
- Professional Misconduct Regulation, provision 38

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