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College of Registered Psychotherapists of Ontario

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Professional Practice and Jurisprudence for Registered Psychotherapists

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Overview

This manual describes the professional and legal obligations of registered psychotherapists. It is divided into three parts. Part 1 discusses what it means to practise a regulated profession. Part 2 discusses CRPO's *Professional Practice Standards*. Part 3 reviews various laws relevant to the practice of RPs.

This manual, and the jurisprudence module it accompanies, serves three purposes:

- to allow the reader to become generally familiar with the professional and legal responsibilities of RPs;
- to serve as a reference when researching a particular professional practice issue; and
- using case studies, to develop the ability to apply general principles to specific situations RPs may encounter.

Note that this manual contains general legal information, not legal advice regarding actual situations. It is advisable for RPs to consult colleagues, supervisors, and legal counsel when dealing with complex, risky situations, or legal disputes.

Glossary of Abbreviations

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

AODA — *Accessibility for Ontarians with Disabilities Act, 2005*

CYFSA — *Child, Youth, and Family Services Act, 2017*

HCCA — *Health Care Consent Act, 1996*

MHA — *Mental Health Act, 1990*

PHIPA — *Personal Health Information Protection Act, 2004*

PIPEDA — *Personal Information Protection and Electronic Documents Act, 2000*

RHPA — *Regulated Health Professions Act, 1991*

Other abbreviations include the following:

CAS — Children's Aid Society

CCB — Consent and Capacity Board

CRPO — College of Registered Psychotherapists of Ontario

CTO — Community Treatment Orders

HPARB — Health Professions Appeal and Review Board

ICRC — Inquiries, Complaints and Reports Committee

IPC — Information and Privacy Commissioner of Ontario

RHRA — Retirement Homes Regulatory Authority

RP — Registered Psychotherapist

SDM — Substitute Decision-Maker

Part 1: Professional Regulation

What is a Regulatory College?

Registered Psychotherapists (RPs) are part of a regulated profession. They have responsibilities to the clients they serve, the public, their colleagues, and their regulatory college, the College of Registered Psychotherapists of Ontario (CRPO).

Regulated Health Professions Act

RPs are regulated under the *Regulated Health Professions Act, 1991* (RHPA) and the *Psychotherapy Act, 2007*. Together, these two Acts provide the regulatory framework for the practice of psychotherapy in Ontario.

The RHPA applies to all regulated health professions in Ontario. It helps protect the public from harm by requiring health professionals to be registered and to meet standards of practice and competence. The RHPA sets limits on the activities that non-regulated health professionals can do; e.g., only registrants of particular colleges, including CRPO, are authorized to perform the controlled act of psychotherapy, defined as

> treating, by means of psychotherapy technique delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgment, insight, behaviour, communication, or social functioning.[1]

CRPO's Role

The *Psychotherapy Act* establishes CRPO to regulate Registered Psychotherapists. CRPO is a regulatory body, not an educational institution or a professional association. CRPO's mandate is to protect the public interest, not the interests of the profession (e.g., CRPO cannot advocate for RP services to be covered by insurance policies). Professional self-interest activities are the role of professional associations, not CRPO.

CRPO is not funded by government. Its revenue comes from fees charged to applicants and registrants. To ensure CRPO remains able to fulfill its mandate, it imposes a fee for late payment and may suspend a registrant's certificate of registration for non-payment.

CRPO has several functions allowing it to regulate RPs in the public interest. These include

- registration requirements to ensure only qualified applicants are registered;
- a Quality Assurance Program to promote continuing competence;
- a Professional Conduct Department that investigates complaints and reports about registrants;
- holding discipline or fitness to practise hearings to consider allegations that a registrant has engaged in professional misconduct, incompetence, or is incapacitated; and

[1] RHPA, s 27(2), para 14.

- a public register to provide transparent information about RPs, their registration status, and any conduct concerns.

Detailed information about these processes is available on CRPO's website. Applicants and registrants are encouraged to review the site to become familiar with the work of CRPO.

There are a number of safeguards, set out in the RHPA, which ensure that all health regulatory colleges, including CRPO, serve the public interest in a fair and open manner. Examples of these safeguards are listed below:

- Council meetings and discipline hearings are open to the public. Anyone may watch the proceedings.

- CRPO must consult with the profession and the public before establishing any regulation and some by-laws.

- Decisions of CRPO committees may be reviewed by other bodies. For example, most decisions of the Registration Committee or the Inquiries, Complaints, and Reports Committee (ICRC) may be appealed to the Health Professions Appeal and Review Board (HPARB). Decisions of the Discipline Committee or the Fitness to Practise Committee may be appealed to the Divisional Court.

- The Office of the Fairness Commissioner makes sure that registration practices are transparent, objective, impartial, and fair.

- CRPO is accountable to the Minister of Health. CRPO must report annually to the Minister and provide additional information to the Minister if requested. The Minister may make recommendations or even issue directives to CRPO. If there are serious concerns, the Minster may audit the operations of the College and has the power to appoint a supervisor to take over its administration.

Regulatory colleges are encouraged to work with each other to develop standards relating to the performance of controlled acts common to several health professions. In the case of psychotherapy, five other regulated professions in Ontario are authorized to perform the controlled act of psychotherapy and to use the protected title "psychotherapist". They are

- psychologists and psychological associates;

- physicians;

- nurses;

- occupational therapists; and

- social workers and social service workers.[2]

[2] The Ontario College of Social Workers and Social Service Workers, while not a *health* profession, is governed by legislation that is generally similar to the RHPA.

CRPO Council and Committees

CRPO has a Council, similar to the board of directors of a corporation, which governs the activities of the College. Council members have a duty of loyalty and good faith to the mandate of the organization, which is to protect the public interest. Council is comprised of registrants, as well as public members appointed by the government. Professional and public members work together to ensure that the views of clients and the public are represented in the regulatory process. Council's activities include setting policy and strategy; approving by-laws, regulations, and budgets; and reviewing the performance of the Registrar (CEO), who is the senior staff-person of the College.

The RHPA requires all health regulatory colleges to have seven committees (sometimes referred to as "statutory committees"). Committees oversee specific areas of the College's work and report to Council. As an example, the Registration Committee sets registration policy and reviews applications where CRPO staff are unsure if they meet the registration requirements. Another College committee is the ICRC, which screens complaints and reports about registrants. Colleges may establish other committees (sometimes referred to as "non-statutory committees") or working groups as needed. For example, CRPO has an Examination Committee that considers appeals from candidates who have failed the registration exam. CRPO periodically recruits registrants to serve on various committees.

Practice Question

Which sentence best describes CRPO's role versus that of a professional association?

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

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

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

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

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

Accountability

The following concepts and resources help ensure RPs practise the profession safely and effectively.

Code of Ethics

CRPO's Code of Ethics sets out certain principles of professional practice — ideals that registrants should aspire to in their professional practice and community roles. These principles differ from practice standards. Practice standards can be thought of as the minimum standard of professional practice expected of all registrants, whereas the principles included in the Code of Ethics are ideals that registrants should strive to uphold.

Code of Ethics

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

Autonomy & Dignity of All Persons
To respect the privacy, rights and diversity of all persons; to reject all forms of harassment and abuse; and to maintain appropriate therapeutic boundaries at all times.

Excellence in Professional Practice
To work in the best interests of clients; to work within my skills and competencies; to maintain awareness of best practices; and to pursue professional and personal growth throughout my career.

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

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

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

Responsible Research
To conduct only basic and applied research that potentially benefits society, and to do so safely, ethically and with the informed consent of all participants.

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

Ethics Scenario
Lenni has been practising as an RP for seven years. They meet CRPO's requirements to serve as a clinical supervisor of students and newer RPs but are concerned about the risks and liability of doing so. Lenni carefully thinks over the implications of offering clinical supervision. They consult with peers, a lawyer, and their professional liability insurance provider. They note in CRPO's Code of Ethics, under the heading Support for Colleagues, the ideal of inspiring others to excellence. They conclude that though they are not obligated to provide clinical supervision, in their circumstances doing so is worthwhile and upholds an ethical principle.

Professional Practice Standards

Professional practice standards explain the ways Registered Psychotherapists are expected to practise the profession. They may be written or unwritten. Written standards include those contained in legislation or College documents. Unwritten standards are requirements that are generally accepted within the profession. Falling below a standard is considered professional misconduct. This manual describes CRPO's written standards in Section 2.

Professional Misconduct

Professional misconduct is behaviour that falls below the minimum standards of the profession. Professional misconduct may lead to disciplinary proceedings potentially resulting in a reprimand, remediation, suspension, or in the most serious cases, revocation of a registrant's certificate of registration.

The full definitions of professional misconduct are found in

- Section 51(1) of Schedule 2 of the RHPA; and
- CRPO's Professional Misconduct Regulation.

The following are a few examples of professional misconduct:

- sexual abuse of a client, (e.g., engaging in sexual touching or remarks);
- failing to maintain professional boundaries (e.g., employing a client);
- failing to keep adequate records (e.g., not retaining emails in the client file; not securely storing files);
- breaching client confidentiality (e.g., identifying a client, even to their family member, without consent);
- fraudulent billing, (e.g., falsely claiming for insurance reimbursement that one's services were supervised); and
- disregarding restrictions on one's certificate of registration (e.g., a registrant who is required to practise with clinical supervision not doing so, or practising a type of therapy without adequate training).

Professional misconduct may also involve inappropriate conduct towards CRPO, including

- publicly challenging the integrity of CRPO (though registrants are encouraged to engage in constructive dialogue about CRPO policy, e.g., by making submissions during CRPO consultations, and by offering to join CRPO working groups, committees, and Council);
- breaching an undertaking (promise) given to CRPO;
- failing to participate in the Quality Assurance Program;
- failing to respond appropriately and promptly to correspondence from the CRPO; and
- failing to co-operate in an investigation by the CRPO or obstructing an investigation by the College.

Practice Question
Which of the following would be considered professional misconduct according to the Professional Misconduct Regulation?

i. Failing to maintain client confidentiality.
ii. Insulting a client by email because they wanted to stop seeing the registrant.
iii. Charging a higher rate because a third party is paying for the service.
iv. All of the above.

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

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

Incompetence

Incompetence refers to a lack of knowledge, skill, or judgment when assessing or treating a client. In serious cases, allegations of incompetence may result in a discipline hearing. If the Discipline Committee finds that an RP is incompetent, it could impose restrictions on the registrant's practice, such as requiring intensive clinical supervision or upgrading courses. In the most serious cases of incompetence, the Discipline Committee could suspend or revoke the registrant's registration.

In any investigation of incompetence, CRPO will usually look at the registrant's records and speak with the registrant directly. CRPO will also interview the clients involved and ask other psychotherapists whether they think the conduct shows incompetence. The investigating committee and deliberating committee (i.e., the ICRC and the Discipline Committee) include RPs to assist in determining the difference between good and bad practice.

Incapacity

Incapacity occurs when a health condition prevents a registrant from practising safely. Usually, the health condition is one that interferes with the psychotherapist's ability to think clearly. Often incapacity is related to substance abuse, addiction, or illness (mental and physical) that impairs the registrant's professional judgment; e.g., a psychotherapist with a condition that includes delusions and lack of insight.

An RP who is incapacitated is not treated as if they have engaged in professional misconduct or incompetence. The investigation looks at the registrant's health condition and the treatment they are receiving or may need. CRPO may require the RP to undergo a specialist examination. If the concern is justified, the registrant may be referred to the Fitness to Practise Committee for a hearing. The Committee may order the registrant to undergo treatment or receive medical monitoring in order to continue to practise, or it may restrict the psychotherapist's practice. In an extreme case (e.g., where the registrant refuses treatment), the Fitness to Practise Committee may suspend or revoke the registrant's registration, in order to protect the public.

Incapacity Scenario 1
Kearan, a psychotherapist, has been drinking a lot more alcohol the last few months. One day Kearan comes back from lunch drunk. Paul, a client, notices that Kearan smells of alcohol and is stumbling around the office. Paul also notices that Kearan has forgotten what Paul told him during recent visits and that he has been inappropriate and rambling in some of his comments. Paul reports this to CRPO.

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

The matter is referred to the Fitness to Practise Committee. Kearan and CRPO agree to an order requiring that he stop working until he is reassessed as able to return to practice. Kearan and CRPO also agree that on return to practice, Kearen is required to receive clinical supervision and regular monitoring of his condition by a physician.

Incapacity Scenario 2
Evan, a psychotherapist, works at a large community agency. He is currently experiencing burnout and has commenced a period of stress leave. Wendy, who works in the human resources department, inquires with CRPO whether the agency needs to report Evan as being incapacitated.

A CRPO staff-person advises Wendy to consider whether clients are at risk of harm, e.g., if Evan denies there is a problem and continues to treat clients. Wendy realizes this is not the kind of situation that falls under the definition of incapacity for CRPO's purposes.

Part 2: Practice Standards

Introduction

The written standards of CRPO deal with matters such as informed consent, confidentiality, and record-keeping, among others. Applicants and registrants are encouraged to regularly review the Standards (available at https://www.crpo.ca/standards-regulations/). Written standards and guidelines assist registrants in the safe, ethical, and effective practice of the profession. They are reviewed periodically based on various factors, including data from CRPO investigations and practice advice questions, evolving societal expectations, the current practice environment, and stakeholder feedback.

Ultimately, the test of whether a registrant has upheld a practice standard (written or unwritten) is based on what a knowledgeable and prudent practitioner would have done in similar circumstances. In a discipline hearing, this decision is made by a panel of members from CRPO's Discipline Committee, often after hearing expert evidence on the issue.

This section discusses many of CRPO's *Professional Practice Standards*. It provides links to the Standards and other relevant resources. It also illustrates the Standards using scenarios and practice questions. Some standards are discussed at length, others briefly, and some are not specifically covered in this manual. There are a few reasons for this variation, including the following:

- CRPO's Practice Advisory Service, which offers information and resources in response to practice questions, tends to receive questions about some standards more than others.
- Some standards are at issue more often in investigations about registrant conduct.
- Some standards are related to detailed laws with which registrants need to be familiar.

While not all of the Standards are discussed in detail, registrants remain responsible for meeting all professional practice standards.

Standard 1.1 Responsibility toward CRPO

Registrants benefit from the trust the public places in them as regulated health professionals. This collective trust is possible only if individual registrants accept their responsibilities toward CRPO. Standard 1.1 explains what these responsibilities include.

Standard 1.1 Scenario 1

CRPO contacted a registrant as part of a random audit to ensure RPs carry appropriate professional liability insurance (PLI). CRPO did not receive a response by mail or email. CRPO suspended the registrant's certificate of registration for failing to provide proof of PLI. The registrant later contacted CRPO showing that extenuating circumstances prevented them from receiving correspondence and that they do have PLI. CRPO lifted the suspension.

Standard 1.1 explains that registrants are required to respond within 30 days to a written request or inquiry from the College. This scenario recognizes that, while extenuating circumstances sometimes arise, it is important to receive and respond to correspondence from CRPO. This includes updating CRPO as soon as one's contact information changes. Doing so is one form of accepting one's responsibilities to the College.

Standard 1.1 Scenario 2

The Inquiries, Complaints and Reports Committee (ICRC) ordered James to attend an in-person caution as an outcome of a formal complaint received about his conduct. College staff contacted James via email and voicemail to notify him that a date and time had been set for his caution. James did not respond to the College's communication and did not attend the scheduled caution. CRPO opened an investigation (sometimes referred to as a Registrar's Report) into James' apparent breach of the ICRC's order.

Standard 1.1 Scenario 3

The College received a mandatory report from Farah's former employer, who stated Farah's employment was terminated for professional misconduct. Once Farah became aware of the report to the College, she began contacting her former colleagues on social media demanding they deny any request for an interview from the College. Farah threatened to sue one of her former colleagues for defamation.

Registrants are obligated to fully cooperate with College investigations and exhibit appropriate behaviour throughout. In this scenario, Farah attempted to tamper with witnesses and obstruct the College's investigation. If this were to occur, the Registrar would open a separate report to investigate the registrant's conduct during the original investigation.

Practice Question

Which of the following is not considered professional misconduct regarding a registrant's conduct toward the College?

i. Failing to attend for a caution before the Inquiries, Complaints and Reports Committee.
ii. Failing to cooperate with the College investigating a matter that was brought by a client complaint.
iii. Failing to respond to a proposed regulation that has been put out to registrants for feedback.
iv. Not participating in the Quality Assurance Program because a registrant feels they know enough.

The best answer is iii. While it may be beneficial to the profession in general to contribute to the regulatory process by providing feedback to any proposed regulations, this is not a mandatory duty that would constitute professional misconduct if it wasn't performed.

Answer i is not the best answer because failing to attend a caution directed by the Inquiries, Complaints and Reports Committee is professional misconduct. Cautions help make the complaints process work.

Answer ii is not the best answer because the College has the authority to regulate the profession, and registrants must cooperate with the College when it is investigating matters. Failing to cooperate is professional misconduct.

Answer iv is not the best answer because the Quality Assurance Program is a required part of being registered with a health profession.

Standard 1.2 Use of Terms, Titles, and Designations

Terms, titles, and designations allow the public to identify who is a regulated health professional and what their qualifications are. Improper use of terms, titles, and designations can cause confusion and risk of harm. Standard 1.2 explains appropriate use of terms, titles, and designations.

Standard 1.2 Scenario 1

Laura, an RP with a Ph.D., teaches at a psychotherapy training institute that operates a student clinic. At the clinic, Laura supervises students who refer to her as “Doctor Laura”. On learning this, the Dean of the school advises her to ask students to stop calling her “Doctor” in the clinic because clients are present. It is ok in the classroom, but not in the clinic. Laura reviews the RHPA and realizes that the Dean is correct. Laura is assisting with the therapy of clients in the clinic and thus is not permitted to call herself (or allow others to call her) “Doctor”.

Standard 1.2 Scenario 2

Marla, a Qualifying registrant, has decided to start a private practice while practising with clinical supervision. As part of her marketing, she has created a profile on an internet psychotherapy directory. Marla shows the content to a colleague who notes that the profile uses the title “RP” without mentioning “Qualifying”.

Marla explains that the online directory did not have “RP (Qualifying)” in the drop-down menu. The colleague rightly points out to Marla that she must always use the appropriate regulated title. In this case, Marla has not yet met the requirements to transfer to the full RP category.

Marla decides to temporarily remove her profile, write to the website about the omission of the RP(Qualifying) title, and maintain this correspondence in her records as evidence of her efforts to ensure the appropriate use of title.

Standard 1.2 Scenario 3

Lars is asked to sign a form so his client can obtain funding for psychotherapy services through a public program. The client has pre-populated the form and notes the registrant as a “psychologist”. Lars does not read the form and signs it. Funding for Lars’ client is denied because the agency could not identify Lars as a registrant of the College of Psychologists of Ontario.

Lars subsequently reviews the form and corrects the error. The client resubmits the form, and funding is approved. Registrants are responsible for their use of title on all documents they sign, as well as all documents issued on their behalf. Improper use of title can impact clients’ access to services.

Standard 1.3 Mandatory Reporting

Confidentiality is a cornerstone of psychotherapy practice; however, in rare instances other factors override this duty. For example, in various situations the law requires registrants to file reports that may contain confidential information. Standard 1.3 reminds RPs about this obligation.

Several of these reporting obligations refer to "reasonable grounds" to suspect or believe a particular event has happened or may occur. Reasonable grounds mean that all the available information indicates that there is more than a mere hunch or possibility. The registrant need not have witnessed the event — the information can come from another person such as a client.

This section lists the mandatory reporting obligations for RPs. CRPO has published a convenient table version of these requirements as well.

Reports under the RHPA

The following are mandatory reports related to health professionals. The RHPA provides immunity to anyone who makes one of these mandatory reports in good faith.

Sexual Abuse Mandatory Report
This mandatory report is required when regulated health professionals, including RPs, have reasonable grounds to believe that an Ontario regulated health professional has sexually abused a patient or client. The mandatory reporting duty applies to information obtained in the course of practising the profession. That is, it does not apply to information learned in the RP's personal life. RPs should refer to the definition of sexual abuse (covered later in this manual), so they know what conduct is reportable.

The report must follow these requirements:

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

There is an additional mandatory reporting obligation where the registrant is providing psychotherapy to another regulated health professional. To illustrate, consider that "A" is an RP treating client "B". B is a regulated health professional, (e.g., a chiropractor, dentist, nurse, etc.). A has reasonable grounds to believe that B has sexually abused one of their clients, "C". In such cases, the registrant, A, must file a mandatory report with the Registrar of B's college, even though this breaches client-therapist confidentiality. The mandatory report must also contain an opinion as to whether B is likely to sexually abuse clients in the future, if the registrant is able to form such an opinion. If B ceases psychotherapy with the registrant, the registrant must immediately file an additional report with B's regulatory college. Again, the report must include an opinion as to whether B is likely to abuse again, if the registrant is able to form such an opinion.

Standard 1.3 Scenario 1

Prisha, an RP, is told by her client, Ivy, that Ivy had an affair with her family doctor who was treating her while the affair was going on. Prisha tells Ivy that she is required by law to report this information to the Registrar of the College of Physicians and Surgeons of Ontario (CPSO). Prisha explains that the CPSO will want to investigate the report. The CPSO will likely want to interview Ivy about the affair. The investigation could lead to a discipline hearing.

However, the law is clear that Prisha cannot include Ivy's name and contact information in her report, unless Ivy is prepared to sign a written consent permitting Prisha to do so. Prisha says that they can call the CPSO right now, on an anonymous basis, to see what the process would be like. Ivy agrees to the telephone call.

After the call Ivy says that she will not give her consent to include her name and contact information. Prisha then provides the report in writing without identifying Ivy.

Practice Question

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

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

The best answer is iv. Sexual abuse includes comments of a sexual nature to a client. Reporting sexual abuse is mandatory. While this situation does not involve sexual intercourse or touching, it is still important that RPs learn that this conduct can be harmful to clients. One never knows what experiences clients have had in their past that might make a joke harmful.

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

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

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

Facility Report
It is mandatory for a facility operator (e.g., clinic, hospital, agency) to file a report if they have reasonable grounds to believe that a CRPO registrant (or a registrant of any other college) has sexually abused a client, is incompetent, or is incapacitated. This report must be made whether or not the health professional is terminated from their position. A facility operator may or may not be a regulated health professional, but they have this duty nonetheless. Such a report must be filed in accordance with the requirements noted above.

Termination Report
Any person must file a report if they end a business relationship (e.g., a partnership, an employee/employer relationship, a corporate relationship, or a space-sharing arrangement) with a regulated health professional on the basis of incompetence, incapacity, or professional misconduct. The report must be made even if the regulated health professional quit or resigned before the business arrangement ended. This duty applies whether the employer or business partner is a regulated health professional or not.

The report must:

- be made in writing within 30 days of ending the business relationship; and
- be directed to the Registrar of the college to which the subject of the report belongs;

Standard 1.3 Scenario 2

Amir owns a group psychotherapy practice. He learns that one RP contractor is struggling with alcohol misuse during work hours. Amir encourages the RP to seek treatment, but the RP denies they have a problem. Yesterday the RP came back into the office after lunch obviously impaired and treated three clients. Amir called the RP's emergency contact to pick the RP up.

Amir seeks advice from his lawyer. The lawyer advises him to temporarily suspend the RP's contract to protect clients while exploring if the RP requires an accommodation based on disability (in this case apparent substance misuse). The lawyer also advises that Amir is required to make a written report to the Registrar of the College about the RP's apparent incapacity and suspension of their contract.

Unsafe Practice by Another RP
CRPO's Professional Misconduct Regulation requires registrants to report to CRPO where they have reasonable grounds to believe another RP engaged in an incident of unsafe practice. Unsafe practice does not refer to any mistake or error. Rather, it involves conduct that poses a significant risk of serious harm. Registrants must not submit a client's identity to CRPO in the report unless the client has given their written consent.

Standard 1.3 Scenario 3

Terry, an RP, learns from his client, Kathy, that another RP strongly recommended that Kathy undergo eye movement desensitization and reprocessing (EMDR) sessions to ease a recent spate of traumatic memories. Since beginning treatment, Kathy notes some abreactions that leave her feeling disoriented and dissociative for several hours after she leaves the EMDR sessions.

Terry is concerned, and with Kathy's consent, he contacts the other RP to discuss these concerns. However, the other RP seems to shrug off Terry's concerns dismissively, stating that those reactions sometimes happen, and that there is nothing to be concerned about. Kathy's distress seems to continue, and she seeks out Terry, expressing concerns about how she is being treated, and indicating that she would be uncomfortable telling the RP of her wish to discontinue the EMDR sessions.

Terry is concerned that EMDR may not be safe for Kathy at this time, certainly not the way it is being conducted. He is also concerned that the RP is not practising EMDR in a safe, effective, or clinically sensitive way. Terry consults with a colleague on a no-names basis and decides to report the incident of unsafe practice to CRPO. Registrants are required to report an incident of unsafe practice by another RP to CRPO.

Mandatory Self-reports

The RHPA, as well as CRPO's regulations and by-laws, list various events that registrants are required to self-report to CRPO. Self-reporting allows CRPO to determine whether an event involving a registrant is relevant to their suitability to practise psychotherapy. It also promotes public trust in the profession and the College. Failing to self-report when required is considered professional misconduct.

Offences
Registrants must inform CRPO when they have been found guilty of an offence by a court. All offences, including criminal offences; offences under federal drug or other legislation; and provincial offences (e.g., highway traffic offences) must be reported to CRPO. Speeding tickets and parking tickets do not need to be reported to CRPO.

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

Reports must be made to the CRPO Registrar as soon as possible after the finding and contain the following information:

- the name of the RP filing the report;

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

Once a report is filed, it will be reviewed by CRPO and may result in an investigation. If there is an appeal that alters the information reported, an updated report must be made. The *RHPA* requires criminal or drug offence findings to be posted on the public register.

Standard 1.3 Scenario 4

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

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

Charges and Bail Conditions
Registrants are required to self-report any current outstanding offence charges and bail or other restrictions. The report must contain the following information:

- the name of the registrant filing the report;
- the nature of, and a description of, the charge;
- the date the charge was laid against the registrant;
- the name and location of the court in which the charge was laid or in which the bail condition or restriction was imposed on or agreed to by the registrant;
- every bail condition imposed on the registrant as a result of the charge;
- any other restriction imposed on or agreed to by the registrant relating to the charge; and
- the status of any proceedings with respect to the charge.

The self-report must not contain any information that violates a publication ban. If there is a change in the status of the charge or bail conditions, the registrant must file an additional report. The RHPA

requires that outstanding criminal or drug charges, and bail or related conditions, must be posted on the public register.

Professional Negligence
RPs found by a court to have engaged in professional negligence or malpractice must report the finding to CRPO. Findings by a tribunal do not need to be reported. Settlements of claims for professional negligence need not be included if they did not result in a court finding.

Reports must be made to the CRPO Registrar as soon as possible after the finding and contain the following information:

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

The report will be reviewed by CRPO and may result in an investigation. Information from the report is placed on the public register. If there is an appeal that alters the information reported, an updated report must be made.

Standard 1.3 Scenario 5

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

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

Other CRPO Self-reporting Obligations
In addition to those listed above, registrants are required to report the following events to CRPO:

- a finding of professional misconduct, incompetence or incapacity, or any similar finding, in relation to another regulated profession in Ontario or to any regulated profession in another jurisdiction;
- a current proceeding for professional misconduct, incompetence or incapacity, or any similar proceeding, in relation to another regulated profession in Ontario or to any regulated profession in another jurisdiction;

- a refusal by any body responsible for the regulation of a profession in any jurisdiction to register or license the registrant;

- resignation from another professional regulator, including whether the RP was in good standing at the time of resignation; and

- any other event that would provide reasonable grounds for the belief that the registrant will not practise psychotherapy in a safe and professional manner.

The last item is a ”catch-all” self-reporting obligation. It is intended to capture serious concerns not specifically listed. These concerns could include, but are not limited to, disciplinary action by an educational institution or a situation where a registrant recognizes they caused serious harm to a client.

Mandatory Reports under Other Legislation

Aside from the RHPA, there are several other pieces of legislation that require registrants to file reports with particular organizations.

Crime
There is no general duty to report someone who has committed a crime. Clients are seeking help and trust registrants to safeguard their privacy to the greatest extent possible. Registrants may only disclose confidential information without the client’s consent if a specific legal exception applies. Exceptions include the mandatory reports listed in this section. Registrants may also disclose confidential information if doing so is necessary to prevent or reduce a significant risk or serious harm (e.g., if the client imminently plans to die by suicide, or threatens the registrant or others with violence).

Another exceptional situation is where the client draws the registrant into a criminal activity by association. For example, what if a client tells the registrant they plan to forge invoices in the registrant’s name, submit these to their insurance plan, keep part of the money, and offer to pay the registrant a cut? If the registrant did nothing, they would be seen as participating in the crime. In such a situation, the registrant should refuse to participate and attempt to gain the client’s assurance they will not move forward with the fraud. They should also seek legal advice regarding other potential steps such as terminating therapy and warning others, such as insurance companies, of potential fraud.

Standard 1.3 Scenario 6

Ayda, an RP, learns from her client that three years ago they assaulted someone and were never charged. Ayda inquires whether this is an issue the client wishes to explore in therapy. From the details, Ayda ascertains that the victim was neither the client’s child, a resident of a retirement home, nor a resident of a long-term care home. Ayda also carries out a risk assessment, which does not indicate that the client plans to assault anyone in the future. Given these particular circumstances, Ayda concludes she does not have a duty to report the client’s past assault.

Child, Youth and Family Services Act
A registrant who has reasonable grounds to suspect that any child is in need of protection must report this to a Children’s Aid Society (CAS). This duty overrides all privacy and confidentiality duties and laws, including the *Personal Health Information Protection Act, 2004* (PHIPA). No legal action may be taken against a registrant for making a report, unless the report is made maliciously or without

reasonable grounds. CRPO cannot discipline a registrant for making such a report in good faith and with reasonable grounds.

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

A psychotherapist has a duty to report with respect to any child under the age of 16. Reports regarding children who are 16 or 17 years old and in need of protection may be made at the discretion of the registrant.

This duty applies to all children, including the child of a client, or a child who is a client, or any other child. However, a registrant has a special responsibility to report information about a client if the information was obtained in the course of their professional duties (as opposed to their personal life). A registrant may be fined up to $5000 for failing to make a report in such a circumstance. The duty to report is ongoing (for new information) even if a previous report has been made respecting a child. The report must be made directly, without relying on anyone else to file the report on one's behalf.

A registrant must make a report when they have reasonable grounds to suspect any of the following:

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

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

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

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

Failure to supervise a child
A report is required if a child has injured another person or damaged another person's property more than once because a person in charge of the child encouraged the child to do so. A report is also

required if a child has injured another person or damaged another person's property more than once because a person in charge of a child has not or is not able to supervise a child adequately.

Standard 1.3 Scenario 7
Lea, an RP, has a client who discloses that they have physically harmed their son. Lea has a duty to make a report to a Children's Aid Society, even if the client reported this in confidence or in the course of assessment or therapy. If two months later the client says something that makes Lea suspect the client has physically harmed their son again, Lea has a duty to make another report.

Standard 1.3 Scenario 8
Julian, a therapist, has an 11-year-old client who has been displaying signs of erratic and violent behaviour. The client reports that they assaulted their friend last week to the point where the friend had to be taken to the emergency department. Julian believes that specialized health care services are necessary to prevent the client from causing serious injury again and recommends a referral to another health care provider. The client's parents do not believe that their 11-year-old child would really hurt anybody, suggesting that the seriousness of the incident was exaggerated by the victim's overreaction. The client's parents refuse to receive information about the referral. In this case, Julian has a duty to make a report to the Children's Aid Society.

This duty to report exists even if the child does not want anyone to know about the incident; the parents refuse to believe the matter is serious; and the parents are angry at the RP.

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

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

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

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

- improper or incompetent treatment or care of a resident that results in harm or a risk of harm to the resident;
- abuse of a resident by anyone;
- neglect of a resident by staff, including management, that results in harm or a risk of harm to the resident;
- unlawful conduct that results in harm or a risk of harm to a resident;

- misuse or misappropriation of a resident's money; or

- misuse or misappropriation of funding provided to a long-term care home.

It is an offence for a registrant to fail to make a report in any of the above circumstances if the therapist provides care or services to long-term care home residents. A registrant may be fined up to $100,000 for failing to make such a report.

Complaints and reports about the care of a resident or the operation of a long-term care home must be investigated by the Ministry of Health if they involve certain matters, including abuse of a resident by anyone, and neglect of a resident by staff. Every person, including an RP, is protected from retaliation for making a report or for cooperating with an investigation. This includes protection from being fired, disciplined, or suspended.

Practice Question

A registrant is not required to report the following regarding a long-term care home resident:

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

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

Answer i is not the best answer because this may constitute verbal and emotional abuse, which must be reported.

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

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

Retirement Homes Act

A retirement home is a residence primarily for persons who are 65 years or older, where the operator of the home provides at least two care services (e.g., assistance with feeding, bathing, dressing, personal hygiene). Retirement homes are overseen by the Retirement Home Regulatory Authority (RHRA). Under the *Retirement Homes Act, 2010*, a person is required to report to the Registrar of the RHRA if they have reasonable grounds to suspect any one or more of the following:

- improper or incompetent treatment or care of a resident that results in harm or a risk of harm to the resident;

- abuse of a resident by anyone;

- neglect of a resident by the licensee or the staff of the retirement home if it results in harm or a

risk of harm to the resident;

- unlawful conduct that results in harm or a risk of harm to a resident; or
- misuse or misappropriation of a resident's money.

Privacy Breach Notification
Under PHIPA, a health information custodian is required to notify an individual if their personal health information is lost, stolen, or used or disclosed without authority. This report must be made at the first reasonable opportunity and must include a statement that the individual is entitled to make a complaint to the Information and Privacy Commissioner of Ontario (IPC).

The custodian must also notify the IPC of the breach in a variety of circumstances, essentially where the breach is significant (e.g., negligent or intentional breaches, theft of personal health information, risk of additional privacy breaches, part of a pattern of breaches, where a mandatory report is also made to a college). The list of circumstances is set out in section 6.3 of the General Regulation made under PHIPA. To decide whether the breach needs to be reported to the IPC, custodians should consult the General Regulation, contact the IPC, or contact their legal advisor.

In addition to the above obligations, health information custodians are required to file annual reports with the IPC. These reports include general data about requests for access, correction, and other statistics as well as any privacy breaches from the previous year.

Standard 1.4 Controlled Acts

Standard 1.4 deals with controlled acts. Controlled acts are potentially dangerous healthcare procedures that may only be performed by a properly qualified professional. In Ontario, a person may only perform a controlled act as permitted by law. Fourteen controlled acts are listed in the RHPA. RPs are authorized to perform one controlled act — the controlled act of psychotherapy.

Registrants should be aware of the complete list of controlled acts so they are able to recognize when they might inadvertently engage in a controlled act.

The Controlled Acts
The controlled acts listed in the RHPA are as follows:

1. Communicating a diagnosis to the individual or a personal representative identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or their personal representative will rely on the diagnosis.
2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
3. Setting or casting a fracture of a bone or a dislocation of a joint.
4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger, beyond the external ear canal, beyond the point in the nasal passages where they normally narrow, beyond the larynx, beyond the opening of the urethra, beyond the labia majora, beyond the anal verge, or into an artificial opening into the body.
7. Applying or ordering the application of a form of energy prescribed by the regulations under this Act.[3]
8. Prescribing, dispensing, selling or compounding a drug as defined in the *Drug and Pharmacies Regulation Act,* or supervising the part of a pharmacy where such drugs are kept.[4]
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.
10. Prescribing a hearing aid for a hearing impaired person.
11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.
12. Managing labour or conducting the delivery of a baby.
13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.
14. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgment, insight, behaviour, communication or social functioning.

[3] Examples of these forms of energy include the use of electricity for aversive conditioning, electromagnetism for magnetic resonance imaging, and soundwaves for diagnostic ultrasound.
[4] As a general rule, if a substance has a DIN (Drug Identification Number), it is usually considered to be a drug. Some non-drug substances have different kinds of drug numberings, such as a Natural Product Number (NPN) or Homeopathic Medicine Number (DIN-HM). These products are generally not considered to be drugs.

Assessment vs. Diagnosis

CRPO registrants are not authorized to communicate a diagnosis to clients; however, they are permitted to *assess* clients. It is important to keep the distinction in mind. A diagnosis is a conclusive statement that identifies a disease or disorder as the cause of a client's symptoms. An assessment describes those symptoms and is aimed toward treatment planning.

As an example, the following statement made by an RP to a client would be an inappropriate communication of a diagnosis: "It appears you are experiencing mild or moderate depression." Depression is a mental health diagnosis, and the way the statement is phrased could lead a client to rely on it.

In contrast, the following statement by an RP to a client would be appropriate as a form of assessment, planning, and referral: "You have reported sadness and low energy. I am proposing we engage in CBT, and I suggest you follow up with your family physician to consider depression or other issues." This statement does not apply a diagnostic label but summarizes what the client reported and makes a recommendation about treatment. It also suggests contacting a regulated health professional who is authorized to communicate a diagnosis. In situations that could confuse a client as to whether they are being diagnosed, registrants should make clear they are not authorized to communicate a diagnosis.

Confusion can arise when an RP works with another professional authorized to communicate a diagnosis. Registrants are permitted to refer to and treat a previously diagnosed condition but may not take on the role of the diagnosing professional.

Standard 1.4 Scenario 1
Rian is an RP who works in the motor vehicle accident sector. Rian receives clinical supervision from a professional who is authorized to communicate a diagnosis to clients, i.e., a physician or psychologist. Normally, Rian conducts a preliminary assessment interview with a client. The supervisor then reviews the assessment, arrives at a diagnosis, communicates the diagnosis to the client, signs a report, and sends the report to the insurance company.

Lately, the practice has been extra busy. To save time, Rian has been discussing cases with their supervisor, then Rian signs the reports for insurance and tells the client about the diagnosis.

Rian's conduct is improper. Even though they work with a professional authorized to communicate a diagnosis, Rian should not be the first care provider to communicate the diagnosis to clients.

Legal Authority to Perform a Controlled Act

Standard 1.4 describes the following three ways a health care provider can receive the legal authority to perform a controlled act:

1. if authorized to do so as a regulated health professional;
2. as an exception or exemption; or
3. if a controlled act is delegated by another regulated health professional who is authorized to perform the controlled act.

Restriction on Delegating the Controlled Act of Psychotherapy

Except in very limited circumstances, RPs are not permitted to delegate the controlled act of psychotherapy to another person. Psychotherapy is a relational process rather than a technique. Providing psychotherapy requires extensive training and accountability. For these reasons, unlike other controlled acts, it generally cannot be delegated.

In exceptional circumstances, with prior approval of the CRPO Council, an RP may delegate the controlled act of psychotherapy. Alternately, an RP may delegate the controlled act of psychotherapy if circumstances exist where time does not allow the RP to obtain prior approval of CRPO Council, and the registrant notifies CRPO of the delegation as soon as reasonably possible.[5] These exceptional circumstances could conceivably involve an individual or public health emergency. To date, CRPO has not provided approval nor received notification of delegation of the controlled act of psychotherapy.

Standard 1.4 Scenario 2

Diana, a registrant, engages in psychotherapy with her client Petra to treat a potentially serious eating disorder diagnosed by Petra's physician. The treatment Diana will perform falls within the controlled act of psychotherapy. Diana is authorized to perform that controlled act and has extensive training to treat the presenting issue.

Standard 1.4 Scenario 3

Frank, an RP, has a client named Connor who reports severe allergies on his intake form. During a session, Connor indicates he is beginning to go into anaphylactic shock. Frank looks inside Connor's briefcase and finds an EpiPen containing a measured dose of epinephrine. Frank injects the epinephrine into Connor's muscle and calls 911. Connor recovers. While Frank did perform a controlled act he is not authorized to perform (injecting a drug), he did so during an emergency, which is a recognized exception to the controlled acts rule.

Standard 1.4 Scenario 4

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

[5] O. Reg. 317/12: PROFESSIONAL MISCONDUCT, s. 1, para 12.

Practice Question

Which of the following is a controlled act?

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

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

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

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

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

Standard 1.5 General Conduct

Standard 1.5 is a ”catch-all” requirement. Registrants are expected to avoid conduct that is disgraceful, dishonorable, unprofessional, unbecoming, and illegal. Examples where this Standard is engaged include, but are not limited to, the following:

- sexual misconduct toward employees, students, supervisees, or in one’s personal life. These groups are not covered by the RHPA’s definition of “sexual abuse”, which applies only to clients. CRPO nonetheless considers these forms of misconduct as unacceptable;
- fraudulent conduct such as tax evasion;
- illegal conduct such as driving under the influence;
- spreading disinformation regarding public health;
- violence, which refers to threats, attempts to use force, or actual use of force, that may cause injury to another individual; and
- blatantly poor communication, such as rudeness or failing to respond to reasonable inquiries from a client.

Standard 1.6 Conflict of Interest

What is a Conflict of Interest?

Standard 1.6 addresses conflict of interest. A conflict of interest is a situation that interferes with a registrant's professional duty. Legally, there is no need to prove a registrant's motivation is actually conflicted. Instead, one looks to what a reasonable person would conclude from the circumstances. In other words, a conflict of interest can be actual, potential, or perceived. Therapists should often ask themselves: Would an objective and reasonable person believe there is a conflict of interest in this situation?

For example, if an RP refers a client to a private addiction treatment facility owned by the therapist's friend, a reasonable person would question whether the RP recommended that business because the client needed it, or to benefit their friend.

Managing Conflicts of Interest

Some conflicts of interest can be resolved through a process of disclosure. The steps would be as follows, applied to the above example of recommending an addiction facility:

- disclosing the nature of the relationship in question (e.g., "My friend owns the facility I'm recommending");
- providing alternative options (e.g., "Here are two other places you could get these kinds of services"); and
- reassuring the client that choosing another option will not affect the client's care (e.g., "You're free to choose any of the places to get treatment; you will still be welcome here as my client").

By being transparent, giving options, and maintaining the same level of care, the registrant ensures their client's best interests are being upheld.

Avoiding Conflicts of Interest

Some conflicts are better avoided altogether as disclosure may not remove the risk of harm to the client. Suppose in the above example that the addiction treatment facility agreed to pay the RP a commission for every successful client referral. Even if the RP were to disclose the nature of the financial arrangement and provide the client with other options, a reasonable person could still conclude that the RP's recommendation is being made with their own financial interest in mind, rather than in the best interest of the client. Standard 1.6 considers accepting or paying referral fees to be a conflict of interest.

In other cases, disclosing the conflict may be difficult or impossible. For example, an RP may discover that two separate clients are personally close to each other. The RP will not be able to share that fact, as each client's information is confidential.

Examples of Conflicts of Interest

In addition to those listed in Standard 1.6, the following are examples of conflicts of interest:

- treating individual[6] clients who know each other well;
- having a dual personal relationship with a client or a conflicting professional role with a client (e.g., supervisor, teacher, parenting coordinator, mediator);
- having a personal relationship with a supervisee, e.g., supervising one's family member. In such a case the supervisor's personal relationship with the supervisee could be perceived as interfering with the supervisor's duty to safeguard the well-being of the supervisee's clients;
- selling a product to a client for a profit; and
- taking payment in kind (bartering) for psychotherapy. The therapist may be perceived as having an interest in undervaluing the consideration offered by the client.[7]

Standard 1.6 Scenario 1

Catherine, a psychotherapist, owns a practice down the street from a massage therapy clinic. She has been practising there for less than a year. She is trying to build her practice and wants people to know she is new to the neighbourhood. Catherine offers to give the massage therapist a free dinner and concert tickets in return for referring clients to Catherine's practice.

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

[6] Different considerations apply in couple, family, or group therapy contexts.
[7] See also Standard 6.1 Fees.

Standard 1.6 Scenario 2

Ayawamat, an RP, recently began recommending the new “Nature’s Calm” meditation app. Clients have responded quite well to it. Ayawamat calls the company to explain how helpful the app has been to his clients.

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

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

As well, registrants should not make blanket clinical recommendations, such as providing a testimonial. Ayawamat can give advice on products and remedies, including recommending an app to clients, provided it is within a client-therapist relationship. Such recommendations should be based on a client’s individual needs, the RP’s professional judgment, and a proper assessment.

Standard 1.6 Scenario 3

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

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

Ethan consults with his clinical supervisor who raises a number of concerns about Ethan’s plan: it creates a dual relationship with the client; it discloses details about Ethan’s personal life; and it undervalues the client’s services (six hours are required to match one hour of Ethan’s services).

Ethan decides to hire someone else.

Standard 1.6 Scenario 4

Adwina has been treating Francesca for the last two years to support her in leaving a violent relationship at home. After two sessions with a new client, Ronald, Adwina realizes Ronald is Francesca's ex-partner.

Adwina tells Ronald she has a conflict of interest and can no longer offer him psychotherapy services. Adwina provides Ronald with three referral options. Ronald asks Adwina to disclose the nature of the conflict of interest. Adwina states that she is unable as the conflict of interest is confidential. Adwina consults with a clinical supervisor to determine whether it's necessary to make Francesca aware of any safety concerns.

Practice Question

Which of the following is a conflict of interest?

i. Charging a client for a missed appointment.
ii. Suggesting that a client could buy lavender cream (for relaxation purposes) from your cousin's store after making full disclosure and providing the necessary assurances.
iii. Agreeing to give a brand influencer $100 for every client referred to you.
iv. Giving a clinic owner an inexpensive bottle of wine every new year.

The best answer is iii. It is a conflict of interest to confer a benefit to someone who refers clients to a registrant. Such referrals should be based on the honest opinion of the referral source and not result from any benefit they might have received.

Answer i is not the best answer because one can charge for a missed appointment so long as this fee has been established in advance.

Answer ii is not the best answer as one can make a referral to a family business if one makes full disclosure, indicates that the client can purchase the product elsewhere, and indicates that not following the recommendation will not alter the relationship.

Answer iv is not the best answer because a token gesture given once a year would not reasonably be understood as conferring a benefit that would alter behaviour. All conflict-of-interest provisions are governed by reasonableness.

Standard 1.7 Dual Relationships

Standard 1.7 cautions registrants about having additional roles or connections with a psychotherapy client. Dual relationships are one of the most common issues investigated by CRPO in complaints and reports about registrants.

Boundaries

An important part of avoiding dual relationships is to maintain professional boundaries. A boundary is the "'edge' of appropriate professional behavior, transgression of which involves the therapist stepping out of the clinical role or breaching the clinical role. Boundaries define the expected and accepted psychological and social distance between practitioners and patients [or clients]."[8]

CRPO distinguishes a boundary crossing from a boundary violation. "Boundary crossing occurs any time a professional deviates from the strictest professional role. Boundary crossings can be helpful, harmful, or neutral. Boundary crossings can become boundary violations when they place clients at risk for harm."[9]

Maintaining professional boundaries is always the responsibility of the RP and not the client. The following examples describe types of boundary crossings and provide guidance to avoid or manage them.

Self-disclosure
Therapists must be cautious when disclosing personal information about themselves to clients. Revealing personal details must be of therapeutic benefit and shared with rapport and sensitivity. When a registrant discloses information about their private life in a non-therapeutic manner, it may confuse or upset the client. Non-therapeutic self-disclosure suggests that the professional relationship is serving the needs of the therapist rather than the client's best interests.

Standard 1.7 Scenario 1

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

Self-disclosure can also involve sharing personal views, reactions, or opinions. Everyone has personal opinions and RPs are no exception. However, therapists should not use their position to promote personal opinions or causes with clients (e.g., religion, politics, lifestyle choices).

[8] Aravind, V. K., Krishnaram, V. D., & Thasneem, Z. (2012). Boundary crossings and violations in clinical settings. Indian journal of psychological medicine, 34(1), 21-24.
[9] Knapp, S. and Slattery, J. M. (2004). Professional boundaries in nontraditional settings. Professional Psychology, 35, 553-558.

Standard 1.7 Scenario 2

Helen pushes for her therapist's views on immigration. At first Karen, the therapist, resists, but eventually says she has some concerns about abuses of the immigration system.
Karen says she has heard, often directly from clients, about how they have lied to immigration authorities. Helen is surprised by this response and discontinues therapy.

In this case, there appears to be no therapeutic benefit to the client for the registrant to share her personal opinion. Even though a client may elicit the therapist's thoughts, the RP does not know the impact and potential harm of sharing personal opinions with clients.

Giving or Receiving of Gifts

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

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

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

Standard 1.7 Scenario 3

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

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

Ignoring Established Customs

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

Touching
Some modalities of psychotherapy, e.g., somatic therapies, may include touch as part of the clinical work. However, personal touching, e.g., comforting contact such as a hand on the client's hand or shoulder, may be easily misinterpreted. A client may view an act of encouragement or consolation by an RP as a crossing of client-therapist boundaries or even a sexual gesture. When it comes to touch between a therapist and client, even if that touch is initiated by the client (e.g., asking for a hug), registrants are encouraged to act cautiously and document any instances. CRPO has a zero-tolerance policy for sexual touching of a client by a registrant, as this constitutes sexual abuse (see Standard 1.8, below).

Boundaries with Non-clients
Registrants must be cautious not to unintentionally cross from a personal relationship into a therapist-client relationship. This means not behaving toward a personal contact in a way that makes them believe they are a psychotherapy client. For example, accepting gifts from a neighbour in exchange for providing regular sessions of personal advice could be interpreted as providing psychotherapy. This kind of boundary crossing is especially risky because once a person is considered a client, the registrant will be expected to uphold all CRPO standards such as consent, confidentiality, and record-keeping. Since the relationship started off as personal, it is unlikely there will have been a consent process, guarantee of confidentiality, or creation of a record. This exposes the registrant to significant liability for failing to uphold numerous practice standards.

Pre-existing Connections

Some dual relationships are not the result of boundary crossings. Rather, a registrant may need to consider taking on a new client who they know of in their community. Similarly, an RP might discover, after having already begun therapy with a client, that they have a personal connection to that client. Standard 1.7 provides guidance on these situations. These situations may be unavoidable in small communities. In deciding how to manage such situations, consider the following questions:

- Is the pre-existing relationship close or distant?
- What is the nature of the therapy being sought or provided (duration, modality, presenting issues)?
- How hard would it be for the potential client to seek help from a different therapist?
- Would safeguards (e.g., informed consent, clinical supervision) be sufficient to manage any risk posed by the pre-existing connection?

Each situation is different and may be ambiguous.

Standard 1.7 Scenario 4

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

David reflects on the situation. He notes he sees this client at hockey games regularly and that the client's role as coach is closer than that of a fellow parent or spectator. In David's community, there are other psychotherapists offering in-person services. Online therapy is another option.

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

The example is intended to highlight the difficulty that exists when drawn into a dual relationship and how problematic it may be to extricate oneself and reestablish normal relationships.

Standard 1.8 Undue Influence and Abuse

Standard 1.8 deals with undue influence and abuse. Undue influence refers to using the power of the therapist's position to sway a client's decision. For example, it would be a form of undue influence, and therefore professional misconduct, to suggest who should be in or out of the client's will.

Abuse refers to improper, harmful conduct. There are several kinds of abuse, including verbal, physical, psychological, and emotional. This section focuses on sexual abuse, which is a particularly harmful, and unfortunately, regularly occurring form of abuse.

Sexual Abuse

Sexual abuse is an extreme boundary violation. Clients have a right to receive care from a psychotherapist in a manner that respects the professional boundary between the client and the health professional, and ensures the client is free from harm. Given the inherent power imbalance between a psychotherapist and their client, any sexual contact by the therapist can cause serious harm to the client.

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

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

Under the RHPA, "client" includes a former client within one year of termination of the therapist-client relationship. College policy states that sexual conduct by a registrant toward a former client must be strictly prohibited within five years of termination, and longer if a power imbalance persists.

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

Examples of Sexual Abuse

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

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

Standard 1.8 Scenario 1

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

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

Preventing Sexual Abuse

It is always the responsibility of the registrant to prevent sexual abuse. Psychotherapists should consider ways of preventing the perception of sexual abuse. For example, if a client begins to tell a sexual joke, or makes comments about the appearance or romantic life of the psychotherapist, the psychotherapist must act to stop it. If the client asks for a date or initiates sexual touching, the RP must say "no," explain why such behaviour between a client and therapist is inappropriate, discourage future incidents, and set appropriate boundaries. If the client does not adhere to the boundaries set by the registrant, or if the client's behaviour has interfered with treatment, the registrant should transfer care of the client to another practitioner.

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

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

It is normal for clients and therapists to have sexual *thoughts* or *feelings* toward each other.

Responding appropriately to such transference or countertransference can assist in the therapy process. The key is for the registrant to seek clinical supervision, personal therapy, or consultation, and not to allow those thoughts or feelings to develop into any sexual touching, behaviour, or remarks by the registrant toward the client.

When a client develops feelings for the therapist, the RP must take action to stop inappropriate contact from proceeding. Registrants are reminded that in the context of the therapeutic relationship, the client is never a mutual participant due to an imbalance of power. By definition, clients come to an RP because they are seeking care from that professional. Clients share sensitive, personal information and rely on their therapist, who has knowledge and skill, for help. Given this reliance and the inherent power imbalance, “consent” is not valid or legitimate.

Where a registrant has developed sexual feelings for a client, they should either

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

Standard 1.8 Scenario 2

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

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

Donna cautions Michael that he and Adoerte are both at significant risk. Donna also says that it is important for Michael to transfer Adoerte’s care right away. Donna recommends that Michael refrain from asking Adoerte to join him for a coffee, even after a transfer of care. Donna is correct in her assessment of the situation and her recommendations are sound.

Treating a Spouse or Partner

Treating a spouse or partner is also considered sexual abuse. A number of court decisions have established that a regulated health professional cannot treat their spouse, except in very limited circumstances, such as an emergency. RPs must not provide assessments or therapy to a spouse or partner and need to direct them to another practitioner.

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

Handling of Allegations of Sexual Abuse by the College

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

At a discipline hearing, the identity of the client is protected. The client may have a role at the hearing; e.g., if a finding is made, the client might make a statement on the impact of the sexual abuse. Where the sexual abuse involves sexual intercourse or particular kinds of sexual touching, and a finding is made, there is a mandatory minimum penalty: the therapist's registration will be revoked for a period of at least five years. In all cases where a finding of sexual abuse has been made, the registrant will be reprimanded, their registration will be suspended for a period of time, and they may be ordered to pay for the costs of any counselling and therapy needed by the client. The College also has a fund for counselling or therapy needed by clients alleging sexual abuse by a registrant.

If a registrant has reasonable grounds to believe that a regulated health professional (whether a registrant of this College or another college) has engaged in sexual abuse, the registrant is required by law to make a report. In this case, the report is made to the Registrar of the college where the health professional is a registrant. This reporting obligation is discussed in detail in the section on Standard 1.3.

Because sexual abuse is such an important issue, colleges take it very seriously. Each college must take steps to prevent sexual abuse by its registrants; e.g., CRPO's Client Relations Committee is required to develop a sexual abuse prevention plan that will educate RPs, the public, and College personnel in this regard.

Practice Question

Which of the following is clearly sexual abuse?

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

The best answer is ii. Such pictures, which could be seen by clients, sexualize the atmosphere at the clinic which is inappropriate in a health care setting.

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

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

Answer iv invites consideration but is not the best answer because the parent may not be the registrant's client. However, it would still be sexual misconduct to date a child client's parent due to the power imbalance between the therapist and the parent as the child's close family member or substitute decision-maker.

Sexual Misconduct

In the RHPA, the term “sexual abuse” is defined to include conduct by registrants toward clients. Inappropriate sexual behaviour toward non-clients may be referred to as “sexual misconduct.” Sexual misconduct may involve a client’s representative, family, or partner. It would also include sexual conduct toward an RP’s supervisees and students, given the RP’s position of authority over these individuals. Sexual misconduct would also include non-consensual sexual activity by an RP in their personal life. As with sexual abuse of clients, CRPO does not tolerate these other forms of sexual misconduct.

Standard 1.8 Scenario 3
Amanda, a psychotherapist, has been treating Joseph, a minor, for a few months. Because Joseph is 14, he is often dropped off and picked up from his appointments by his parents or older siblings.

On the weekend, Amanda goes out to a concert with a few friends, where she meets Zander. After spending much of the concert together, they decide to meet up the following day for a coffee date. While on the date, Zander mentions that he and Amanda technically first met a few months ago when he picked up his brother from therapy.

Zander, knowing his brother is a client of Amanda, may have been influenced by the power dynamic and understanding that Amanda is a trusted professional who has been helping his brother. While Amanda did not commit sexual abuse because Zander is not a client, it would be inappropriate to continue the relationship once she is made aware that her date is the sibling of a client. Under the undue influence and abuse standard, RPs are expected to refuse sexual advances from clients, their representatives, or family members.

Standard 2.1: Consultation, Clinical Supervision and Referral

Standard 2.1 discusses how to work within the limits of one's abilities as a professional.

Scope of Practice

A key concept in defining professional limits is *scope of practice*. A regulated health profession's scope of practice is a general description of what that profession does. Under the *Psychotherapy Act*, the scope of practice statement reads as follows:

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

In Ontario, no health profession has an exclusive scope of practice. Members of other professions have overlapping scopes of practice and can do some of the same work that RPs do.

It is acceptable for RPs to incorporate some non-psychotherapy activities as an adjunct to their main psychotherapy practice. For example, an appropriately trained RP might guide clients in yoga poses or breathing exercises to promote grounding and relaxation, before engaging in psychotherapy.

When working outside the scope of practice of psychotherapy, registrants need to be vigilant to avoid treating or advising clients in ways that pose a risk of harm.

Standard 2.1 Scenario 1

In therapy with an RP, a client raised concerns about medication they were prescribed by their psychiatrist. After the session, the RP texted the client links to articles about possible adverse effects of that medication. The client reported to CRPO that the RP was discouraging them from taking their medication.

The RP explained they intended the article to be just one factor the client should consider, and that the client should speak with their physician. CRPO advised the RP to be cautious in the future as providing information about medication is outside the scope of practice of psychotherapy and could create a risk of harm to clients.

Individual Competence

No RP has the knowledge, skill, and judgment to practise every aspect of psychotherapy. Rather, each RP has their own area of competence and is required to practise within that area. Standard 2.1 discusses the obligation to provide services only if a registrant is competent to do so. Standard 2.1 also explains the steps to take if a situation falls outside a registrant's scope of competence. These situations include, but are not limited to, times when

- a client presents with a complex condition or one the registrant does not have experience working with;
- a registrant plans to learn a new modality of therapy; or
- a registrant plans to serve a new client population, e.g., seeing couples or families instead of

only individual clients; beginning work with clients from an Indigenous community without prior experience.

Standard 2.1 Scenario 2

Anup is contacted by his client's lawyer who requests he draft a detailed letter to be used in court. The lawyer explains the purpose of the letter is to make custody recommendations for the client's children. Anup has never drafted a letter for court and has only met his client's wife on one occasion during a joint session. Anup has never met his client's children.

Anup drafts a letter recommending his client obtain full custody of his children. He presents information relayed by his client as facts, e.g., that the children are not safe to be in the custody of their mother.

In this scenario, Anup has acted improperly and outside his area of competence. Performing parenting assessments requires specific education and training. Anup has made recommendations that could cause harm to the client's children, and Anup did not follow a proper process.

Standard 2.1 Scenario 3

Pat receives a request from parents who are seeking services for their child. Pat has never worked with children before but has been considering ways to expand their practice for some time. Pat wonders if this might be a good opportunity to expand their practice to include working with children. Pat reviews section 2 of the *Professional Practice Standards*, which notes that registrants require upgrading before changing their area(s) of practice.

After careful consideration, Pat decides that based on their current training and experience, they are not yet competent to provide services to children. Pat decides to upgrade their skills by taking relevant courses. Once they begin practising with child clients, Pat engages a clinical supervisor who has experience in the field to ensure they are providing safe and effective care.

Standard 3.1 Confidentiality

This section summarizes key aspects of legislation related to Standard 3.1. The most relevant legislation is PHIPA, which deals with health information privacy and applies to all regulated health professions in Ontario. Registrants may also need to comply with the *Personal Information Protection and Electronic Documents Act, 2000* (PIPEDA), which is federal legislation that applies to non-health personal information used in commerce. For example, PIPEDA may apply if a registrant teaches courses or sells e-books, because these may be considered business activities outside the provision of psychotherapy to clients.

Personal Heath Information Protection Act (PHIPA)

PHIPA is Ontario's health information privacy legislation.[10] CRPO and the Office of the Information and Privacy Commissioner of Ontario (IPC) have separate but related jurisdiction over health information privacy. While CRPO may refer allegations of misconduct by a registrant to a discipline hearing, it cannot require a registrant to take specific action regarding a health record. In contrast, the IPC can make various orders regarding personal health information, e.g., directing a health information custodian to correct errors in a health record or to grant access to a record to an authorized individual.

Personal Health Information
Personal health information refers to almost anything that would be in an RP's client files or discussed between an RP and the client. Information is covered by PHIPA if it

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

Health Information Custodians
The health information custodian ("custodian") is a person or organization responsible for health records. If an RP is working independently or in sole practice, they are the custodian of any health information collected during the course of practice. If an RP works for a health organization such as a community health centre or a mental health agency, the organization is usually the custodian of health records. The custodian develops privacy policies for their organization, which must meet PHIPA

[10] While this section provides an overview of PHIPA, CRPO has developed more detailed resources, including a step-by-step guide for developing a health information privacy plan.

requirements and explain how health information will be protected. Privacy policies should clearly explain how and when personal health information will be collected, used, and disclosed.

Two or more psychotherapists who work together could decide to act as a single organization for the purposes of PHIPA and could create a single privacy policy. This would allow for consistent record-keeping practices, and the therapists would have shared responsibility for complying with PHIPA. Alternately, they could decide to be separate custodians. Under this approach, each therapist would be responsible for creating their own privacy policies.

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

Standard 3.1 Scenario 1

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

Collection, Use and Disclosure of Personal Health Information

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

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

1. Disclosure to Other Healthcare Providers

Under PHIPA, RPs may assume that they have a client's implied consent to disclose personal health information to the client's other health providers unless the client instructs otherwise.[11] For example, in circumstances where it is necessary to provide care to an individual, but not reasonably possible to obtain consent in a timely manner, the client's health information may be shared with other providers. However, to avoid misunderstandings, many practitioners do not disclose information to other providers without the client's explicit consent, except in emergencies. Caution is particularly important where the information is sensitive.

Despite the circumstances in which sharing a client's personal health information is permitted, when a client or client's substitute decision-maker says that they do not want information to be shared, the

[11] Section 20(2). The IPC refers to this as the "circle of care". See Information and Privacy Commissioner of Ontario, *Circle of Care: Sharing Personal Health Information for Health-Care Purposes* (2015): online: https://www.ipc.on.ca/wp-content/uploads/resources/circle-of-care.pdf.

information cannot be disclosed unless another provision in PHIPA permits it, e.g., to prevent a significant risk of serious harm.[12]

2. Disclosure to Members of the Client's Family
Generally speaking, RPs must obtain consent before disclosing personal health information to members of a client's family. However, personal health information may be disclosed in emergencies. It may also be disclosed for the purpose of contacting family members, friends, or other persons who may be potential substitute decision-makers, if the individual is injured, incapacitated, or ill, and not able to provide consent. This may be particularly relevant for registrants working in acute care settings.

3. Disclosure Related to Risk
An RP may disclose a client's personal health information if the RP believes on reasonable grounds that disclosure is necessary to eliminate or reduce a significant risk of serious bodily harm to the person or anyone else.[13]

4. Missing Persons Act
Ontario's *Missing Persons Act, 2018* allows a police officer to require anyone to produce records for the purpose of locating a missing person. This power does not involve criminal investigations but is meant to ensure the safety of missing persons. The Act has several safeguards, including the following:

- An officer must have reasonable grounds before making an urgent demand for records, and they must use a specific form.
- If the officer agrees, the person with the relevant information may provide it orally instead of providing written records.
- Police officers must report their use of urgent demands for records within their police department.
- Police departments must report annually on their use of urgent demands for information to locate missing persons.
- The Minister of Community Safety and Correctional Services must review the Act within five years.

5. Disclosure under Other Laws or for Legal Proceedings
PHIPA allows disclosure of personal health information under other laws or for the purpose of a legal proceeding. For example, PHIPA permits disclosure of personal health information to CRPO if this information is required in a College process such as a complaint investigation or the Quality Assurance Program.

[12] The IPC refers to this as a 'lock-box'. See Information and Privacy Commissioner of Ontario, *Lock-box Fact Sheet* (2005), online: https://www.ipc.on.ca/wp-content/uploads/resources/fact-08-e.pdf.
[13] For additional guidance about this limit to confidentiality, see CRPO's guideline, *Disclosing Information to Prevent Harm*.

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

- The *Healthcare Consent Act, 1996* (HCCA) or *Substitute Decisions Act* allow disclosure for the purposes of determining, assessing, or confirming capacity.

- Various Acts deal with compensation or benefits for injury or disability, e.g., workplace injury, social benefits, or motor vehicle accidents. If a client needs to prove the nature or extent of their disability, injury, or recovery, registrants may be requested or required to provide health information about the client.

- Disclosure to an investigator or inspector is permitted when authorized by a warrant, or by any provincial or federal law, for the purpose of complying with the warrant or facilitating the investigation or inspection.

Additionally, as discussed under Standard 1.3: Mandatory Reports, there are some circumstances in which disclosure of personal health information is required.

Practice Question

Jessica and Alyia are getting divorced and advocating custody arrangements for their children. Jessica is alleging Alyia suffers from depression and should not be given custody. Jessica's lawyers contact Alyia's psychotherapist, Kamala, and request disclosure of Alyia's client record. What should Kamala do?

i. Disclose Alyia's record to Jessica's lawyer.
ii. Disclose Alyia's record to the judge directly.
iii. Acknowledge the request, then make Alyia aware and ask whether she consents to the disclosure.
iv. Call Jessica's lawyer and refuse to provide the record because Alyia does not have depression.

Answer iii is the best answer. Unless an exception applies, clients must consent to disclosure of their record to a third party. One exception is if the registrant receives a summons, subpoena, or court order. If a registrant is unsure about how to respond to legal requests, they should contact their clinical supervisor and legal counsel.

Answers i and ii are not the best answers because there is no indication that Alyia has consented to the disclosure, or that a legal exception applies allowing for disclosure without consent.

Answer iv is not the best answer because even disclosing the identity of a client to a third party is a disclosure of confidential information.

Access to Personal Health Information

Every client has a right to access their own personal health information. One important exception is when granting access would likely result in a risk of serious harm to the client's treatment or recovery, or a risk of serious harm to the client or another person. An RP or other custodian who receives a written request must respond by either granting or refusing the request within 30 days. It is also a good idea to respond to verbal requests as soon as possible. If the request cannot be fulfilled within 30 days, the person should be advised of this in writing.

If a person makes a request to access their personal health information, the custodian must do one of the following:

- permit the person to see the record and provide a copy at the person's request;
- determine, after a reasonable search, that the record is unavailable, and notify the person of this in writing, as well as their right to complain to the IPC; or
- determine that the person does not have a right of access because of the risk of serious harm and notify the person of this as well as their right to complain to the IPC.

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

Correction of Personal Health information

Individuals generally have a right to request corrections to their own personal health information.[14] The timelines noted above regarding access to personal health information apply similarly to correction requests.

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

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

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

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

- prepare a concise statement of disagreement that sets out the correction that the RP refused to make;
- require the registrant to attach the statement of disagreement to their clinical records and disclose the statement of disagreement whenever the RP discloses related information;
- require the RP to make all reasonable efforts to disclose the statement of disagreement to anyone to whom the registrant has previously disclosed the record; and

[14] For more information about record-keeping, refer to section 5 of the Standards.

- make a complaint about the refusal to the Information and Privacy Commissioner.

Complaints
Every health information custodian must have a system in place to deal with complaints regarding personal health information. Clients should also be aware of their right to complain to CRPO and the IPC.

Practice Question

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

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

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

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

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

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

Personal Information Protection and Electronic Documents Act (PIPEDA)

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

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

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

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

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

Limiting collection
An organization must collect only information needed for identified purposes.

Limiting use, disclosure and retention
An organization must use, disclose, and retain only personal information that is necessary for the identified purposes, and is obtained with consent. It should be retained no longer than necessary.

Accuracy
Personal information must be as accurate, complete, and up-to-date as is necessary for the purposes for which it is to be used.

Safeguards
An organization must protect personal information with appropriate safeguards in order to protect against loss, theft, unauthorized access, disclosure, copying, use, or modification.

Openness
An organization must make its privacy policies readily available.

Individual access
Upon request, an individual must be informed of the existence, use, and disclosure of their personal information, and be given access to it. An individual may request corrections to the information. Access may be prohibited in limited circumstances.

Challenging Compliance
An organization must have a complaints procedure relating to personal information and must investigate all complaints.

Standard 3.2 Consent

This section expands on Standard 3.2. Clients have the right to consent (agree) before receiving healthcare. A practitioner who provides an intervention without the client's consent could face criminal charges (e.g., for assault), a civil suit (e.g., for compensation), or professional consequences (e.g., a disciplinary action by their college). The rules on obtaining consent to treatment come mainly from the HCCA. The HCCA applies to all regulated health professionals in Ontario. Registrants should familiarize themselves with this statute. The key principles are covered here.

Psychotherapy and consent are both ongoing processes. At minimum, consent is obtained at the outset of treatment. Once initial consent has been provided, it will often be appropriate to rely on the client's implied consent to continue with therapy (indicated by the client continuing to attend and participate). However, explicit consent will need to be sought if there are changes in the nature of the therapy or the client's condition. RPs need to use professional judgment to apply the principles of informed consent in a way that supports client autonomy and effective treatment.

Elements of Valid Consent

To be valid, a client's consent must meet the following criteria.

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

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

Be voluntary
The psychotherapist cannot pressure a client to consent to an intervention. This is particularly important when dealing with younger or older clients who may be overly influenced by family members or friends. This is also important where the assessment or therapy will have financial or legal consequences for the client (e.g., the client will lose their job or be penalized if the client refuses to consent). The registrant should inform the client that consent is the client's choice.

No misrepresentation or fraud
An RP must not make claims about the assessment or therapy that are not true, e.g., telling the client that a particular therapy will result in improvement when in fact the results are uncertain. Clients must be given accurate, factual information and opinions based in truth and fact.

Be informed
It is necessary that the client understand what they are agreeing to. The registrant must provide information to the client before asking the client to give consent, and the registrant must respond appropriately to client requests for additional information. This issue is covered in more detail below.

Standard 3.2 Scenario 1
Isabella, an RP, proposes that her client Liam, who has indicated that he is overwhelmed in groups, go on a rural retreat. After Liam arrives at the retreat, he learns that there will be strictly enforced rules of total silence. There is no way for Liam to leave and he finds the silence emotionally excruciating. Liam complains to CRPO.

Isabella tells CRPO that she was relying on Liam's implied consent by his description of feeling overwhelmed by people in groups. Isabella was afraid Liam would not go if he knew about the strict silence. The ICRC issues a decision critical of Isabella for not obtaining informed consent because: she did not explain the nature of the retreat, how the retreat would help Liam, or set out alternatives; she misrepresented the benefits of the retreat, as there was little evidence to support her view that a strict regime of total silence would help Liam; and she did not explain the emotional risks of attending the retreat.

What Makes Consent Informed

In order for consent to be considered informed, clients must understand what they are agreeing to. Generally speaking, the following information should be provided to clients when seeking their consent:

Nature of the Assessment or Therapy
The client must have a reasonable understanding of what the RP is proposing to do. For example, before beginning therapy, therapists should explain why they are asking personal questions and why the client should be candid.

Who Will Be Doing the Assessment or Therapy
Will the psychotherapist be doing the intervention personally or will a supervisee, supervisor, or colleague do it? If it is another person, are they registered with CRPO, another college, or unregistered? Is the treating therapist receiving clinical supervision?

Material Risks and Side-effects
The RP must explain any material risks and side-effects. A risk or side-effect is material if a reasonable person would want to know about it. For example, if there is a high likelihood of a modest side-effect (e.g., emotional distress), the client should be told. Similarly, if there is even a low risk of a serious side effect (e.g., triggering traumatic memories), the client needs to be told.

Reasons for the Assessment or Therapy
Therapists must explain why they are proposing the intervention. What are the expected benefits? How does the intervention fit in with the overall treatment goals? How likely is it that the hoped-for benefits will occur?

Consequences of No Intervention
One option for a client is to do nothing. The therapist should explain to the client what could happen if the client chooses not to consent to the intervention. If it is not clear what will happen, the therapist should say so, providing outcome scenarios if possible.

Particular Client Concerns
If some aspect of the intervention would be of special interest or concern to the client, the client should be informed. This requires the therapist to be reasonably aware of and sensitive to particular client concerns or interests, such as strongly held values or beliefs, or even certain personal considerations.

For example, clients ascribing to a particular religion would need to know if an aspect of the intervention would violate their beliefs.

Alternatives
If there are reasonable alternatives to the intervention, the client must be told. Even if the psychotherapist does not recommend the option (e.g., it is more aggressive or carries more risk), they should describe the option and tell the client why they are not recommending it. Also, even if the therapist does not offer the alternative intervention (e.g., it is provided by a member of a different profession, such as a physician), they must inform the client, if it is a reasonable option.

Ways of Receiving Consent

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

Verbal Consent
A client may give consent by a verbal statement. Verbal consent is the best way for the therapist and client to discuss the information and ensure the client really understands it. Making a detailed note of the discussion in the client record may provide useful evidence later on, if there is a complaint. A note is especially important when written consent is not obtained.

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

Implied Consent
Clients may give consent by their actions. For example, the registrant may consider the client willingly attending and sharing information in therapy as implied consent to continue participating. Similarly, a client could simply nod their head to indicate consent. The main disadvantage of implied consent is that the RP has no opportunity to check with the client to make sure they truly understand what is being agreed to. Therefore, registrants should not rely on implied consent for significant or complex decisions and in these situations should obtain verbal or written consent.

Standard 3.2 Scenario 2
Ava, a therapist, meets a new client, Emma, for video-conference therapy. Emma complains about feeling stressed and tired. Ava says: "I would like to better understand your personal and family background and your health history. There could be a lot of things making you feel tired and stressed, and this information will help me understand what you're going through. If you are uncomfortable with any of my questions, please let me know. OK?" Emma nods her head.

Ava can assume that she has obtained implied consent to proceed. Because the therapy is virtual, Ava must remain particularly sensitive to any changes in Emma's body language and tone of voice. It would be prudent of Ava to reaffirm consent at appropriate intervals during the session.

Consent Where the Client Is Incapable

A client is not capable of giving consent when they do not understand the information provided, or when they do not appreciate the reasonably foreseeable consequences of the decision.

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

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

Substitute Decision-Makers

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

- The substitute must be at least 16 years of age. However, there is an exception where the substitute is the parent of the client, e.g., a 15-year-old mother can be the substitute decision-maker for the care of her child.

- The substitute must be capable. In other words, substitutes themselves must understand the information and appreciate the consequences of the decision.

- The substitute must be able to act (i.e., available) and willing to assume the responsibility of giving or refusing consent.

- The substitute must not be prohibited by a court order or separation agreement from acting as the client's substitute decision-maker.

- There must be no higher-ranked substitute who wishes to make the decision. (See *Rankings for the Substitute Decision-Maker*, below.)

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

The HCCA also lays out the following principles on which a substitute decision-maker must base their decisions:

- The substitute must act in accordance with the last known capable wishes of the client. For example, if a terminally ill client, while still thinking clearly, said: "Don't send me to the hospital, I want to die at home," the substitute needs to obey those wishes, in so far as it is possible to do

so.

- If the substitute is not aware of the last known capable wishes of the client, or if the last known wishes are unattainable, the substitute must act in the client's best interests. For example, if a proposed therapy is simple and painless, would make the client more comfortable through a difficult illness, and has little risk of harm, the substitute decision-maker should, in general, consent to it.

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

Rankings for the Substitute Decision-Maker
The ranking of the substitute decision-maker is as follows (from highest ranked to lowest ranked):

1. A court appointed guardian of the person.

2. A person who has been appointed attorney for personal care. The client would have signed a document appointing the substitute to act on the client's behalf in health care matters if the client ever became incapable.

3. A person appointed by the Consent and Capacity Board to make a health decision in a specific matter.

4. The spouse or partner of the client. A partner is defined in the HCCA as "either of two persons who have lived together for at least one year and have a close personal relationship that is of primary importance in both persons' lives." This means a partner does not need to be a spouse or sexual partner of the client.

5. A child of the client, 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 siblings of the client), and they cannot agree, the Public Guardian and Trustee may then make the decision.

Children and Consent to Therapy

Child and family therapy can present complex consent and capacity issues, including whether a child has the legal capacity to consent to their own therapy. While RPs sometimes base conclusions about capacity on a child's age, the issue is more complex, and capacity needs to be determined on a case-by-case basis.

Many older children (e.g., 12 to 17 year olds) are capable of consenting to their own psychotherapy. They do not require a substitute decision-maker. In borderline cases, registrants should document their clinical opinions about the young person's capacity, including how capacity was determined. Capacity is usually determined by discussing the proposed therapy with the child and asking questions about their understanding of the therapy itself and of the implications of participating or not participating. Even if a child has the capacity to consent to treatment, registrants should consider with the child whether the psychotherapy is in their best interests in their particular context, and whether some parental involvement in the therapy process is desirable.

In general, young children may not understand the nature and implications of deciding to receive therapy or not. While capacity needs to be determined on a case-by-case basis, many young children will require a substitute decision-maker, usually a parent. Unless a parenting agreement or order states otherwise, the presenting parent can make decisions about the child receiving therapy. In situations of two parent families, it is legally permissible to accept the consent of one parent on behalf of another unless the RP has reason to believe that the other parent does not agree. However, there are risks in not performing due diligence. For example, failing to involve both custodial parents in a child's treatment can limit successful outcomes for the child, and is one of the most common complaint issues received by the College.

Registrants are advised to have policies and practices in place to manage issues related to obtaining consent to treat children and adolescents. For example, when treating a young child whose parent acts as a substitute decision-maker, it is advisable to inquire if the child has another custodial parent, obtain the other parent's consent if applicable, and review any relevant parenting agreements or orders. Including both custodial parents, where applicable and possible, can reduce the perception of bias on the part of the therapist (i.e., that the therapist is more aligned with one parent than another). This perceived bias can ultimately interfere with the child's care. In situations where the registrant cannot reach the other parent to obtain consent, the registrant will consider the best interests of the child in making all decisions about proceeding with psychotherapy and will document their attempts to reach the parent as well as the rationale for all clinical decisions made.

Therapy with children in high-conflict child custody and access cases, especially those coupled with intimate partner violence, is highly complex and requires significant training and experience supported by regular supervision and consultation. In these situations, registrants may be required to make complex decisions about psychotherapy with children based on the best interests and wishes of the child. All decisions must be made with appropriate supervision and clearly documented. In such cases, the onus will be on the registrant to provide support justifying their decisions.

Treatment cannot be provided if joint substitute decision-makers (e.g., two parents with custody) do not agree with each other about whether to consent. In such a situation, the Public Guardian and Trustee, the Consent and Capacity Board (discussed below), or a court, may become involved. In the interim, the child will not be able to receive the therapy disputed by the parents.

Standard 3.2 Scenario 3
Olivia is six years old. Her mother schedules an intake appointment for play therapy to deal with problematic emotions and behaviour amid the parents' divorce. Due to Olivia's vulnerable age and her lack of understanding of the nature of the proposed therapy, the RP determines Olivia does not have the capacity to consent to treatment, and seeks consent from her substitute decision-maker, in this case her parent(s). The RP asks if there is another parent with custody, discusses how the other parent may wish to be involved in therapy, requests to speak to the other custodial parent and get their signature on the consent form, and requests to be sent any parental agreements or orders regarding consent to healthcare.

Standard 3.2 Scenario 4
Noah is 13 years old. His father has been paying for and driving him to therapy. Noah's therapist has determined that Noah understands therapy and the foreseeable consequences of participating or not participating, and therefore, has the capacity to consent to treatment. The therapist does not discuss Noah's treatment or personal health information with Noah's father, except with Noah's consent.

Emergencies

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

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

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

Standard 3.2 Scenario 5
Anna, a psychotherapist, is seeing her client Paula at the office. Paula suddenly collapses in an apparent heart attack. There is a defibrillator in the room across the hall from Anna's office. Without trying to get consent from a substitute decision-maker, Anna uses the defibrillator. It is appropriate for Anna to act without consent in these circumstances.

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

Practice Question
Obtaining a broad consent, often called a blanket consent, in writing from the client on their arrival at the office is usually a bad idea because

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

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

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

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

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

Practice Question

Which of the following is the highest ranked substitute decision-maker (assuming that everyone is willing and able to act as a substitute)?

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

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

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

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

Consent and Capacity Board

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

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

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

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

Standard 3.3 Communicating Client Care

Standard 3.3 reflects the importance of communicating with other providers about a client's care, when appropriate. These other providers may have their own practices, work in organizations such as clinics or hospitals, or they may work alongside an RP in a multidisciplinary setting.

Multidisciplinary Settings

Multidisciplinary settings are places where members of different professions work together and where clients may be seen by multiple health care providers. Unique issues can arise in these situations. Registrants can ask themselves the following reflection questions to help plan for, arrange, and navigate multi-disciplinary practice issues:

- Who is the health information custodian that owns the records?
- Will the setting have shared records, or will the RP have separate records?
- How does the setting deal with the wording used in the records? Will everyone use the same abbreviations?
- What happens if the RP leaves to practise elsewhere? Will the client be told where the therapist has gone? Will another therapist from the setting take over the client's care? Will the client be given a choice? (The client should be given a choice, although some settings will only do so if the client asks.)
- Will there be one person who has overall responsibility for the care of the client? If so, who? If not, how will the client's care be coordinated?
- How will disagreements in the approach to the care of the client be dealt with? If it is the RP who disagrees, when and how do they tell the client?
- How will the client be made aware of any of the above?

Practice Question

Which of the following is a benefit of interprofessional collaboration?

i. There is less record-keeping required.
ii. Client care can be better coordinated.
iii. Clients can be charged more fees.
iv. All of the above.

The best answer is ii. When healthcare providers treating the same client share information, treatment is better coordinated, and health care providers do not give inconsistent treatment.

Answer i is not the best answer because the amount of record keeping will usually be about the same. There may even be more record-keeping involved as healthcare providers record the discussions they have with each other.

Answer iii is not the best answer because charging more fees does not benefit the client. Hopefully, if care is well coordinated the client will require less treatment and the overall fee charged to the client will be less.

Answer iv is not the best answer because answers i and iii are not the best answers.

3.4 Electronic Practice

Standard 3.4 deals with electronic practice. Electronic practice, or virtual therapy, occurs where therapist and client meet using communication technology (e.g., telephone, video-conference, secure messaging platform), instead of face-to-face. As this topic is extensive, CRPO has developed several resources to assist registrants with electronic practice. In addition to Standard 3.4, these include the following:

- an Electronic Practice Guideline;
- a checklist on security for electronic practice;
- advice on selecting a communication platform;
- FAQs about cross-border electronic practice; and
- an interactive Cross-border Therapy Tool for identifying inter-jurisdictional practice issues.

Readers are encouraged to review these materials and reflect on the following scenarios and practice questions.

Standard 3.4 Scenario 1

Yara, an RP, has a client who is moving from Ontario to Prince Edward Island, and would like to continue therapy electronically. Yara notices that PEI has a college for counselling therapists. After contacting them, she learns the title “counselling therapist” is restricted in PEI to members of that college. Because Yara uses the title “registered psychotherapist” or “RP”, she concludes she would not contravene the rules in PEI by continuing to provide services to her client after the move.

Standard 3.4 Scenario 2

Eugenia, an RP, offers virtual therapy to clients. In one session, she notices the surroundings of a regular client appear to be very different. She inquires and the client tells her they are on vacation. Eugenia asks for details about the client’s location, explaining that without this information, it may be more difficult for her to contact someone in an emergency if there was such a need.

Practice Question

Tatianna, an RP (Qualifying), is considering expanding her practice to include electronic as well as in-person therapy. Which of the following actions does she not need to take?

i. Confirm that her professional liability insurance coverage applies to electronic services.
ii. Discuss with her clinical supervisor her readiness to offer this form of service.
iii. Familiarize herself with the video-calling features on Facebook.
iv. Prepare policies and templates to facilitate the informed consent process with clients.

The best answer is iii. Facebook is not designed for the private exchange of health information. Tatianna would need to research reputable platforms for offering electronic therapy.

Answer i is not the best answer because registrants are required to carry professional liability insurance. Standard 3.4 expects registrants who engage in electronic practice to have insurance that covers those services.

Answer ii is not the best answer because Qualifying registrants are required to practise with clinical supervision. Electronic practice raises a variety of clinical and ethical considerations requiring attention.

Answer iv is not the best answer because registrants need to provide information to clients about the risk and benefits of electronic practice and how to prepare for a session (e.g., find a private spot, if possible, test one's internet connection and the communication platform).

3.7 Affirming Sexual Orientation and Gender Identity

Standard 3.7 reflects federal and provincial laws that prohibit conversion therapy while respecting the ability of registrants to have open, supportive conversations with clients about sexual orientation and gender identity.

Ontario became the first province to limit the practice of conversion therapy — also known as reparative therapy — in 2015. Under the RHPA, it is an offence to provide "treatment that seeks to change the sexual orientation or gender identity of a person under 18 years of age".[15]

Treatments that seek to promote or provide acceptance or the facilitation of one's coping, social supports, or identity exploration are not included in the prohibition. Registrants are not expected to avoid discussions of gender or sexual identity provided they are being conducted in a supportive manner that does not seek to influence the client's identification.

More recently, the federal government has also prohibited the practice of conversion therapy. As of January 7, 2022, it is a crime punishable by up to five years in prison to cause another person to undergo conversion therapy. It is also a crime, punishable by up to two years in prison, to promote, advertise, or profit from providing conversion therapy.

The federal government employs a more robust definition of conversion therapy than in Ontario. The law defines conversion therapy as a "practice, treatment or service designed to change a person's sexual orientation to heterosexual, change a person's gender identity to cisgender, change a person's gender expression so that it conforms to the sex assigned at birth, repression of non-heterosexual attraction or sexual behaviour, repression of a non-cisgender gender identity, repression or reduction of a person's gender expression that does not conform to the sex assigned at birth."

Practices that seek to affirm one's identity, relate to the exploration of an integrated personal identity, and are not based in the assumption that one sexual orientation, gender identity, or gender expression are preferred over another, are not included in this definition.

Please note that unlike the provincial legislation, the federal law is not exclusive to minors. Regardless of the age of the client, it is a crime under federal law to practice conversion therapy.

[15] Section 29.1.

4.1 and 4.2 Clinical Supervision

Clinical supervision is a central aspect of psychotherapy training and practice. Section 4 of the Professional Practice Standards discusses the minimum expectations for providing and receiving clinical supervision. In addition to the Standards, CRPO provides detailed supervision-related information to applicants, registrants, and clinical supervisors. Applicants and registrants should become familiar with these resources.

The following are issues that, in CRPO's experience, pose challenges for clinical supervisors and supervisees.

Who is Responsible?

CRPO frequently receives questions about who is ultimately responsible or liable for a client: the clinical supervisor or supervisee. In the simplest terms, clinical supervisors are responsible for providing adequate supervision. Supervisees are responsible for seeking out supervision as needed, and for the care they provide to clients. The following scenarios illustrate how these responsibilities could play out.

Standards 4.1 and 4.2 Scenario 1
A client contacted their therapist's clinical supervisor. The client was concerned because the therapist had been texting them socially. The client subsequently reported to CRPO that the supervisor wasn't doing enough in response. For example, the supervisor did not discuss the possibility of referring the client to another provider. As well, the supervisor did not educate the supervisee about the inappropriateness of their actions.

This example highlights the responsibility of supervisors to address concerns about a supervisee's actions. While it was the supervisee who sent the inappropriate texts, once the client made the supervisor aware, the supervisor needed to take action to rectify the situation as best they could. This may have included reporting the supervisee to CRPO.

Standards 4.1 and 4.2 Scenario 2
Findlay is an RP (Qualifying). Their client unexpectedly contacted them in crisis. Findlay immediately contacted their clinical supervisor for direction on how to respond to the situation, which Findlay hadn't dealt with before. The clinical supervisor responded that they did not have time that day to discuss the matter. The clinical supervisor also refused to permit Findlay to contact another peer or colleague as that would reduce the supervision fees Findlay would eventually owe the clinical supervisor for advice.

This scenario shows the need for supervisors to be available for emergencies, or to have a backup plan in place, such as an alternative supervisor or peer to contact. Supervisors are responsible for providing support to supervisees in complex or risky situations.

Standards 4.1 and 4.2 Scenario 3
Christa, an RP (Qualifying), works at an agency. Her client, a 14-year-old, discloses for the first time ongoing abuse by a family member. After session, Christa remembers that her manager, who is also her clinical supervisor, has the day off before the long weekend. Christa notes to discuss this issue with her clinical supervisor next week.

This scenario involves a potentially urgent problem the supervisee did not share with her supervisor in a timely manner. Supervisees are responsible for seeking out supervision regularly and when needed. In this situation, if the supervisee could not reach the supervisor, they could have contacted an alternate, or a children's aid society. They could also have contacted CRPO's Practice Advisory Service. While the Practice Advisory Service is not designed to handle emergencies or to substitute for clinical supervision, it can provide resources and guidance around professional obligations.

General Professionalism

Clinical supervisors and supervisees are in a professional relationship and need to observe appropriate conduct. Given the power imbalance in the relationship, clinical supervisors have a particular responsibility to maintain professional boundaries with supervisees and uphold the trust supervisees place in them.

Practice Question
Which of the following is inappropriate conduct by a clinical supervisor?

i. Reporting to CRPO about the supervisee's refusal to follow instructions necessary to assure client safety.
ii. Refusing to approve the supervisee to see a client with a particularly complex presenting issue.
iii. Completing an evaluation saying the supervisee needs to further develop some competencies.
iv. Borrowing money from a supervisee.

Answer iv is the best answer. Due to the power a clinical supervisor holds over their supervisee, borrowing money is an example of an inappropriate boundary violation by the supervisor.

Answer i is not the best answer because clinical supervisors are obligated to file a mandatory report with CRPO if another RP, including a supervisee, engages in unsafe practice.

Answer ii is not the best answer. Clinical supervisors must intervene if they become aware a supervisee plans to take on a client the supervisee is not competent to treat.

Answer iii is not the best answer because evaluation and feedback are part of a normal supervisory relationship.

5.1-5.6: Record-keeping and Documentation

Section 5 of the Standards covers record-keeping, including clinical, appointment, and financial records. It also discusses report-writing, issuing accurate documents, and secure record storage. Readers should refer to this section of the Standards.

The following are issues that, in CRPO's experience, pose challenges for registrants.

Identifying the Custodian

In sole private practice, it is usually clear that the RP themself is responsible for client records. In employment settings, it is also generally straightforward that the employer (e.g., hospital, agency), is the custodian of client records.

Complications can arise in group practice or contractor arrangements. For example, if an RP has an office in a private group clinic, is the RP, another provider, or the clinic itself ultimately responsible for health records? These situations can be further complicated if the RP has more than one practice setting. If an RP works remotely, they may administer both practices from the same physical location, making it even more relevant to separate and organize records appropriately.

It is important to agree in advance about who is ultimately responsible for the records. If working in more than one setting, it is important to separate records as needed so as not to confuse one group of clients with another. When a business relationship terminates, the health information custodian is responsible for retaining the original record, unless the record is transferred to another provider.

Practice Question
Aija, an RP, recently accepted a contractor position with an established practice that hires mental health professionals from all professional backgrounds. As her first day approaches where she will begin to see clients, Aija notes that it was never expressly stated whether the practice will maintain client records or whether it expects contractors to maintain their own records. What is the best course of action for Aija?

i. Decide to act as the health information custodian, as it allows her to ensure PHIPA compliance.
ii. Do nothing, assuming that the practice will be the health information custodian.
iii. Ask the practice owner on her first day of work to confirm whether Aija or the practice will have health information custodian duties.
iv. Ask the practice owner prior to her first day of work whether Aija or the practice will maintain the health records.

Answer iv is the best answer, as Aija quickly sought clarity on the matter and confirmed which party would be responsible for maintaining health records. Importantly, she also gave herself enough time to prepare in response. That is, she made sure she was able to act in a PHIPA-compliant manner from her first day of work should she be responsible.

Answers i and ii are not the best answers because it is important for all parties to be clear about who will have responsibility for health records. In these scenarios, Aija did not confirm with the practice owner, which may lead to confusion and disagreement over who is responsible for the records.

Answer iii is not the best answer because it does not give Aija adequate time to prepare a record-keeping system prior to seeing clients if the practice owner confirms she is expected to act as the health information custodian.

Requests for Access and Disclosure

Registrants can expect to receive a variety of requests for access to or disclosure of client records. Some requests are relatively straightforward (e.g., an individual client requesting a copy of their own health record). Clients have a right of access to their own health records, subject to limited exceptions listed in section 52 of PHIPA.

Some requests may not be straightforward, for example if the request comes from a third party, relates to a legal proceeding, or involves a joint therapy record, e.g., couple or family therapy. Registrants may need legal advice tailored to their specific situation. The following are general questions to help analyze access and disclosure requests:

- Does the person requesting access or disclosure have legal authority? For example, is it the client's own lawyer requesting access on behalf of the client? Is it a custodial parent requesting the record of their child who does not have capacity to decide for themself?

- Does the client need to be informed of any risks? For example, if the file is being requested for a legal proceeding, could some of the information be upsetting or irrelevant?

- Do any redactions need to be made? For example, if one member of a couple requests access

to their own therapy record, the registrant cannot provide access to information about the other member of the couple without that person's consent.

- Will a summary or report suffice instead of the record? Consider asking the requester if the entire record is required versus an alternative.

- Is it necessary to oppose release of the records? In contentious situations where individuals disagree about disclosure of the record, registrants should seek legal advice, including whether to oppose legal requests to disclose the record.

When providing access or disclosure, the custodian keeps the original record and sends copies to others who have authorization. The only exception arises when there is a legal requirement to provide the original record (e.g., if required in a police, Coroner's, or College investigation, or with a summons). In such a circumstance, the custodian should keep a legible copy of the record. RPs are encouraged to review relevant legislation, guidance from the IPC, and seek legal counsel to ensure they are upholding their legal responsibilities.

Standards 5.1-5.6 Scenario 1
Andrea provided couple therapy to Millie and Eamon for three months. The couple recently decided to separate, and Millie requested a copy of their client record. Andrea contacted Eamon and asked whether he consented to Millie obtaining a copy of their client record. Eamon refused.

Andrea explained to Millie that she cannot grant access to the full record without Eamon's consent. Millie will only be able to receive the portion of personal health information about her own care, to the extent it can be reasonably severed from information about Eamon.

Standards 5.1-5.6 Scenario 2
Susil brought her daughter, Hae, aged five, to receive play therapy from Ronan. Susil told Ronan she has full custody of Hae and therefore consent from Hae's father is not necessary. Ronan requested Susil provide a copy of the custody order to store on file.

A few months into therapy, Ronan received an email from Hae's father requesting Hae's client record. Ronan responded to the email with careful wording so as not to confirm that Hae is a client (since confirming this would be a disclosure of personal health information). Ronan went on to write in general that he is not permitted to disclose client information to a non-custodial parent without client consent unless a legal exception applies.

Standards 5.1-5.6 Scenario 3
Zella received a signed letter from her client, requesting Zella to disclose the client's record to her lawyer and the client's ex-partner's lawyer. Zella is aware her client's ex-partner was abusive and is concerned about her client's safety should he gain access to her record.

Zella consults with her clinical supervisor and seeks legal advice before deciding how to respond to the client's request for release of records. Ultimately, Zella explains to her client that some of the information is sensitive and inquires whether a summary report would be sufficient instead.

6.1 Fees

Standard 6.1 discusses the way registrants charge for their services. CRPO does not regulate the amount of fees registrants charge, as long as they are not excessive (e.g., so high that they exploit a client's or a supervisee's dependency on the registrant).

Examples of Improper Billing

Administering fees involves issuing invoices and receipts. The following are examples of improper billing:

- indicating that a clinical supervisor provided therapy to a client when the supervisee did;
- indicating that the registrant's practice is supervised when no actual supervision meetings take place;
- indicating the wrong date for the service;
- indicating that one service was performed when, in fact, another service was provided; e.g., indicating that the fee was for psychotherapy when in fact personal fitness training was provided;
- billing for services at more than the registrant's usual rate because the service is being paid for by an insurance company;
- indicating that a service was performed when, in fact, no service was performed; e.g., indicating that a client visit occurred when, in fact, the client missed the appointment; and
- issuing a receipt implying services were provided to someone who was not present during a session, e.g., to access insurance benefits.

Standard 6.1 Scenario 1
Arav, an RP, has a posted rate of $120 per visit on his website. However, if the client does not have extended health insurance coverage, Arav reduces the rate to $100 per visit.

The above scenario is contrary to the Professional Misconduct Regulation. In effect, Arav's posted fees are not honest and accurate. Arav is, in effect, billing clients with insurance more than his actual regular fee. It would be acceptable for Arav to lower his actual fee in individual cases of financial hardship. Arav must do this on a case-by-case basis, and not through a general policy intended to hide his true fee.

6.2 Advertising

Standard 6.2 covers advertising. The following are common pitfalls to avoid:

- exaggerating one's qualifications;
- not checking how someone else advertises on one's behalf; and
- using testimonials.

Standard 6.2 Scenario 1
A recently graduated RP (Qualifying) is setting up their online profile on a well-known psychotherapy directory. The directory has a pre-populated list where therapists can select and advertise the mental health conditions they treat. Wanting to attract as many clients as possible, and having learned about these conditions in various lectures, the Qualifying registrant chooses most of the options, including eating disorders, borderline personality disorder, suicidality, and self-harm.

The registrant is advertising inappropriately. Advertising needs to be accurate and verifiable. Treating the serious conditions or situations noted above requires extensive training and supervision, which is generally not completed upon graduation from one's initial training program.

Standard 6.2 Scenario 2
An RP owns a group practice. One contractor who joined recently is a new graduate. They have submitted their application to register with CRPO. CRPO staff check the application and notice the new graduate is listed as an "RP (Qualifying)" on the group practice's website. CRPO writes to the applicant and the RP who owns the clinic. The owner writes back apologetically, explaining that it was the website administrator who decided to write the title "RP (Qualifying)" on the new contractor's profile.

Both the owner and the applicant are responsible for monitoring how their practice is advertised. The owner should have trained the website administrator on selecting the appropriate title. The applicant should have contacted the owner as soon as they spotted the incorrect title.

Standard 6.2 Scenario 3
Aashi, an RP, works in private practice in a small city. While searching her own name online, she notices that an independent website has labeled her as one of the top three rated psychotherapists in her city. She decides to add this prominently to her own website, reasoning that it is ok because she did not choose this designation for herself.

Unfortunately, Aashi may be engaging in improper advertising. By promoting a statement by another organization about her practice, she is using a testimonial, which is not permitted. In addition, a rating by a website is not a reliable indication of the registrant's competence or ability to treat a specific client's issues.

6.3 and 6.4 Ending Therapy

The final two CRPO Practice Standards are inter-related. Standard 6.3 discusses discontinuing services with a particular client, while Standard 6.4 deals with closing, selling, or relocating one's entire practice. The key to both Standards is planning (i.e., having a list of potential professionals to refer clients, arranging with someone to let clients know if the registrant has had an unexpected emergency) and notice (i.e., communicating with clients in advance to the extent possible).

Standards 6.3 and 6.4 Scenario 1
Céline works as a contractor at a group private practice clinic. In this arrangement, clients are considered to be clients of the clinic rather than individual practitioners. Céline is not satisfied with recent changes to the revenue-sharing arrangement and the limited availability of clinical supervision. She provides notice to the owner that she is terminating her contract. While the clinic is ultimately responsible for continuity of client care, Céline also has a responsibility as treating therapist to let clients know of her departure if possible. If Céline plans to practise elsewhere, she can follow the procedure around self-referral (see Standard 1.6: Conflict of Interest and Standard 1.9: Referral).

Standards 6.3 and 6.4 Scenario 2
Krishna, an RP, wants to stop working with a particular client because the client has stopped paying him. Krishna decides to stop seeing the client immediately. The client experiences significant emotional distress once the therapy stops and misses 10 days of work. The client complains to CRPO. After investigating the complaint, CRPO requires Krishna to appear before a committee to be cautioned.

Krishna is cautioned that he should have given notice that non-payment of services would result in discontinuation of service. He is reminded that in future, in similar circumstances, in addition to giving adequate notice, Krishna should offer assistance in finding alternative services, such as referring the client to a publicly-funded mental health agency and reminding the client that in an emergency the client may phone a crisis line or go to the emergency department. The fact that a therapist has not been paid by a client does not remove their duty to a client who is facing a risk of harm.

Standards 6.3 and 6.4 Scenario 3
A CRPO staff-person receives a call from a client asking how they can get a copy of their health record, given that their RP died a couple of years ago. The staff-person reviews the last registration renewal completed by the deceased RP. All registrants are asked to list an individual or organization as a health information custodian successor. The staff-person reaches out to the successor asking for permission to pass on their contact information to the former client.

Putting It All Together

Until now, this section has focused on one practice standard at a time. Some situations, however, raise multiple practice standards. The following are topics that come up in CRPO's work relatively frequently. They illustrate how RPs can reflect on a scenario and find direction from several practice standards.

Child Custody Matters

A common source of questions to College staff and investigations of RP conduct is in the area of psychotherapy with parents and children involved in custody disputes. This topic can present a variety of dilemmas for registrants, including the following:

- whether to provide therapy to children when parents are actively engaged in child custody and access disputes;
- what to do when one parent presents with a child for therapy without the knowledge of the other parent;
- whether and how to proceed when one parent opposes treatment, and the other parent or child supports it;
- how to determine capacity to consent with children of different ages and abilities;
- what constitutes a child's best interests in such complex cases;
- what to document in the child's file in light of who may have access to it;
- being asked to write a report or serve as a witness in a family law proceeding; and
- being accused of favoring one parent and alienating another in a child's treatment.

In general, therapy with children and youth is most successful when important adults in the young person's life are involved in change; when all parties are informed, in agreement, and in support of the therapy; and when the best interests of the child are the focus. When faced with ethical and legal dilemmas, RPs should consider the following questions based on the Practice Standards:

- Does the registrant have the appropriate training and competence to work with children, families, high-conflict couples, custody and access disputes, or potential domestic abuse? (Standard 2.1 Consultation, Clinical Supervision and Referral)
- Are there conflicts of interest to be aware of (e.g., providing family therapy to a child and two parents, then working with the child and one parent amid their custody dispute against the other parent who is now a former client)? (Standard 1.6 Conflict of Interest)
- Is therapy with the child in the child's best interests?
- Has the registrant clarified their role and responsibilities with all parties involved?
- Does the child client have the capacity to provide their own informed consent to treatment? If so, is it prudent to suggest involvement in treatment of one or two parents?

- Has the registrant engaged in age-appropriate informed consent conversations with all parties including about confidentiality and its limits? (Standard 3.1 Confidentiality; Standard 3.2 Consent)

- Does the registrant have a policy in place regarding whether, under what circumstances, and for whom they will write reports of a child's therapy for use in a custody proceeding? Has this been clearly communicated to all involved?

- If asked to write a report for use in a custody proceeding, does the registrant have a clear understanding of whose consent is required for the release of their personal information and has the registrant sought that consent? Does the registrant have a clear understanding of whose consent is required for release of the child's information? Do parents need to provide informed consent as the child's substitute decision-makers? If so, which parent(s)?

- If writing a report for use in a child custody proceeding, has the registrant ensured separation of facts from interpretations? Are facts and opinions reasonable, supportable, and within the RP's scope of competence? As an example, the statement that one's client is "a good parent" is an unclear opinion and unverifiable by the RP. (Standard 5.2 Report-writing)

Risk Assessment and Safety Planning

Risk assessment and safety planning are integral aspects of the work of Registered Psychotherapists. Risk assessments are structured analytical tools to identify "red flags" indicating risk of harm. Safety planning involves responding to identified risks by taking into account the client's needs and circumstances.

Risk Assessment

Risk assessments, while useful, are not infallible. Their reliability depends on the client feeling comfortable and safe enough to be honest about their situation. Additionally, harm or victimization can occur even when an individual is considered "low risk."

Registrants conduct risk assessments and safety planning in response to various concerns including suicide, self-harm, harm to or by third parties, and medical risk (e.g., knowing the signs when an eating disorder or head injury requires emergency medical attention). Using the context of intimate partner violence as an example, risk assessments may include the following or similar elements:

1) perpetuator-focused factors, which include, but are not limited to,
    a. history of abuse;
    b. escalation of violence;
    c. criminality;
    d. substance abuse; and
    e. attitudes supporting violence.
2) victim-focused factors, which include, but are not limited to,
    a. concerns about future violence;

b. barriers in accessing support;

c. victims who have a biological child with a different partner; and

d. victims who have been assaulted by the perpetuator while pregnant.

Safety Planning
Safety plans should be highly individualized, but will often take the following circumstances into consideration:

1) immediate escape plans;

2) creating safe environments at home, at work, and in the neighborhood; and

3) guidance for active violent incidents.

Using risk assessments and safety plans can help registrants fulfill their obligations under the CRPO Practice Standards. This includes, but is not limited to, the following Standards:

- only treating individuals within a registrant's area of competence, recognizing when an individual's case is either too complex or falls outside the registrant's practice area, and making appropriate referrals (Standard 1.9: Referral; Standard 2.1: Consultation, Clinical Supervision and Referral);

- understanding when it is necessary to breach confidentiality under the duty to report (Standard 1.3: Mandatory Reporting; Standard 3.1: Confidentiality); and

- sharing relevant information with the permission of a client to the other members of a client's circle of care (Standard 3.3: Communicating Client Care).

CRPO does not have specifically developed tools for registrants; however, the following resources may be useful:

- Inventory of Spousal Violence Risk Assessment Tools Used in Canada

- Safety Planning Resources from Victim Services Toronto

- Ontario Domestic Assault Risk Assessment Training Program

- Canadian Domestic Homicide Prevention Initiative

- Ontario Hospital Association and Canadian Patient Safety Institute Suicide Risk Assessment Guide

- Nunavut Guide to Risk Assessment and Safety Planning for Victims of Family Violence

- British Columbia Guide to Safety Planning

Drug-assisted Therapies

Research continues to advance, along with public and professional interest, in drug-assisted therapies. For some presenting issues, clinical literature supports the use of therapist-guided client administration of psychedelic substances such as psilocybin, MDMA, and ketamine. Registrants have asked about CRPO's position. The existing Practice Standards shed light on this issue, as follows:

- The registrant must be appropriately trained and competent in the therapy modality to be used (Standard 2.1: Consultation, Clinical Supervision and Referral).
- The psychoactive substance must be possessed legally. Depending on the substance and state of the law, this could be through a clinical trial, Health Canada Special Access Program, or exemption granted by the Minister of Health to the *Controlled Drugs and Substances Act* (Standard 1.5: General Conduct).
- The registrant collaborates appropriately with the prescribing physician (Standard 1.4: Controlled Acts; Standard 3.3: Communicating Client Care).
- Claims made about the therapy are regarded as reasonable professional opinion. Comply with laws prohibiting advertising of controlled substances (Standard 6.2: Advertising).
- As with any therapy, registrants maintain professional boundaries (Standard 1.7: Dual or Multiple Relationships; Standard 1.8: Undue Influence and Abuse).

Social Media

Social media is an extension of everyday conduct and communication, though the audience and impact can be greater than in other communication forums. As outlined in the examples below, CRPO's Practice Standards apply as much in the realm of social media as they do in other forums:

- Accepting a 'friend' request from a client, or 'liking' a client's content could be considered a boundary crossing or dual relationship (Standard 1.7: Dual Relationships).
- Posting information online about a client without their informed consent violates their confidentiality. Even if the client's name is not mentioned, people with partial knowledge could ascertain the client's identity (Standard 3.1: Confidentiality).
- Publicly posting violent images or spreading hate online could constitute conduct unbecoming a registrant. Using one's RP credential at the same time would aggravate the situation by explicitly linking the profession to the conduct (Standard 1.5: General Conduct).

Social Media Scenario
CRPO received a complaint about an RP from a member of the public, who was never a client of the RP. They alleged that the RP publicly mocked them on social media, including by stating a diagnosis they might have. The registrant denied authoring the posts, claiming that they were being impersonated. The registrant did not provide evidence to support this claim.

CRPO's Inquiries, Complaints and Reports Committee (ICRC) required the registrant to attend for an oral caution and to complete ethics education. While the author of the posts could not be proven definitively, the ICRC noted that the registrant did not appear to take prompt action disclaiming the posts after they were written. The ICRC also noted the registrant did not demonstrate insight into the inappropriateness of the posts.

Part 3: Laws

Introduction

This section covers the most relevant laws affecting RPs that have not already been discussed above. There are several types of law that affect the practice of RPs.

The Constitution

The Canadian constitution includes the *Constitution Act, 1867* and the *Constitution Act, 1982*. All laws in Canada must be consistent with the constitution. The *Constitution Act, 1867* indicates that the regulation of professions is within the jurisdiction of each province. The Canadian Charter of Rights and Freedoms, which is part of the *Constitution Act, 1982*, requires laws not to unreasonably limit certain rights such as freedom of expression, inter-provincial mobility, and equality under the law. The *Constitution Act, 1982*, recognizes and affirms aboriginal and treaty rights.

Constitution Scenario
Judy lives in Chelsea, Québec, is registered with CRPO, and practices both physically and electronically with clients who live in Ontario. The constitutional right to inter-provincial mobility means she does not need to live in Ontario to be registered with CRPO. Since the regulation of professions is under each province's jurisdiction, Judy is restricted in the work she can do with clients who live in Québec. If she wants to practise as a psychotherapist in Québec, she would need to qualify for and obtain a psychotherapist permit from the Ordre des psychologues du Québec.

Legislation

Legislation refers to written laws passed by provincial legislatures or the federal Parliament. When draft legislation is first introduced in the legislature or Parliament, it is known as a bill (e.g., Bill 141). After a bill is passed into law, it becomes an act, also referred to as a statute. A number of acts are discussed throughout this manual.

Regulation

Many acts include clauses that provide for the subsequent creation of regulations under the act. Regulations provide more details on how the act will be implemented. Under the RHPA, regulations can be proposed by the College (e.g., regarding registration, professional misconduct, and the Quality Assurance Program) or by the Minister of Health (e.g., regarding controlled acts or professional corporations).

Case Law

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

Case Law and Constitution Scenario
The RHPA and CRPO's Professional Misconduct Regulation restrict some of the ways RPs may express themselves. For example, RPs are not permitted to use testimonials in their advertising. RPs are also not allowed to use the title "doctor" when offering or providing healthcare (though registrants with a PhD may use the doctor title in an academic setting). Several other health professionals are also subject to these rules. Ontario courts have found restrictions on testimonials and the doctor title to be constitutional, specifically that they do not unreasonably restrict freedom of expression (*Yazdanfar v. The College of Physicians and Surgeons*, 2013 ONSC 6420 (CanLII); *Berge v College of Audiologists and Speech-Language Pathologists of Ontario*, 2016 ONSC 7034 (CanLII)).

By-laws

By-laws are made by the College Council and deal primarily with internal operations. They also address some administrative matters relating to registration, such as the payment of annual fees, information on the public register, and requirements for professional liability insurance.

Policies

In addition to developing regulations and by-laws, the College publishes official documents such as professional practice standards, policies, and position statements. Policies are not actually law; however, they may be considered as evidence in interpreting whether a registrant met their professional obligations, and to assist in consistent decision-making. CRPO's Professional Misconduct Regulation states that it is professional misconduct to contravene a standard established by the College. CRPO also issues guidelines, which provide additional information and direction for registrants, to help them understand how to meet practice standards. Policies and position statements generally provide guidance to Registrants on specific issues or share CRPO's position on issues with the public.

Indigenous Healthcare Law and Policy

This section provides a brief introduction to law and policy at the intersection of the practice of psychotherapy by RPs and Indigenous peoples in Canada. This overview is not intended to be comprehensive. Registrants are strongly encouraged to develop their learning on Canada's Indigenous people and the ongoing effects of colonization. CRPO may develop learning content focused on this topic as part of registrants' ongoing professional development requirements. A variety of general learning resources are also available online for registrants to review.[16]

[16] For example, Assembly of First Nations, *It's Our Time: The AFN Education Toolkit*, https://education.afn.ca/afntoolkit/; Métis Nation of Ontario, "Culture & Heritage", https://www.metisnation.org/culture-heritage/; Pauktuutit Inuit Women of Canada, *The Inuit Way: A Guide to Inuit Culture*, https://www.relations-inuit.chaire.ulaval.ca/sites/relations-inuit.chaire.ulaval.ca/files/InuitWay_e.pdf; Government of Canada, "Indigenous Peoples and Communities", https://www.rcaanc-cirnac.gc.ca/eng/1100100013785/1529102490303; The Canadian Research Institute for the Advancement of Women, *Colonialism and Its Impacts*, https://www.criaw-icref.ca/wp-content/uploads/2021/04/Local-Women-Matter-3-Colonialism-and-its-impacts.pdf.

United Nations Declaration on the Rights of Indigenous Peoples

In 2007, the United Nations General Assembly adopted the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). UNDRIP "establishes a universal framework of minimum standards for the survival, dignity and well-being of the indigenous peoples of the world".[17] UNDRIP touches on healthcare in various ways, including by affirming that "Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health."[18] In 2021, the Government of Canada passed legislation committing itself to the implementation of UNDRIP in Canadian law.[19]

Calls to Action

In 2015, the Truth and Reconciliation Commission (TRC) published several reports following its inquiries into the pervasive consequences of Canada's system of residential schools for Indigenous people. The TRC issued its Calls to Action, including for governments to establish goals and report on progress to close gaps in health outcomes between Aboriginal and non-Aboriginal communities, including for indicators such as mental health and addictions.[20]

One aspect of closing health outcome gaps is ensuring appropriate competencies are held by RPs interested in working with Indigenous communities, including familiarizing themselves with mental health trends that may differ from the general population to ensure appropriate care. For example, Call to Action #33 acknowledges Fetal Alcohol Spectrum Disorder (FASD) as a high priority health need in Indigenous Communities.

In 2019, the National Inquiry into Missing and Murdered Indigenous Women and Girls issued Calls for Justice, including for governments "to ensure that equitable access to basic rights such as employment, housing, education, safety, and health care is recognized as a fundamental means of protecting Indigenous and human rights, resourced and supported as rights-based programs founded on substantive equality."[21] The Calls for Justice also include cultural competency training for public servants and service providers.[22]

Healthcare Access and Equity

In Canada, health policies pertaining specifically to Indigenous communities tend to fall under the general theme of access to care and ensuring equity in accessed services. RPs should be aware of programs available to Indigenous clients and be able to suggest resources where necessary. RPs should also be aware prior to making any suggestions that Métis people are often excluded from federal health benefit programs.

RPs should make themselves aware of other programming offered locally or provincially to support clients.

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[17] United Nations Department of Economic and Social Affairs Indigenous Peoples, online: https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html.
[18] Art 24, para 2.
[19] See Government of Canada, *Implementing the United Nations Declaration on the Rights of Indigenous Peoples Act*, online: https://www.justice.gc.ca/eng/declaration/index.html.
[20] *Calls to Action* 19, 55.
[21] *Calls for Justice* 1.1.
[22] *Calls for Justice* 17.8, 18.18.

Non-insured Health Benefits (NIHB) for First Nations and Inuit
NIHB provides eligible First Nations and Inuit individuals with coverage for health benefits that are not ordinarily covered through social programs, private insurance, and provincial or territorial health plans. This includes mental health counselling, in addition to vision care, dental care, medical supplies, prescriptions, and medical transportation. RPs providing services through NIHB must be authorized for independent practice, which means being registered in the full RP category, having completed 1000 direct client contact hours, 150 clinical supervision hours, and having this confirmed by CRPO.

An eligible client must be a resident of Canada and any of the following:

- a First Nations person who is registered under the *Indian Act* (commonly referred to as a status Indian) as may be expressed by a status card;
- an Inuk recognized by an Inuit land claim organization, as may be expressed by an ID card; or
- a child less than 18 months old whose parent is a registered First Nations person or a recognized Inuk.

Every 12 months, an eligible client can receive 22 hours of counselling performed by an eligible provider, including Registered Psychotherapists, on a fee-for-service basis. Additional service hours may be approved on an individual basis.

Beneficiaries of the program may use the client reimbursement process or may request that service providers directly bill the program through Express Scripts Canada.

Jordan's Principle
Jordan's Principle is a legal principle that seeks to ensure substantive equity for First Nations children in accessing products, services, and supports they need, including health, social, and educational services. Depending on the needs of an individual, psychotherapy may potentially be covered by Jordan's Principle.

The principle was put in place following the death of Jordan River Anderson (October 22, 1999-February 2, 2005) from Norway House Cree Nation in Manitoba. Jordan was born with complex medical needs, which spurred a conflict between the provincial and federal government as to which body was responsible for paying for the at-home care suggested by his medical team. As a result of the conflict, Jordan was kept in the hospital until his death in 2005.

Jordan's Principle seeks to ensure that First Nations children can access needed products, services, and supports. It requires federal and provincial governments to resolve payment issues separately without acting as an impediment to care.

A child under the age of majority in their province/territory of residence can access funding through Jordan's Principle if they permanently reside in Canada and meet one of the following criteria:

- They are registered or eligible to be registered under the *Indian Act*.
- They have one parent or guardian who is registered or eligible to be registered under the *Indian Act*.
- They are recognized by their nation for the purposes of Jordan's Principle.
- They are ordinarily a resident on a reserve.

The Government of Canada has information on accessing Jordan's Principle. The First Nations Child and Family Caring Society has also published information on Jordan's Principle. In addition, a 2019 Canadian Human Rights Tribunal ruling discusses the implementation of Jordan's Principle.

Inuit Child First Initiative
The Inuit Child First Initiative seeks to ensure Inuit children have access to services when they need them. It covers health, social, and educational products and services.

All Inuit children can request funding through the Inuit Child First Initiative provided they are

- recognized by an Inuit land claim organization; and
- under the age of majority in their province/territory of residence.

Information on the Inuit Child First Initiative from the Government of Canada can be found on this Government of Canada web page.

Developing Policies
The federal government has committed to developing distinction-based Indigenous health legislation. The goals of the initiative are to

- establish overarching principles as the foundation of federal health services for Indigenous peoples;
- support the transformation of health service delivery through collaboration with Indigenous organizations in the development, provision, and improvement of services to increase Indigenous-led health service delivery; and
- continue to advance the Government of Canada's commitment to reconciliation and a renewed nation-to-nation, Inuit-Crown and government-to-government relationship with Indigenous peoples based on the recognition of rights, respect, co-operation, and partnership.

Consultations have been initiated, but as of the date of this publication, no substantive announcements have been made.

Exemption from the RHPA

The RHPA establishes the governing framework for regulated health professionals in Ontario. It also sets out exemptions for "aboriginal healers," defined in the Act as an aboriginal person who provides "traditional healing services to aboriginal persons or members of an aboriginal community."

Even though traditional Indigenous healing is outside the scope of the RHPA, CRPO has established a voluntary registration pathway that recognizes those trained in Indigenous practices that overlap the scope of psychotherapy.

Human Rights and Accessibility Legislation

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

Human Rights Code

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

If a person feels that a therapist or organization has violated the *Human Rights Code*, the person may make a complaint (called an "application") with the Human Rights Tribunal of Ontario. If the Tribunal finds that a psychotherapist has violated the *Human Rights Code*, it may order the psychotherapist or organization to pay damages. It may also require the therapist or organization to take other action, such as completing training or implementing a human rights policy.

Since the Human Rights Tribunal does not have the power to suspend or revoke a registrant's certificate of registration, a person who believes their human rights have been violated may also file a complaint with CRPO.

Duty Not to Discriminate

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

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

It is not discrimination to make clinical decisions for reasons other than prohibited grounds. For example, if an RP does not have the competence to treat or continue to treat a person, a registrant should not initiate or continue therapy with a client. Such a decision to refuse or discontinue services must be made in good faith, communicated sensitively, and documented. It is discriminatory to claim one lacks competence as a pretense for refusing to provide service based on protected grounds.

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

Duty to Accommodate

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

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

Examples of accommodation may include the following:

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

Human Rights Code Scenario 1
Nancy, a psychotherapist, determines that she is not competent to continue to treat her client because the client's mental health condition has become increasingly complex. The client is unhappy about Nancy's decision and believes that Nancy has always had a problem with them because of their race and religion. Nancy should carefully communicate her reasons for terminating the client-therapist relationship, so the client is not left with a misunderstanding that the decision was made because of the client's race or religion. Nancy must continue to provide support for the client until an appropriate referral is made.

Human Rights Code Scenario 2
Simon, an RP, has a new client named Jennifer who has an intellectual disability, and he finds it difficult to communicate with her. Simon should ask Jennifer what he can do to better communicate with her. If Jennifer has a support person who sometimes provides assistance, she may ask to bring that person to Simon's office.

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

Human Rights Code Scenario 3
Evelyn, an RP, has a client who has been diagnosed with a mental illness. Evelyn has been having increasing difficulty interacting with her client. The client has also been rude towards Evelyn and staff. While no client has a right to be abusive, Evelyn may consider whether the behaviour is caused or exacerbated by the person's illness. Evelyn cannot stop providing services because of the client's mental illness, unless Evelyn concludes she is not competent to continue treating the client, or there are significant health and safety concerns for Evelyn or her staff.

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

Accessibility for Ontarians with Disabilities Act

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

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

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

Relevant accessibility standards are listed below.

Customer Service Standard

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

- implement policies, practices, and procedures regarding the provision of goods and services to persons with disabilities, that are consistent with the principles of dignity, independence, integration, and equal opportunity, and that deal with the use of assistive devices and the availability of any measures that make services accessible (e.g., teletypewriter or TTY, elevator);

- permit service animals and support persons in public areas of premises. A service animal includes an animal that is readily identifiable as being used for reasons relating to a person's disability. It also includes an animal for which a health professional, such as an RP, has

provided documentation confirming that the person requires the animal for reasons relating to disability;

- provide reasonable notice of any temporary disruptions to any accessibility features or services, including the reason for the disruption, the anticipated duration, and a description of any alternate services;

- provide training to all employees and anyone else who deals with members of the public or third parties, which must include the following:
    a. a review of the purposes of the AODA and the requirements of the Customer Service Standard;
    b. how to interact with persons with disabilities who use assistive devices, use a service animal, or are assisted by a support person;
    c. how to use accessibility equipment and devices that the business makes available; and
    d. what to do if someone with a particular type of disability is having difficulty accessing the providers' goods or services; and

- establish a process for receiving and responding to feedback about accessibility and make information about the process readily available to the public. This process must permit people to provide feedback in person, by telephone, in writing, or electronically, and the process must specify actions that will be taken if a complaint is received.

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

Integrated Standard

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

Information and Communication Standard
The Information and Communication Standard requires organizations to ensure that information available to the public, and the organization's communications with the public are accessible or may be made accessible. This includes making any feedback system accessible upon request, ensuring that any emergency or public safety information available to the public is made accessible upon request, and providing accessible information formats and communication supports upon request.

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

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

Employment Standard
The Employment Standard requires employers to provide an accessible workplace. This includes the following:

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

Built Environment Standard

The Ontario government has not yet developed a comprehensive standard on the built environment. Once developed, it will apply to the construction of new buildings and to major renovations.

AODA Scenario 1

Samir, an RP, has an office with one employee who provides administrative support. Under the AODA Customer Service Standard, Samir must create an accessibility plan for providing accessible customer service, information, and communications.

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

Mental Health Act

Ontario's *Mental Health Act* (MHA) applies to health care provided by psychiatric facilities. The MHA provides authority for admission to psychiatric facilities and for detention, psychiatric assessment, treatment, and the implementation of community treatment orders (CTOs).

Types of Admission to a Psychiatric Facility

Voluntary Admission
A person may go to a psychiatric facility voluntarily and be admitted upon the recommendation of a physician. A voluntary client may leave a psychiatric facility at any time and has the right to refuse treatment if they are capable of making treatment decisions.

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

to the client or another person.

Informal Admission
An informal client is a person whose substitute decision-maker has consented to admit them to a psychiatric facility. If the client is 16 years old or over and objects to admission, consent may only be given on the client's behalf in limited circumstances.

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

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

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

The test for involuntary admission is that the physician, upon examining the client, is of the opinion that

a. the client is suffering from a mental disorder of a nature or quality that will likely result in serious bodily harm to the client or to another person, or serious physical impairment of the client, unless the client remains in the custody of a psychiatric facility; and

b. the client is not suitable for admission or continuation as an informal or voluntary client.

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

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

Use of Restraints

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

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

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

Application for Psychiatric Assessment (Form 1)

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

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

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

Situation 1

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

a. the physician has reasonable cause to believe that the person

i. has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;
ii. has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or
iii. has shown or is showing a lack of competence to care for themselves; and

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

Situation 2

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

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

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

MHA Scenario 2
Ivy, an RP working at a psychiatric facility, meets a voluntary client, Paula, and observes that Paula shows signs of self-harming behaviour. Ivy is aware that a voluntary client cannot be detained or restrained and is concerned that Paula may try to harm herself. Ivy consults with the physician in charge of Paula's care. The physician assesses Paula and issues a Certificate of Involuntary Admission. Paula is entitled to speak to a Rights Advisor about the decision to involuntarily detain her, and she is entitled to a review of this decision before the CCB.

Community Treatment Orders (CTOs)

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

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

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

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

MHA Scenario 3
Maria, an RP, is asked by her client, Hugo, to be a part of his community treatment plan. Maria agrees to be involved in Hugo's care in the community. Hugo's physician contacts Maria to discuss her involvement and signs a CTO. Hugo subsequently meets with Maria, and it appears that he has destabilized. He tells Maria he has stopped taking his medication. Maria consults the treatment plan and confirms that Hugo is required to take medication as a term of the CTO. Maria shares this information with the physician who issued the CTO.

Practice Question
If a voluntary client in a psychiatric facility reports to an RP that they are having suicidal thoughts and are planning to immediately leave the facility, the RP should

i. Restrain the client and call security.
ii. Provide counselling, immediately notify the person responsible for the administration and management of the psychiatric facility or their delegate (i.e., the officer in charge), and document the incident.
iii. Affirm to the client that they are free to leave and help them pack their belongings.
iv. Provide counselling and document the incident.

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

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

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

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

Public Health

The discipline of public health studies and responds to health concerns at the population level. In Canada, responsibility for public health is shared among federal, provincial, and municipal governments.

The Public Health Agency of Canada is the federal agency responsible for public health. Legally, the federal government can impose public health restrictions in federal domains such as cross-border, air, and marine travel.

Public Health Ontario provides information about numerous aspects of public health in the province. Because each province is responsible for the delivery of healthcare and education, as well as regulating property, business, and professions, many public health decisions are within the provincial jurisdiction. For example, during parts of the COVID-19 pandemic, the Ontario government provided directives on when healthcare providers should offer in-person versus virtual care, guidance on infection prevention and control, and rules for masking in public and in healthcare settings.

Regional and municipal public health units monitor and coordinate programs regarding health situations affecting their communities.

CRPO will communicate public health information relevant specifically to registrants, in particular during public health emergencies. Registrants are encouraged to review applicable public health advisories. Registrants are required to observe any applicable mandatory public health measures in effect at a given time.

Municipal Licensing

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

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

Registrants are responsible for ensuring they meet the licensing requirements and standards of their municipality. If the College requires a higher standard or a different standard than the municipality does, the College's standard must always be followed, as the RHPA is a provincial statute which takes priority over a municipal by-law.

Contract Law

A contract is a legally binding agreement. People enter contracts by agreeing to exchange something of value (sometimes referred to as the offer and acceptance of consideration). Contracts may be entered in writing or orally. A person who breaches a contract by not fulfilling their part of the agreement may be required to compensate the other party.

Common contracts for RPs include the provision of psychotherapy for payment with a client or joining a

practice as an employee or contractor. A key point is not to enter into a contract that would prevent the RP from meeting their professional obligations. For example, an RP must not agree with a potential client that they will not keep any records of the therapy. Entering into such a contract would go against the RP's professional obligation to maintain records. Likewise, an RP must not promise something to an employer that would go against CRPO requirements. For example, an RP cannot agree with their employer that they will recommend that all clients try a certain product, because it may not be in the interest of all clients to try that product.

Non-solicitation Clauses

A recurring contractual issue among RPs is non-solicitation. A non-solicitation clause aims to prevent an employee or contractor from asking clients to see them at their other practice. An agency may have valid reasons to discourage this, particularly while the RP is still working at the agency (e.g., to avoid the perception that agency staff is treating the organization as a referral source).

The situation is often different in a group private practice context where the motivation is financial. It is common for an RP to leave a group practice and offer clients to transfer to the RP's new practice if they wish. Courts have refused to enforce non-solicitation clauses that overly restrict a former employee's right to earn a livelihood. From CRPO's perspective, the client's best interests are paramount. RPs should not enter into agreements that prevent a client from making an informed choice of where to receive care, e.g., RPs should not promise their employer that after their employment ends they will never treat a client who they saw through the employer.

Negligence

A 'tort' is a legal wrong that is civil (between private parties) as opposed to criminal in nature. A major tort for RPs to be aware of is negligence or malpractice. An RP engages in negligence if they

- owe a duty of care to a person, e.g., to a client;
- their actions fall below the standard expected of a reasonable psychotherapist; and
- their actions cause injury or harm to the person.

An individual found to have committed negligence or malpractice may be required to compensate the injured party. An example of negligence would be failing to follow up on a client's disclosure of suicide risk, followed by suicide of the client. If a therapist acts reasonably and the client still incurs harm or injury, the therapist would not be liable for negligence.

Another tort relevant to RPs is breach of fiduciary duty. A fiduciary is someone in a position of trust or power relative to a beneficiary or dependent. An example is a psychotherapist and their client, respectively. A fiduciary is required to act in the best interests of the beneficiary. Examples of breaching one's fiduciary duty include sexual abuse of a client or entering into business transactions with a client.

Apology Act

An apology can help repair a relationship; however, people have worried that an apology could motivate legal action or be used against them. Ontario's *Apology Act, 2009*, encourages expressions of sympathy, regret, or contrition. The Act prevents apologies being used as evidence in civil lawsuits or as admissions of fault. Exceptions include criminal and certain financial matters.