In the Matter Of:

Professional Ethics, Standards and Conduct

COLLEGE OF PSYCHOLOGISTS OF ONTARIO

January 22, 2018

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4 BARBARA WAND SEMINAR IN PROFESSIONAL ETHICS,
5 STANDARDS AND CONDUCT
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7 MONDAY, JANUARY 22, 2018
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1 DR. RUTH BERMAN: In the case among those
2 of you who are online, it occurred to me that many of
3 you may be unfamiliar with the name "Barbara Wand" and
4 are curious as to why this program bears her name.
5 Although that knowledge dates me personally, I thought
6 it important to share a very brief history with you.
7 Dr. Barbara Wand, a psychologist prominent in her own
8 right, was the first female and the longest-serving
9 registrar of the first provincial regulatory body for
10 psychology, affectionately known as "OBEP", the
11 Ontario Board of Examiners in Psychology, the
12 precursor to this college.
13 As a tribute to her, on her retirement
14 from that position in the late 1980s, the Board, OBEP,
15 made the decision to develop and offer in her name to
16 all college registrants and graduate psychology
17 students an annual continuing education program that
18 reflected the principles that embodied her life's
19 work. Dr. Wand was an articulate, highly respected
20 and strong advocate for the statutory regulation of
21 psychology both in Ontario and across the country, and
22 for its adherence to high professional standards of
23 care and conduct in the public interest. In doing so,
24 she helped to lay the foundational building blocks
25 upon which the mission and values of the current

1 college have been built. I am honoured to have known
2 her personally as a colleague, mentor and friend.
3 I believe that this morning our
4 attendance is likely the largest we have ever had for
5 this seminar. In addition to the over 130 attendees
6 in this room, I understand that over 1,300 more are
7 participating online. It's evident that through the
8 availability of new technology and the decision by
9 council to no longer a registration fee, this program
10 is clearly now more accessible to more participants
11 than was possible in the past.
12 This last year has been a very busy and
13 productive year for council. As you are aware,
14 included among its many other activities was the
15 adoption of a Revised Standards of Professional
16 Conduct, the first major revision since 2009, the
17 development and introduction of the mandatory
18 continuing professional development program and the
19 review and consideration of a number of important
20 legislative amendments related to the RHPA which I
21 understand to be a central focus of today's agenda.
22 I want to use the opportunity to thank
23 the College staff, the committees and my fellow
24 council members for the wisdom, time and energy they
25 dedicated to the above projects, as well as to thank

1 the many College members who contributed valuable
2 input during the various consultation phases. I
3 understand that Ms. Judy Cohen, another council
4 member, is here. Judy, are you here? Sick. Oh,
5 okay, well, I'm sorry about that. I hoping she was
6 here. I understood she would be and I wanted to
7 introduce her to you.
8 And finally, on behalf of council as well
9 as all of you here this morning, I'd like to express
10 my gratitude to the College staff for once again so
11 ably organizing this event this morning, one that I am
12 confident will be instructive and from which I am sure
13 we will all greatly benefit going forward. Thank you,
14 and again, welcome.
15 BARRY GANG: Okay. So I'm not -- I'm
16 going to go very quickly because I don't want to get
17 between you and some wonderful speakers this morning.
18 As you've heard, there is a tremendous turnout,
19 roughly a third of the membership here. It's great
20 news that so many people are being able to
21 participate, but it comes with some challenges as
22 well.
23 Those of you who are in the room will be
24 able to ask questions easily by lining up at the
25 microphone. Sorry to make you do that, but we want it

1 for the benefit not only of the people in the room,
2 but for the benefit of the people who are listening in
3 online. We are going to try and monitor the questions
4 and give them to the speakers as well but, as you can
5 imagine, it's going to be very difficult to monitor
6 that many. What we've done is made a commitment to
7 answer all the questions that can't be answered today,
8 and we will put them on the website as a Q and A in
9 the Barbara Wand section.
10 Invariably, with the number of users who
11 have, you know, a lot of different kinds of setups and
12 providers and interfaces and all those things that I
13 truly don't understand, it's not whether there will be
14 technical problems; it will be what kind there will be
15 and how easy they are to solve. So I'm told that the
16 most frequent questions in the past or the most
17 frequent solutions to the questions in the past were
18 to try and exit and reload the webcast if you're
19 having trouble, to try a different browser, refresh
20 your screen, and apparently, that solves a lot of the
21 problems. But please feel free, I believe that those
22 of you that are online have an email address to
23 communicate with us around technical problems. It's
24 smorton@cpo.on.ca, and Stephanie will be monitoring
25 that. Worst case scenario, if you miss a part of it,

1 this will be available on the College website likely
2 -- the whole presentation likely within about 24
3 hours, so you won't need to miss anything.
4 Many of you have already asked and
5 probably will want to ask again or later how many
6 credits -- how many CPD credits will you get for this.
7 Those of you who are watching together in groups, or
8 those of you who are here will get -- will be able to
9 claim one credit for the value of interacting with
10 others around professional things in Category A8, and
11 three credits for three hours of learning in Category
12 B2.
13 Anybody who is concerned about how to
14 document it, just keep your email confirmation of
15 registration. If you're with a group and you don't
16 have your own email, just correspond with whoever it
17 was that did register and keep the trail in case you
18 ever need it.
19 So we have two speakers we're very
20 fortunate to have, and I'm going to introduce them
21 both right now to save us time later so that you get
22 more of them and less of me. So our first speaker is
23 Peter Osborne. Peter -- many of you who have been to
24 Barbara Wand seminars in the past may have heard and
25 enjoyed Peter speak before. He is a partner with

1 Lenczner Slaght LLP. His law practice has a
2 significant emphasis on professional regulation and
3 related matters, particularly around the regulated
4 health professions in Ontario and across Canada.
5 For many years, he has been our general
6 counsel. He appears regularly before a wide range of
7 courts and tribunals across Canada, in cross-border
8 proceedings and in discipline regulatory and
9 arbitration proceedings in numerous jurisdictions.
10 He has extensive experience with the
11 Ministry of Health and Long Term Care in matters
12 affecting Ontario's regulated health professions. He
13 is a graduate of Osgoode Hall Law School, a member of
14 the Law Society of Upper Canada and the Advocate
15 Society, and is a regular instructor for both of those
16 bodies.
17 He teaches the bar admission course and
18 advocacy both in Ontario and for the Law Society of
19 Newfoundland and Labrador. He has taught trial
20 advocacy at the University of Toronto Faculty of Law
21 and at Osgoode Hall Law School.
22 Together with our former registrar, Dr.
23 Catherine Yarrow, Peter co-authored the chapter, "The
24 Regulation of Psychology in Ontario" in Dr. David
25 Evans' textbook, Law Standards and Ethics in the

1 Practice of Psychology both in the second and third
2 editions.
3 After Peter, after you hear from Peter,
4 you're going to hear from Rick Morris. Dr. Morris is
5 the registrar and the executive director at the
6 College. He has a background in child and family
7 psychology and worked for many years, before coming to
8 the College, in children's mental health both as a
9 direct psychological service provider and in senior
10 clinical and administrative positions. He frequently
11 makes presentations to both member and non-member
12 groups both in Ontario and beyond, in a variety of
13 professional practice topics.
14 He is the former chair of ACPRO, the
15 Association of Canadian Psychology Regulatory
16 Organizations, the national association of regulators
17 of psychology in Ontario. He also serves on many
18 committees for the international Association of State
19 and Provincial Psychology Boards, which is known as
20 ASPPB, and has been named a fellow of that
21 organization. As well, he's a recipient of the
22 Ontario Psychological Association Barbara Wand Award
23 for Excellence in the area of professional ethics and
24 standards. So now for the interesting stuff, Peter,
25 it's all yours.

1 PETER OSBORNE: Thank you very much,
2 Barry. Can everyone hear? I am delighted to be here
3 this morning with all of you, if somewhat intimidated
4 being one lawyer.
5 (Fire alarm ringing)
6 PETER OSBORNE: Well, we're off to a good
7 start, anyway. Why don't we just, as we're getting
8 started, see if that's going to end? I don't know if
9 that's someone's phone or if it's the fire alarm.
10 Just give us one second here. True to Barry's
11 premonition, we're off to our start. It's just a
12 test. All right. We're being tested, fair enough. I
13 feel a little better about things. Can folks hear
14 over the bell? All right, thank you.
15 Good morning again, and thank you very
16 much to Lynette and Ruth and all of council, Rick,
17 Barry and all of you for having me here. It's truly a
18 testament to the practice in the College that about a
19 third of the members of this College are participating
20 today. All right. I get the hint.
21 (Notification regarding fire alarm)
22 PETER OSBORNE: I confess I am getting a
23 bit of a complex. I usually get at least three or
24 four minutes into it before the room evacuates, but
25 we'll see how we do today, and it's a perfect day here

1 in Toronto for a number of the topics that we have to
2 talk about in that it's very foggy, visibility is
3 poor, so that's a perfect backdrop to talk about this
4 year's recent developments in legislation and in case
5 law as it affects the professional practice of
6 psychology in Ontario.
7 I want to talk to you a little bit about
8 legislation. As I say, what our friends at Queen's
9 Park and on Parliament Hill have been up to over the
10 last year or 18 months with respect to matters that
11 affect all of us involved in the practice of
12 psychology, and also what our friends in the courts
13 have been up to and what the judges have said in a
14 couple of cases, what the Health Professions Board has
15 said in a couple of cases that affect matters that I
16 think all of you may encounter in your practices. And
17 please, we're going to cover a number of topics today,
18 but I would very much like for this to be a discussion
19 amongst us, rather than simply by me.
20 So, please, as we go along, if you have
21 questions or comments or observations that you can
22 share with your colleagues, please don't hesitate to
23 interrupt. Particularly as we move from one topic to
24 another, I very much would like you to do that. And
25 as I say, a number of the issues that we're going to

1 talk about are very much live issues for the practice
2 today. They are unsettled both as to clinical
3 guidelines and best practices and, in some cases, also
4 the law is very much developing as we go along.
5 So I'm sort of reminded of the Chief
6 Justice who spoke when I was called to the bar and
7 chuckled that when you first start law school, your
8 friends or family will ask you a question about law,
9 and invariably your answer is "I don't know", and by
10 the time you finish three years of law school,
11 articling and the bar admission course, you are much
12 more educated and you know that the correct answer is,
13 "Well, it depends" and that's exactly what we're going
14 to run into today.
15 So what are we going to talk about today?
16 I'd like to speak with you about a number of topics;
17 medical assistance in dying, which is a big issue and
18 I think a growing issue for those in the practice of
19 psychology; Bill 89, Supporting Children, Youth and
20 Families Act, some of the changes to the law as it
21 affects mature minors and children in need of
22 protection; the Psychotherapy Act, I know a topic near
23 and dear to the hearts of many here today and some of
24 the issues that arise out of those changes. I'll just
25 pause for just a moment.

1 (Information regarding fire alarm)
2 PETER OSBORNE: All right. And then some
3 comments on Bill 87, the Protecting Patients Act,
4 which is really an amending piece of legislation that
5 makes some significant changes to the RHPA, the
6 Regulated Health Professions Act and the Code
7 underneath the RHPA, and we'll talk about how those
8 affect you.
9 Privacy legislation, PHIPA, PIPEDA and
10 MPHIPA as we affectionately call them, in other words,
11 the federal, provincial and municipal privacy and
12 protection of information Acts, and this is as much a
13 refresher as an update on the new legislation, but I
14 think it's important for all of us just to keep a very
15 close eye on how you keep your clinical notes and
16 records, your practice documents, and the Information
17 Privacy Commissioner is becoming more and more active
18 particularly with respect to our HPA practitioners,
19 and I think it's a good time for a reminder to all of
20 us about what's required there. And as a subset of
21 that, we'll touch briefly on the mandatory reporting
22 obligations that we have under the provincial
23 legislation, PHIPA, the Protection of Health
24 Information Privacy Act.
25 So we'll chug along and, as I say, I

1 apologize for the musical interlude behind me, but
2 just put up your hands if you're having real trouble
3 hearing me. I'm afraid that this might continue on
4 for heaven knows how long and I just don't want to
5 lose that time.
6 And after we talk about some of the
7 legislation, I want to touch base with you very
8 briefly on three decisions; one involving a dentist,
9 two involving massage therapists, and the decisions of
10 the courts that affect the definition of a patient, a
11 client and in particular when the practitioner/client
12 relationship starts and ends, and you might be
13 surprised I think with some of the observations from
14 the courts in that regard, and it's worth just a quick
15 reminder of what the courts are up to there.
16 So can we talk for a few minutes just
17 about MAID, Medical Assistance in Dying, and what the
18 courts have been up to there and in the Legislature
19 and what is happening. The legislation is about a
20 year-and-a-half old, but it's an opportune time I
21 think for all of us to have a look at what's been
22 happening, what is ahead for us in the next few months
23 and over the next year, and where we're headed.
24 It's interesting, I wonder if I could ask
25 a quick show of hands, have any of you been asked to

1 participate in the delivery of medical assistance in
2 dying services by way of an assessment or as part of a
3 determination about capacity and capability, some of
4 the issues we'll talk about? Has anyone come across
5 that in their practice yet? Okay. Interesting.
6 The statistics from Ottawa suggest that
7 more and more psychologists across Canada are being
8 asked to intervene. As we'll come to talk about in a
9 few minutes, right now medical assistance in dying can
10 be administered only by physicians and nurse
11 practitioners, but they suggest that the numbers of
12 psychologists becoming involved is increasing
13 exponentially and will continue to do so over the next
14 few years. So I'll bet if we ask for the same show of
15 hands at the next Barbara Wand, we'll see a much
16 higher number of folks who have been asked to
17 participate in it, and it raises, to steal Rick's
18 phrase, some tricky issues to say the least.
19 So what are we talking about when we talk
20 about medical assistance in dying? If I can skip
21 ahead a few slides here, what we're really talking
22 about are circumstances in which you are asked as part
23 of a clinical team to participate in various forms of
24 the administration of a substance to bring about the
25 end of life.

1 Who can administer such a substance? As
2 I said, physicians and nurse practitioners. But when
3 can medical assistance in dying assistance be offered
4 and what does it mean?
5 The Criminal Code provides that a person
6 may receive medical assistance in dying if they meet a
7 number of criteria. So to be eligible, they have to
8 be eligible health services funded by a government in
9 Canada. It raises all sorts of issues, as a quick
10 side note, with respect to those seeking refugee
11 status or whom are new to Canada. I'll just pause for
12 a quick second here.
13 (Instructions regarding fire alarm)
14 PETER OSBORNE: Ruth, I know it was you
15 who did this. So the eligibility criteria for medical
16 assistance in dying; 18 years of age. Right now,
17 services are not available to minors, including mature
18 minors, at all in Canada. Something to bear in mind,
19 particularly for those patients and clients who are
20 mature minors, 16 to 18 years old, an issue under
21 discussion, but right now anyone who receives medical
22 assistance in dying has to be at least 18 years of age
23 and capable of making decisions with respect to their
24 health, which is a real issue for a couple of reasons
25 that we're going to talk about in a moment.

1 They have a grievous and irremediable
2 medical condition. In other words, you have to be
3 crystal clear that there is no cure or treatment for
4 the debilitating or disabling disease from which
5 they're suffering.
6 The individual has made a voluntary
7 request for assistance in dying that was not made as a
8 result of external pressure, for obvious reasons;
9 right? Financial or other pressure. It has to be a
10 decision by the individual without any external
11 pressure whatsoever.
12 And they, of course, give informed
13 consent, no surprise there, I think, with respect to
14 the treatment we're talking about, having been
15 informed of the means that are available to relieve
16 their suffering. In other words, you've got to ensure
17 that they have been given all of the options in
18 respect of treatment or palliative care for the
19 condition from which they suffer. So in short, the
20 illness or disease of disability has to be incurable,
21 but they have to be provided with all of the options
22 and means available to alleviate the suffering.
23 It's interesting, what is relevant to us
24 here today, so the Act received Royal assent in June
25 2016. Royal assent, remember, our federal law is

1 passed by the House of Commons, the Senate of Canada
2 and then signed into law by the Governor-General on
3 behalf of the Queen with the advice of Parliament. So
4 it's when the Governor-General actually signs the bill
5 that it becomes effective, and that's what happened
6 about a year-and-a-half ago.
7 So the obvious question, how do we
8 determine if a person has a grievous and irremediable
9 medical condition? That's the threshold issue. So,
10 we talked about the criteria, but what's interesting
11 for us is the reference to an illness, disease or
12 disability or the state of decline that causes
13 enduring physical or psychological suffering that's
14 intolerable and cannot be relieved under conditions
15 they consider acceptable.
16 So it's physical or psychological
17 suffering. It sounds pretty good in the sense that it
18 seems to suggest that an individual can qualify for
19 medical assistance in dying if they suffer only from a
20 psychological illness, as opposed to psychological and
21 physical. That's what the Act appears to say, but
22 we've got to think twice before we get involved in
23 assessing or determining that a person has consent and
24 is capable and competent to give that consent for
25 medical assistance in dying.

1 Other factors under the Act make it
2 practically impossible at the moment for a patient
3 whose only illness is mental to qualify for assistance
4 under the Act. Among the factors you want to take
5 into account is subsection (d) of this section -- and
6 this is set out in the materials -- natural death is
7 reasonably foreseeable, taking into account all of the
8 medical circumstances, without however a prognosis
9 necessarily having been made as to the length of time
10 they have remaining.
11 So there is no hard and fast rule that a
12 person can't be expected to live longer than one month
13 or six months or a year or what have you. But it's
14 interesting, "natural death has become reasonably
15 foreseeable". So what does "reasonably" mean? It's
16 an objective test.
17 So in other words, it's not sufficient if
18 just you or the physician administering the service
19 believes herself or himself that death is foreseeable.
20 It has to be objective; what would the reasonable
21 professional in the circumstances in which you are in,
22 if you're part of a team involved in making this
23 decision, agree professionally as to the correct
24 answer whether natural death is foreseeable or not,
25 taking into account all of the medical circumstances.

1 So although, as I say, just to recap, the legislation
2 says psychological suffering alone is sufficient,
3 you've got to be very, very careful if there is no
4 physical suffering or physical disability whatsoever
5 that a person qualifies for MAID as it's been
6 colloquially called.
7 If you're involved, what does the Act
8 provide? It provides you some protection, not
9 surprisingly. As you know, typically, ending a life
10 is an offence under the Criminal Code. There is a
11 specific exemption for individuals like you who are
12 involved in a decision to end a life, assuming
13 compliance obviously with all of the provisions, and
14 that is provided in section 242 of the Code, no
15 particular surprises there.
16 And if there were any doubt, it's
17 clarified in the paragraph at the bottom of our page
18 there. I'm at slide seven, which I suppose I should
19 have said from time to time. I'll try to do that for
20 those joining us electronically, but it specifically
21 provides the protection for your profession. No
22 social worker, psychologist, psychiatrist, therapist,
23 medical practitioner, et cetera, commits an offence if
24 they provide information to a person on the lawful
25 provision of medical assistance in dying. In other

1 words, everyone is entitled to have their questions
2 answered and to understand how this is brought about.
3 Not surprisingly, again, you need a
4 witness. Who can be a witness? It cannot be you if
5 you're providing the service or involved with the
6 nurse practitioner or the physician in providing the
7 service.
8 You actually need two witnesses to
9 consent to medical assistance in dying and they have
10 to be independent, again, no particular surprises
11 there. Eighteen years old. They cannot be a
12 beneficiary under the will or otherwise someone who
13 will obtain a financial or other benefit from the
14 death, and they cannot be an owner or operator of any
15 healthcare facility at which the person making the
16 request is being treated or any facility where they
17 reside.
18 We've all seen pictures in the news even
19 over the last couple of weeks of some of the horrific
20 conditions in which individuals, and particularly
21 elders and those who are suffering from either or both
22 physical and psychological illnesses have been living,
23 and these protections are directed specifically to
24 those who are in charge of their care or their
25 residence not being able to be involved as a witness

1 in the provision of MAID, and they can't be directly
2 providing care. In other words, you've got to get
3 somebody completely independent of the situation to
4 assist, and then of course you've got to meet all of
5 the criteria we talked about.
6 Upcoming developments: It's interesting,
7 particularly for the profession of psychology, the
8 government has realized that there are a number of
9 issues and concerns about the legislation. The
10 obvious issue we talked about a minute ago about
11 someone who appears to be suffering only from
12 psychological illness, how do you determine if death
13 is reasonably foreseeable? In many instances, death
14 may not be foreseeable at all, let alone in the
15 reasonably near term.
16 So the federal government has authorized
17 an independent review that began December 2016. Some
18 of you may be involved in that, I don't know, and it's
19 got to report by the end of this coming year and that
20 is done under the auspices of the Council of Canadian
21 Academics. The Department of Justice and the Ministry
22 of Health are involved and the mandate of that review
23 is to determine if the Act should be expanded to
24 include Canadians suffering from mental illness. It
25 already is according to the legislation itself.

1 What about mature minors? Should that be
2 a factor that is -- and should those who are mature
3 minors but not yet 18 be eligible for assistance at
4 all, and what about those with competence-eroding
5 conditions who make advance requests? In other words,
6 right now you've got to be satisfied that the patient
7 requesting help is competent and capable of making the
8 informed decision. Can you do that in advance?
9 You can't under the current Act. Should
10 you be able to? In other words, my condition is
11 deteriorating, I have early onset dementia, what have
12 you, anything, I think I would like to request in
13 advance medical assistance with dying a year down the
14 road if my condition worsens. So as I say, the review
15 is to report at the end of the year, so stay tuned
16 because there are going to be some very interesting
17 developments when that report comes out, I think, and
18 certainly a consideration in Ottawa with respect to
19 whether the legislation should be amended.
20 So what does this all mean for us? Your
21 present obligations, again, psychologists,
22 psychological associates, are not authorized to
23 administer a substance to bring around the end of
24 life, but again are certainly involved in assessments
25 with respect to competence and capability.

1 Psychological illness only, it technically qualifies
2 under the Act. Proceed with substantial caution. The
3 explanatory notes and the other sections we looked at
4 suggest that right now, in fact, that is not
5 sufficient if there is no concurrent physical illness.
6 Lots of issues about a person who is capable of
7 consenting and yet at the same time has a
8 psychological illness that is incurable and for which
9 the current conditions are intolerable.
10 What about some of the changes being
11 talked about? I don't know if there are any comments
12 or observations. What about expanding this for mature
13 minors? Does that cause concerns for any of those
14 particularly in clinical practice about extending
15 eligibility for MAID to those who are minors? Any
16 issues/concerns, or is your sense that that is
17 reasonable, assuming all of the other conditions are
18 met? Any thoughts?
19 (Question from the audience)
20 PETER OSBORNE: So the Act would propose
21 to say, at least in the first instance, 16 and above.
22 That's the proposal, which is a fair point because
23 there are lots of discussions afoot, as you know, in
24 different clinical circumstances about what a mature
25 minor is. Anyone else have any thoughts about minors?

1 What about the involvement of parents? Should a
2 consent of a parent or guardian be required, or is
3 that something specifically that should not be
4 required if the patient meets the other criteria? Any
5 thoughts? Yes?
6 (Question from the audience)
7 PETER OSBORNE: Right now -- sure,
8 certainly. Dr. Berman asked, where you've got a
9 mature minor with a psychological illness, they are
10 not age of majority -- a physical illness, I'm sorry.
11 (Question from the audience)
12 PETER OSBORNE: Physical illness, patient
13 cannot voluntarily provide informed consent, cannot
14 communicate that consent, what is the role if any for
15 substitute decision-makers in determining whether
16 medical assistance in dying can be administered; is
17 that fair? And the short answer right now is there is
18 no role for substitute decision-makers, which puts a
19 really strong or high burden on you as medical
20 practitioners.
21 The concern is seen at least in the early
22 days of this legislation and the legality of medical
23 assistance in dying in Canada, it's too risky to allow
24 substitute decision-makers to provide consent on
25 behalf of a patient who is unable to do so. So, it's

1 interesting because you're right, Ruth, there are many
2 circumstances where a physical disability or illness
3 may well prevent the patient from giving that informed
4 consent. And that may be one of the amendments that
5 comes to the fore when the changes come into effect,
6 but right now the fear is that there could be abuse of
7 the legislation and therefore there is a concern about
8 expanding it too far and too fast. Any other
9 questions or observations or thoughts on that?
10 Okay. So you will see requests as you
11 come forward, as I say, about whether you can
12 participate in making an assessment about capacity
13 and/or act as a witness. And we have one more
14 question. Yes?
15 PARTICIPANT: So just looking at how it's
16 stated in here, enduring physical or psychological
17 suffering, so when you're talking about it, you're
18 kind of separating physical from psychological, but
19 sometimes they go together. Sometimes, a person who
20 is physically ill is also psychologically suffering
21 because of that illness and so it may exacerbate and
22 intensify their suffering because they have both, and
23 likely they do have both, so they are not always
24 separate. So I'm just wondering how, you know, when
25 you look at the law, they're very specific, are they

1 really talking about it as separate entities or are
2 they combining them here because they sometimes go
3 together?
4 PETER OSBORNE: Very fair observation.
5 Everyone hear the question? So I think the takeaway
6 for today in the current state of the law -- and
7 you're quite right, where both are present, physical
8 and psychological suffering, you would meet that
9 component of the criteria for sure. The issue is --
10 and it may be rare, as you say, because typically the
11 clinical presentation of a grievous and irremediable
12 physical harm may very well bring psychological
13 suffering with it as you say. The takeaway is where,
14 even though it may be rare, there is only
15 psychological suffering, the alarm bells should be
16 going off for you. Yes.
17 PARTICIPANT: Thank you. As I listen to
18 you, I was thinking about the context of being in a
19 multi-cultural, multi-factorial interpretation of
20 laws. What is the information to date in situations
21 whereby it's not just the question of mature minors,
22 but it's a question of communities whereby decisions
23 of this sort are delegated to a religious entity that
24 has interpretations for the family as a whole? And I
25 was just wondering whether you have any existing

1 feedback on this issue and where this is going in
2 terms of the feedback about the process of
3 clarification as cases evolve. Thank you.
4 PETER OSBORNE: No, it's a very good
5 question, and right now there is no accommodation in
6 the law for those types of situations. One of the
7 things that council that's looking at this and is to
8 report by the end of this year is considering is the
9 impact of this law on those community and cultures
10 where there are group decisions made historically and
11 how those fit into this. First Nations people, for
12 example, where in many circumstances a council of
13 elders may typically be involved in decisions of
14 healthcare as well as property and other things;
15 different cultural and religious backgrounds from
16 other countries as well as within Canada where, in
17 whatever circumstance, more than just the individual
18 is involved.
19 And right now, the courts and the
20 government have taken a relatively hard line and said
21 you've got to comply with the eligibility criteria in
22 the Act. So you've got to be sure, number one, that
23 the patient requesting assistance themselves is
24 capable as we looked at in doing it; and number two,
25 they have reached that decision without any external

1 pressure.
2 So that's going to be an issue that's
3 going to be very relevant as we see some of these
4 changes going forward, and that's often in many
5 communities a harder determination to make if you're
6 involved than you might think. You've got the patient
7 who is grievously ill before you saying this is what I
8 want, I'm aware of options, and it's particularly a
9 decision that I have made, and you have the sense from
10 all of the external factors, the factual matrix, as we
11 call it, that in fact it's not an independent decision
12 and others are involved. And it's a great question
13 because it becomes all the more immediate an issue
14 where you've got a physical disability where the
15 person themselves can't communicate consent, to the
16 point you raised a few minutes ago. So lots, lots of
17 concern here.
18 My sense of this as this develops, it's
19 very early days in Canada. Some of the U.S. states,
20 as you know, are more advanced and frankly more
21 liberal in the eligibility criteria. Proceed with
22 caution, and this is one case where I think more is
23 preferable to less. If you are unsure about giving an
24 opinion about consent and capacity to a physician who
25 may ask you as a psychologist or a psychological

1 associate to assist in providing your professional
2 opinion as to the capacity of the person who is
3 seeking the treatment, if you are unsure, seek a
4 second opinion. If you are not sure, decline to give
5 the opinion in the circumstances.
6 It can be considered again in a month
7 down the road as the condition may progress. Just
8 satisfy yourself and, above all else, as you do with
9 anything in your clinical practice, chart it. So this
10 is one point where a fulsome clinical note about all
11 of the criteria you considered with the Act at hand --
12 and the College put out a practice advisory earlier
13 this or last year, excuse me, I think it was March or
14 April 2017, about MAID and how it affects you.
15 Just take a few moments. This is not a
16 decision that's made on an emergent or uninformed
17 basis. So take a few minutes to think through the
18 issues and what you are being asked to do. It's a one
19 way street obviously, so you want to be certain that
20 you've got things sorted out and you've complied with
21 the legislation.
22 Anything else on MAID? You've got a
23 sense of where that's at? All right. So stay tuned,
24 as I say. Perhaps at the next Barbara Wand or
25 something we could do an update on what the council

1 has reported at the end of the year and what changes
2 to the legislation, if any, have come into effect.
3 So let's switch gears for a second if we
4 can and talk about child welfare laws and what's new
5 in that regard. You are all obviously very familiar
6 with assessing and treating children, young adults and
7 adolescents, and there is a real sense afoot,
8 particularly with the current government in Queen's
9 Park, about empowering children, empowering young
10 people, and across a broad spectrum of topics and
11 areas, giving them a lot more power in decision-making
12 that affects them.
13 And Bill 89, the new Act, is one example
14 of that, Supporting Children, Youth and Families Act.
15 So it came into force this past summer, and really the
16 central purpose of the Act is to strengthen the rights
17 of children and participate in decisions that affect
18 them.
19 The preamble speaks volumes to some of
20 the broad and sweeping changes in this legislation.
21 Children are individuals with rights to be respected
22 and voices to be heard. Everything from family law,
23 custody, access, those sorts of things, the provision
24 of medical treatment, all across the board there is an
25 increasing involvement in the child herself or himself

1 in the provision of care and in all sorts of things
2 that affect their rights, as opposed to a decade or so
3 ago when parents or guardians had overwhelming and
4 almost complete discretion with respect to decisions
5 affecting children for whom they were responsible.
6 This is in part directed towards
7 allegations of abuse in some residential facilities,
8 in foster care relationships, and as well in families
9 where the biological parents have custody of their
10 children but there have been cases of abuse. So the
11 government looked right across the board at how to try
12 to empower children to be more involved in decisions
13 affecting them, and those affect both rights as well
14 as responsibilities on you as those who are practising
15 psychology in Ontario.
16 Among other things, what does the Act do?
17 It increases the age of protection from 16 to 18. So
18 that's one of the most significant changes in the
19 legislation. There is mandatory reporting for young
20 people under 16, and we'll come to what that means and
21 when that applies in a minute, and voluntary reporting
22 for people over 16.
23 There are a number of factors that apply
24 to children between the ages of 16 and 18 but, among
25 other things, a person who is over 16 but under 18

1 cannot be brought to a place of safety, often a
2 shelter or a foster care facility, without their
3 consent, so a big difference for a young person over
4 16 versus one who is under 16.
5 The Act provides a statement of rights of
6 children and young persons which is worth a read.
7 It's quite general. It's certainly not specific to
8 the practice of psychology but it does set out
9 generally the rights of children and young persons,
10 and again, most of them relate to advocacy and their
11 right to be involved in decisions affecting them.
12 There's a focus on support services to
13 assist families in remaining together. There is an
14 increasing reluctance to break up nuclear families
15 unless the child is in need of protection and there is
16 no reasonable alternative but to remove them from the
17 care of their parents. And similarly, there's a
18 strong emphasis on trying to keep siblings together in
19 whatever circumstances arise. So if the kids are
20 removed from the home, for example, there's a very
21 strong presumption on trying to find a solution that
22 keeps the kids at least together among themselves.
23 Increased provincial government oversight
24 of local service providers, lots of controversy about
25 that, whether or not that's simply going to provide

1 more policing, more compliance costs for facilities,
2 more involvement of Queen's Park, as opposed to
3 translating into better conditions day-to-day for
4 kids. And there is a recognition that services to
5 Indian and native children -- and that is the phrasing
6 used right in the Act referring to those entitled to
7 status under the Federal Indian Act -- native
8 children, families should be provided in a manner that
9 recognizes their culture, heritage and traditions and
10 the concept of extended family.
11 So what does that mean? There is an
12 emphasis here -- and this harkens back to the question
13 we had a few minutes ago about the circumstances in
14 which an issue arises. It's interesting, our MAID
15 Medical Assistance in Dying legislation doesn't take
16 factors into account at all -- at least in the current
17 legislation -- about culture, heritage and traditions.
18 We're thinking about extending that
19 protection to kids under the age of 18, and the
20 provincial Act specifically requires that cultural
21 heritage and tradition's concept of an extended
22 family, which varies greatly from culture to culture
23 and among different religions, be taken into account.
24 So there is specific reference in this legislation to
25 native children, Métis, First Nations and the concept

1 of the family in each of those cultural groups.
2 Lots of criticism about this legislation.
3 I would be interested if any of you have had this come
4 up in any of your clinical practices yet. The
5 organization, Real Women of Canada, for example,
6 describes the bill as another attack on the family by
7 the Province of Ontario. There are lots and lots of
8 criticisms in numerous organizations about how this
9 legislation is going to actually be implemented and
10 what's it going to mean.
11 There is significant concern about gender
12 identity and gender expression as factors to be
13 considered in the best interest of the child. They
14 are specifically referenced in the definition in the
15 legislation as factors to be considered when you're
16 considering the best interests of the child. So
17 particularly as you're dealing with children who are
18 under the age of 16, and getting younger and younger,
19 it's a real factor about how these factors are to be
20 taken into account and how practically, when you're
21 determining the best interests of the child in an
22 extended family situation, you consider gender
23 identity and gender expression, for example.
24 Interestingly, the legislation no longer
25 refers to a child's religion as a specific factor, and

1 yet a child's creed is listed in the Act as a factor
2 that must be considered, and "creed" is again defined
3 as something that considers and includes religion. So
4 typical lawyers in doing that, the short answer I
5 think is that religious and religious history and
6 cultural history of the child's background is a factor
7 you should take into account.
8 Lots of concerns. I don't know if anyone
9 has any thoughts on this as to whether the concerns
10 about the Act are warranted or whether from your
11 perspective this isn't all that earth-shattering in
12 terms of changes. I know some organizations have said
13 we've got to think about this, particularly
14 psychologists and psychological associates involved in
15 these situations.
16 Consider the situation where a child
17 identifies by a gender different than his or her birth
18 gender. The best interests of the child require this
19 to be taken into account, or there can be a risk of
20 intervention and perhaps the removal of the child from
21 the home situation. What do I do in those
22 circumstances? Has anyone come across situations like
23 this or been involved in assessments or considerations
24 of circumstances where this part of the new
25 legislation has come into play yet? No one present in

1 the room anyway.
2 All right. Well, it's interesting. Keep
3 a weather eye on this because it is going to be an
4 issue, I think, as we go forward over the next year.
5 The legislation has only been in effect, as I say, for
6 about a little over a year, but there is going to be a
7 concern for sure in circumstances where there are
8 gender identity issues, the child is a minor and there
9 is an assessment to be made, particularly where the
10 decision on which the assessment is based is whether
11 the best interests of the child require the removal of
12 the child from the home.
13 So there is lots of fierce debate going
14 on about whether or not this part of the Act is too
15 intrusive, appropriate and necessary for the
16 protection of kids, or whether or not it strikes that
17 right balance, and I think you're going to be right in
18 the middle of this debate as it continues over the
19 next year or two. So I would be interested in
20 thoughts and observations as you go forward and
21 consider what factors are taken into account, and I
22 would be interested in knowing from you over the next
23 year or so how those are really playing into your
24 clinical practice and what practical considerations
25 are arising. Yes? We'll give you the mike.

1 DR. RUTH BERMAN: I have a question and
2 then a comment. My question -- this bill replaces
3 what was the Child and Family Services Act.
4 PETER OSBORNE: That's right.
5 DR. RUTH BERMAN: Beyond what you've
6 listed here, have there been any changes made to the
7 definition of a child in need of protection, or those
8 still remain as they were?
9 PETER OSBORNE: Everyone hear that; any
10 differences to the definition of a child in need of
11 protection? The principal change being the age is now
12 raised.
13 DR. RUTH BERMAN: The age.
14 PETER OSBORNE: Sixteen to eighteen.
15 DR. RUTH BERMAN: Okay.
16 PETER OSBORNE: So some differences, as I
17 say, can't remove a child who is over 16 but under 18
18 to a care facility without their consent, but there
19 are reporting obligations in respect of kids all the
20 way up to 18 now.
21 DR. RUTH BERMAN: Okay. I'm not sure how
22 this particular case relates to your highlighting the
23 issue of gender identity and gender expression. I had
24 heard of a case where parents were considering
25 adopting a child, and as part of the routine

1 investigation that's undertaken to look at parent
2 suitability, their fundamental Christian beliefs was
3 highlighted and they were denied the right to adopt
4 because they were very opposed to homosexuality. And
5 the concern was this was a young child, that should
6 that child, you know, experience some sort of gender
7 identity issues that needed to be addressed within the
8 family that these parents would not have the best
9 interests of the child in mind and were denied the
10 right to adopt. So I don't know if this legislation
11 in particular, you know, impacted on that. I think it
12 would be different legislation but, nevertheless, I
13 think it sort of speaks to some of the same issues.
14 PETER OSBORNE: Absolutely, and the
15 criteria for adoption, which you're right, is a
16 completely different regime, are going to have to fit
17 together with these, and right now there is no case
18 law of which I am aware where the courts considered
19 that exact thing, Dr. Berman. So for example...
20 DR. RUTH BERMAN: I don't know if it
21 happened in Ontario.
22 PETER OSBORNE: Okay.
23 DR. RUTH BERMAN: Or it happened in
24 another jurisdiction.
25 PETER OSBORNE: It may well have been in

1 another jurisdiction was Dr. Berman's point, and there
2 is lots of literature and an increasing body of
3 literature out of the United States and the United
4 Kingdom in particular about correlating the best
5 interests of the child in the whatever country,
6 province or state's laws with respect to protection of
7 children and how that intersects with adoption
8 criteria. It's not an easy issue, and really there is
9 an awful lot to be sorted out here which has not been
10 resolved yet. Thank you very much, Barry. So lots to
11 think about there, and it's something for sure that
12 you're going to encounter, I think, in clinical
13 practice and is well worth keeping an eye on.
14 Psychologists, as I say, are going to be
15 at the forefront of this, and right now there are
16 really no guidelines or regulations behind the Act
17 that I think make it easier for you in your day-to-day
18 practice in terms of applying some of these criteria.
19 And really, if I were Prime Minister or if I were
20 Premier, that to me is the starting point with all of
21 this legislation.
22 We have these new rights, we have these
23 new obligations and precious little clinical
24 guidelines. So I always want to -- especially as I
25 was preparing for today for example, I put myself in

1 your situation and I say, all right, what's the
2 takeaway for me? What do I have to do to comply
3 obviously with my legal obligations but, more
4 importantly, to provide the best clinical practice I
5 can to my clients? What do I do in this situation?
6 And I think our governments federally and
7 provincially could do us a huge favour if they would
8 give us a lot more practical guidelines, rather than
9 having this sorted out incrementally really by way of
10 a process of evolution over the next few years. So
11 the other side of that coin, however, is that there is
12 a real voice for you, as members of this College and
13 this profession, in developing the standards and
14 guidelines I think as these come forward and are
15 developed over the next year or two. Barry.
16 BARRY GANG: Yes, there's a question
17 online. We have received actually some questions from
18 earlier, but they came after the topic was changed, so
19 we'll get to them either later or in the Q and A. But
20 this one has to do with reporting obligations, and the
21 question is what is the threshold? Is at risk enough,
22 or does evidence of abuse, neglect trigger a report?
23 PETER OSBORNE: The short answer, I
24 think, and particularly the safe answer from a risk
25 management perspective, is a clinical conclusion that

1 the individual, the young person is at risk, and the
2 mandatory reporting obligations apply where the child
3 is under 16. There is a discretion built into the Act
4 in circumstances, as I say, where the child is between
5 16 and 18, but the short answer is if you conclude
6 that the child is at risk, my sense would be -- it
7 obviously depends on the individual circumstances --
8 but you should report that, particularly where the
9 child is under 16. Okay. So lots to think about in
10 this legislation. Barry, another one.
11 BARRY GANG: One more question. You
12 addressed some of it already, but this person is
13 asking whether or not there is a suggestion that a 16
14 or 17-year-old must agree to the report.
15 PETER OSBORNE: Everyone hear that; must
16 a 16 or 17-year-old agree to the report? The short
17 answer is no. If you conclude under the discretionary
18 criteria that a report is warranted and it's not
19 mandatory in all circumstances for the older kids, you
20 may well have a reporting obligation with or without
21 their consent. As I say, what does require their
22 consent is the removal to a safe facility outside the
23 home, for example, in other words, taking the children
24 from the family.
25 BARRY GANG: Because I think the

1 understanding is that it's not -- it's an option to
2 report after 16, not mandatory, and I think that's
3 where some of the confusion may be.
4 PETER OSBORNE: Correct, correct,
5 exactly. It's an option. So it's clearly mandatory
6 below 16, discretionary above 16 to 18. It's
7 optional, it is not required in all circumstances at
8 all. So, the important thing is there are -- what's
9 new is there are circumstances in which a child 16 to
10 18 may be entitled to protection, but it's certainly a
11 lower threshold, a lower standard than children under
12 16. Yes?
13 PARTICIPANT: I was under the impression
14 that this Act wasn't being proclaimed until this
15 spring. Am I mistaken?
16 PETER OSBORNE: The Act came into force,
17 yeah, on June 1, 2017, and I can -- if people are
18 interested, I could provide by way of email to Rick
19 and Barry, there are stages in respect to which
20 different sections of the Act, different provisions
21 come into force on more or less a rolling basis. But
22 it is in force now, and I can provide you with a more
23 detailed schedule and I can do that, and I'm sure we
24 can find a way to make it available to everybody how
25 that applies and specifically which sections are

1 applicable at which time. It comes in more or less on
2 a rolling basis over a two-year period. Yes, sir.
3 PARTICIPANT: Yeah, I've noticed that
4 there is an increasing number of cases that involve
5 mixed jurisdictions both within Canada and with regard
6 to Canada and the U.S. Now, it seems to me, for
7 example, the U.S. is moving in a different direction.
8 They are expanding the definition of religious
9 liberty, which I think means more power for families
10 when it comes to the children. Is there any thought
11 or anybody talking about how to come together with
12 cross-jurisdictional issues and how this will affect
13 things, or among even the profession of psychology
14 itself at the level of the APA or the colleges?
15 PETER OSBORNE: I'd be interested in
16 thoughts on that. There may well be a number of folks
17 in the room who would know that better than I from
18 your other areas of involvement. But at least at
19 present, there is no official collaboration between
20 governments, for example.
21 There is, as I say, the discussion about
22 creed, religion, the involvement, as we talked about a
23 few minutes ago, of extended family. And I know that
24 particularly the governments of our three territories;
25 Nunavut, the Northwest Territories and the Yukon, with

1 significant First Nations, Inuit and Métis populations
2 are very interested in ensuring exactly that. So I
3 think for the moment in terms of the baseline law,
4 practising in Ontario, you've got to ensure that you
5 comply obviously with Ontario law.
6 But it's an excellent question and I
7 think there has got to be a lot more fulsome
8 discussion on precisely that, because right now there
9 is precious little integration even among Canadian
10 governments across provinces and territories, let
11 alone in the U.S. And you're right quite, the current
12 direction in the United States is very different from
13 that occurring in Canada. And as we see tele-therapy
14 and other methods of delivery for remote delivery of
15 psychological services becoming more and more
16 prevalent, I think that's going to be an issue that
17 we're going to have to wrestle with, and I would hope
18 that there is some guidance on that as we go forward
19 for sure.
20 Okay. Good to switch gears for a minute
21 if we can, and as I say, I will try to be around after
22 and certainly reachable by email as well, and we can
23 continue the discussion because there are lots of
24 issues with respect to all of these points that are
25 yet to be resolved.

1 Can we talk about psychotherapy for a
2 minute and where we're headed with this? This, as
3 many of you know -- I know it's near and dear to the
4 hearts of any -- could bring about some real changes
5 for the professional practice in the years to come.
6 So there is a new regulation in effect. The list of
7 controlled acts, the one that is nearest and dearest
8 to our hearts, communicating a psychological
9 diagnosis, has now been expanded, so psychotherapy is
10 now a controlled act in the province of Ontario.
11 There is again a two-year transition
12 period for this new regime that began December of last
13 year and continues through to the end of December
14 2019, and members of six colleges will be authorized
15 to provide the controlled act of psychotherapy. Of
16 course, psychology, psychotherapy, mental health
17 therapists, social work and social service workers,
18 nurses, occupational therapy and physician, so six
19 colleges involved in this and whose members will be
20 authorized to perform the controlled act.
21 Again, many of you are familiar with
22 this, but it's interesting, what is psychotherapy? It
23 is defined specifically in the Regulated Health
24 Professions Act -- so again, this is Ontario only --
25 treating by means of a psychotherapy technique

1 delivered through a therapeutic relationship, an
2 individual's serious disorder of thought, cognition,
3 mood, emotional regulation, perception or memory. It
4 has to be one that may seriously impair the
5 individual's judgment, insight, behaviour,
6 communication or social functioning.
7 Lots of controversy and discussion, as
8 you all in this room and on the web are aware, about
9 whether or not this definition is too broad, too
10 narrow, whether or not this should be a controlled
11 act, and where precisely the line is between
12 psychotherapy that is a controlled act as defined
13 here, and what many in the profession have referred to
14 as psychotherapy or therapy previously, which is not
15 caught by this definition and therefore is not a
16 controlled act, the performance of which is
17 restricted.
18 So again, I think the high level takeaway
19 for us is the controlled act, as it's defined, has
20 five distinct components or parts: treatment,
21 recognized psychotherapeutic technique, it's offered
22 within the context of a therapeutic relationship,
23 serious disorder and a risk of impairment. So that is
24 the definition for the moment of psychotherapy as it's
25 defined.

1 What do folks think about this? Is this
2 an issue in your practice today? Is this becoming an
3 issue? Any thoughts or questions about that,
4 concerns? Is it the right balance? Is it the right
5 definition? What is your sense of it? Any
6 observations, or is this an issue that has come up in
7 your practice at all or in the clinical setting in
8 which you do practice?
9 Does a certain approach that's being
10 considered for a client, is this a controlled act that
11 has to be performed only by a member, can someone else
12 perform it? Are folks pretty clear on where the line
13 is in terms of the criteria or not really a big issue
14 for your practice? Any thoughts or observations?
15 Yes, ma'am.
16 PARTICIPANT: So if you're supervising a
17 non-regulated member, are they allowed to perform
18 psychotherapy with you as their supervisor, is my
19 first question. And my second is, do the other
20 professions such a physicians and nurses, nurse
21 practitioners, do they have to go through an
22 evaluation process to determine their competence at
23 psychotherapy before providing it?
24 PETER OSBORNE: Okay. Good questions
25 both. Let me deal with the second one first. As I

1 understand it, in each of the six professions, right
2 now there are no specific competency testing regimes,
3 in other words, a certificate or something beyond
4 their certificate of registration to practice. But
5 for all practitioners, as certainly with psychologists
6 and psychological associates, as you know, every
7 certificate of registration is restricted to those
8 areas in which the member is competent, and that's a
9 factor for all of the six regulated health
10 professionals.
11 They've got to ensure that they are
12 competent to administer the treatment, which as you
13 know is -- or the assessment -- is a theme throughout
14 almost all of the regulated professions even beyond
15 health regulated professions in Ontario, which makes
16 sense. I have always thought it's sort of ironic or
17 something that technically I'm licensed to represent
18 an accused in a murder trial and I wouldn't for a
19 moment hold myself out as being competent to do that.
20 But lawfully, legally, I'm entitled to represent them.
21 So that's the short answer on the second part of your
22 question.
23 And with respect to the first part, in
24 other words -- and help me, I've just had a complete
25 brain freeze, I apologize.

1 PARTICIPANT: A regulated member
2 supervising...
3 PETER OSBORNE: A regulated member
4 supervising, can that person who is under supervision
5 perform the controlled act of psychotherapy, and our
6 friends at the College may wish to speak to that as
7 well, Rick or Barry, with respect to the College
8 policy on supervision.
9 DR. RICK MORRIS: Right. The standards,
10 the new standards that came into force, do not permit
11 the supervision of non-regulated providers in the
12 controlled act of psychotherapy. But when you
13 originally asked your question -- and that's really
14 important to make a distinction -- you said can
15 members supervise non-members in psychotherapy. The
16 answer to that is yes.
17 What you have to really be careful about
18 is the controlled act of psychotherapy rather than
19 just psychotherapy, because psychotherapy as a
20 technique, I guess, is still in the public domain.
21 Anybody who was able to last year do psychotherapy can
22 continue to do psychotherapy unless it crosses the
23 line to become the controlled act of psychotherapy.
24 So the only thing that is controlled is
25 what Peter has described as psychotherapy that meets

1 these five criteria, and for me, the most important
2 criteria are the last two: It is being provided to an
3 individual who has a serious disorder where that
4 serious disorder causes a risk of -- and he has left
5 out the word "serious impairment", because that is
6 also in the definition. So it's really just that --
7 for me, it's a very, narrow small end of the
8 psychotherapy continuum that is protected or is
9 restricted. All the rest of the psychotherapy that
10 we've been doing and we've been supervising people in
11 doing is still public domain and is still subject to,
12 you know, the same things that we were doing last year
13 or the year before.
14 PETER OSBORNE: One more question from
15 the floor.
16 PARTICIPANT: I have a question which I
17 call the "grey zone question", and it's particularly
18 applicable to those of us who are working with
19 children and youth, and it has to do with the
20 interpretation, in addition to what is written and
21 agreed upon, of serious disorder. And I would like to
22 ask the grey zone question which is, in cases where at
23 the starting point it was not clear that it is a
24 serious disorder, and as the assessment or
25 intervention evolved it moves to the category of

1 serious disorder, what happens to your role as a
2 psychologist?
3 PETER OSBORNE: Good question. Any
4 thoughts on that? I would think that might arise in
5 your practice more often than you might think where
6 the progression of the illness increases as your
7 treating relationship continues. And the short answer
8 is I think in your question, which is it's a grey
9 zone. So where that point is reached where you have
10 to -- you are performing a controlled act, and
11 therefore it must be performed by a registered member
12 of one of the colleges occurs, is a question of
13 professional judgment.
14 And you are quite right, I can foresee
15 and I think the legislation foresees scenarios where
16 exactly that occurs and a non-regulated professional
17 may be providing the therapy at the outset of the
18 relationship, and there comes a point where the
19 decision is made, hey, this is now sufficiently
20 serious because, as you say, the serious disorder
21 factor is now met. That although I believe that I
22 have been competent and lawfully entitled to perform
23 and provide the therapy up until now for the last year
24 or what have you, going forward, it's a controlled act
25 and must be provided by a registered member of the

1 profession. And so there is no clear line on where
2 that is for sure. It's a good question and it's going
3 to require professional judgment as you go as to where
4 that line is.
5 I like to hope that the courts and the
6 health professions board, for example, would give some
7 considerable deference to those clinical psychologists
8 and professionals making that judgment call, and it is
9 circumstances where I think that very reasonable,
10 competent professionals might very well disagree on
11 whether or not that occurred on June 1 or September
12 9th or what have you.
13 So I think the key takeaway for that is
14 to be vigilant to the fact that the relationship and
15 the condition, the disorder, may progress such that
16 something that wasn't a controlled act now is; and as
17 always, to back yourself up just from a protection and
18 risk management perspective and chart in your clinical
19 notes why that decision was made now. I was
20 comfortable, a non-registered individual providing
21 treatment until now. This client has reached the
22 stage where, in my view, this now constitutes the
23 controlled act of psychotherapy and here is why I
24 think I reached that decision on this date as opposed
25 to a month ago or two months down the road. Barry.

1 BARRY GANG: There's a few questions.
2 One of them is what about people who are unregulated
3 providers of things that they are calling psycho-
4 education, supportive counselling, things that they're
5 saying are not really therapy, are these in any way
6 affected by the changes.
7 PETER OSBORNE: Fair question. And you
8 know, I might ask you or Rick as well on that. I
9 mean, I guess the legal answer would be you've got to
10 go back to the criteria in the Act and say, all right,
11 are they met. So if there is psycho-education, et
12 cetera, and some of the other things you mentioned,
13 Barry, do we have a situation where the five criteria
14 in the definition can be met. And again, I can
15 foresee circumstances where, to borrow your phrase,
16 it's in the grey zone for sure.
17 BARRY GANG: I can add to that, that
18 nothing really has changed unless somebody is
19 performing the controlled act of psychotherapy. So
20 those people who are unregulated and have been able to
21 figure out a way to do these things without violating
22 either the Psychology Act or the RHPA, that won't
23 change for them. I am not sure that the label
24 "controlled act of psychotherapy" is as important as
25 an intervention that would meet those criteria.

1 So I think that they might be running
2 some risk and putting their clients at risk if they
3 were doing things without calling it the "controlled
4 act of psychotherapy" that met the definition. But
5 those who have been doing counselling and
6 psycho-education and things like that where it's not
7 the controlled act of psychotherapy are in no
8 different a place I think, if you agree.
9 Another question is can we clarify
10 whether the Psychotherapy Act includes assessment; and
11 if so, what that could mean. I don't believe that it
12 does. I think it's just those things -- it starts
13 with treatment, and if it isn't a treatment, you can
14 stop there.
15 PETER OSBORNE: I think that's exactly
16 right and that's an important point, a good question
17 for the individual joining us by web to clarify, and a
18 good reminder to me to emphasize that for you. Barry
19 is exactly right. It begins with the proposition that
20 there is treatment. So assessment unto itself without
21 treatment would not be caught in the definition of the
22 controlled act of psychotherapy.
23 BARRY GANG: So as you can imagine, we're
24 getting a lot of questions. Do we have time to go
25 through a few more?

1 PETER OSBORNE: Absolutely.
2 BARRY GANG: Okay. So is every member of
3 the College of Registered Psychotherapy permitted to
4 perform the controlled act of psychotherapy? I can
5 take a stab at it if you want. As long as they don't
6 have a term limitation or condition on their own
7 certificate, they would be, and the same is true for
8 members of this College.
9 PETER OSBORNE: That's exactly right.
10 BARRY GANG: One sec. Okay. That's a
11 Bill 89. Are family, group and couples therapy
12 considered psychotherapy?
13 PETER OSBORNE: Good question.
14 BARRY GANG: It's a very good question.
15 Rick and I maybe can pass this back and forth, but I
16 mean, there is the mention of an individual's serious
17 disorder within the definition. I don't think this
18 has been tested in any way, but it could be that if
19 your intervention is directed towards -- you know, you
20 may be using family techniques and such. If it's
21 directed towards remediating a situation as described,
22 it may very well be. I don't know if, Rick, you want
23 to....
24 DR. RICK MORRIS: It hasn't been tested
25 yet.

1 PETER OSBORNE: Yeah, Barry and Rick are
2 right. This hasn't been tested. To my knowledge,
3 there have been no cases whatsoever in Ontario. My
4 sense of this is, given the way the definition is
5 worded and the references as Barry highlighted to an
6 individual, if even one of the individual in couples
7 or family therapy would meet the definition here, my
8 sense would be that the safe course of action at least
9 until this is tested and clarified further, would be
10 that that constitutes the controlled act, and
11 certainly if it applied obviously to two or more in
12 the couples or family group being treated, it would
13 apply for sure.
14 But it hasn't been tested, still to be
15 sorted out. But I would be I think uncomfortable were
16 it me providing psychotherapy and considering it not
17 to be a controlled act if, as I say, one of the
18 individuals in the group being treated would meet the
19 definition. I know we have another question over
20 here. Yes.
21 PARTICIPANT: I'm just wondering about
22 whether or not there are implications for graduate
23 students in psychology in terms of how they get their
24 training with more serious conditions. So many
25 psychologists learn how to do psychotherapy with

1 serious impairment while they are in practica or
2 internships during grad school and they are not yet
3 part of the registration process, and I'm wondering if
4 under this legislation that's an option to do
5 psychotherapy, for example, in an in-patient hospital
6 setting under the supervision of a registered
7 psychologist.
8 PETER OSBORNE: That's a great question.
9 Dr. Morris.
10 DR. RICK MORRIS: I'll play lawyer. The
11 legislation does anticipate this, not just for
12 psychotherapy but also for any of the controlled acts.
13 It anticipates that someone has to have an opportunity
14 under the supervision of a qualified person to learn
15 how to do it, whether it's communication of diagnosis
16 or some of the things that happened sort of in the
17 more physical interventions in terms of medicine and
18 that sort of thing.
19 So one of the exceptions that you'll see
20 in the RHPA is that the restriction on the controlled
21 act does not apply to those who are fulfilling the
22 requirements to become a member of the College and it
23 specifically says that person who is fulfilling the
24 requirements can do the controlled act under the
25 supervision of someone who is qualified and authorized

1 to do it. So the PhD students and others are
2 certainly covered in that way.
3 PETER OSBORNE: Any other questions or
4 observations? Barry, anything else from the folks
5 online?
6 BARRY GANG: Here is a question. How is
7 this Act reinforced? Who will monitor Jane Doe who is
8 doing counselling? The Jane Doe who is doing
9 counselling is not doing the controlled act, if one of
10 us hear about a person who is not regulated doing the
11 controlled act, who should we contact, who is going
12 after the person?
13 PETER OSBORNE: Always, always a good
14 question, who will bell the cat. So I think everyone
15 heard that, and the short answer is that there are no
16 changes to the enforcement mechanisms in the Act,
17 which means we're under the regime as it currently
18 exists. So obviously, the colleges, the six colleges,
19 this college in particular relevance to us, have
20 authority to regulate the practice of psychology, for
21 example, including this controlled act.
22 Where you've got someone who is
23 performing what is now a controlled act and is not
24 qualified, is not a member of one of the six colleges,
25 I think that should be reported to one of those six

1 colleges. And all of them, including psychology, have
2 the ability under the Act to bring proceedings for
3 unauthorized practice, and I know that this college
4 does that in appropriate circumstances from time to
5 time.
6 So the procedural code under the RHPA
7 provides that a college can go to court and seek an
8 injunction, seek a prohibiting order, essentially, a
9 declaration that the individual is performing the
10 controlled act, that they are not qualified and
11 authorized to perform it, and a court order requiring
12 them to cease from doing that. And typically, the
13 courts have been quite deferential to the colleges in
14 inappropriate circumstances in ensuring that the
15 public is protected.
16 Where the legislature has seen fit to
17 make this a controlled act, the courts are generally
18 pretty careful in denying an order for a person who is
19 not a member of one of the authorized colleges from
20 performing that act. And in the rare circumstance --
21 and it is rare where a person doesn't comply with the
22 court order -- they can be found in contempt, fined
23 and all sorts of other remedies as well. So that's
24 the basic route I think by which that would be sought
25 to be addressed, sometimes more effective in theory

1 than in practice.
2 It's difficult, it's expensive, it can be
3 time consuming, but I think that our takeaway should
4 be that if you are aware of an unauthorized person
5 performing the controlled act, just as you would be
6 with respect to communicating a diagnosis, the report
7 should be made so it can be evaluated. Yes?
8 PARTICIPANT: In one of the slides, you
9 talk about government funding, the money that is being
10 put towards. Can you talk about that?
11 PETER OSBORNE: Certainly. Psychotherapy
12 is an initiative and a priority of the current
13 government in Ontario and they have announced
14 additional funding of just over $72 million for
15 psychotherapy over the next three years. Equally
16 interesting, however, there is precious little
17 definition about how that money is actually supposed
18 to be used and how it is going to practically increase
19 access to psychotherapy.
20 Currently, there is not a Legal Aid
21 model, if you will, where psychotherapy provided by
22 independent practitioners, those in private practice,
23 can be funded through a government fund, and it is
24 really in the course of being sorted out how this is
25 going to come into force. Are there others who can

1 add to that at all, because I know that's a topic that
2 is front and centre at Queen's Park now and at the
3 Ministry of Health and Long Term Care precisely, as
4 you say, how this money is going to be implemented to
5 actually increase access to psychotherapy. Anyone
6 come across that or been involved in this? Yes.
7 (Question from audience)
8 PETER OSBORNE: So the question is are
9 the two things related; in other words, making
10 psychotherapy a controlled act and access to funding.
11 So no, in the sense that the idea is that they are to
12 be concurrent but certainly, as I understand it, the
13 funding is for the controlled act of psychotherapy and
14 not assessment or things of that nature, as Rick and
15 Barry were talking about, that would not meet the
16 definition.
17 That said, I think the general sense of
18 the funding is that mental health services and the
19 provision of psychological services in particular in
20 the province are underfunded. That has to be a
21 priority, particularly in remote and non-urban rural
22 areas. It's just not available, and I think that
23 while they are not related, as the controlled act
24 regime comes into force and therefore the provision of
25 psychotherapy that meets the definition is restricted

1 to those who are qualified, there has got to be more
2 funding made available so that access to psychotherapy
3 is not decreased at the very time it should be
4 increased. So a real issue and I think a real sense
5 that, however this money is deployed, $72 million is
6 not going to be sufficient to achieve that objective
7 particularly as it is rolled out over a few years.
8 Good, good question.
9 PARTICIPANT: So I don't have personal
10 experience with this, but there was a letter in
11 today's Star from the head of Family Services
12 Association talking about 10,000 people getting
13 psychotherapy online through their organization. So
14 I'm not sure if they are -- you know, who is
15 evaluating how serious their disorders are or what is
16 happening in that area, but obviously it sounds like a
17 government initiative. They have to get lots of money
18 to treat that many people.
19 PETER OSBORNE: Absolutely.
20 PARTICIPANT: So we might want to look
21 into it.
22 PETER OSBORNE: And I will as well. No,
23 thank you. Yes, sir.
24 PARTICIPANT: I'm wondering how the
25 controlled act will impact on how we refer to the term

1 "psychotherapy" in our sessions with clients, in our
2 notes and in our reports, when we're doing
3 psychotherapy that doesn't meet the definition of
4 psychotherapy. Are we no longer going to be in a
5 position to call that psychotherapy? Because for
6 instance, it would then imply that the person had a
7 serious disorder, particularly if we were sending out
8 a note and for other reasons.
9 PETER OSBORNE: It's a good question, and
10 certainly over the course of the matters that I've
11 been involved with for many years, looking at clinical
12 notes and records of psychologists and psychological
13 associates, psychotherapy of course is referred to
14 throughout the treatment notes. My sense of it is,
15 where you are providing treatment, I would make
16 reference in the notes at some point perhaps early on
17 in the relationship or where you reach the point where
18 you think the treatment being provided meets the
19 definition in the statute, that you say so in your
20 notes.
21 And to be clear, that's my own sense
22 again from a risk management perspective. I'm not
23 suggesting for a moment that that's required in the
24 legislation but, to me, if you make it clear in your
25 notes that the treatment you're providing meets the

1 Act and I'm a member of the College authorized to
2 perform the controlled act; or the therapy I'm
3 providing, an assessment or what have you, does not
4 fit the definition and therefore does not -- is not a
5 controlled act that only a member of the College can
6 provide, if that's clear, I wouldn't be too fussed
7 about the fact that a month later in a treating note
8 or something the word "psychotherapy" appears.
9 I think the practical matter is it's
10 going to appear all the time and none of us are going
11 to be perfect in terms of the way in which we define
12 it each time we use it. So just try your best to make
13 it clear the nature of the treatment you're providing
14 -- controlled act, yes or no -- and then I think the
15 courts in most circumstances would give some deference
16 and professional deference to those circumstances
17 where you made it clear that you weren't providing the
18 controlled act even though you referred to in your
19 notes psychotherapy, for example.
20 PARTICIPANT: Thanks. That's helpful.
21 PETER OSBORNE: You're welcome. It's an
22 interesting area. So I know we've got just a couple
23 of minutes before you'll be relieved to know we can
24 get a coffee and a quick snack. Are we good to leave
25 psychotherapy just for the moment, and we can just

1 take a minute before we break if you wish and switch
2 gears and just do a quick note on elder abuse and then
3 we'll carry on with a couple of different topics after
4 we have a few minutes to get a refreshment.
5 BARRY GANG: So we have a lot of
6 questions from the online participants. There are ten
7 times as many of them as there are of the people here.
8 You will all have the benefit of the questions and
9 answers as soon as we can put them up on the website,
10 and we will come back at 10:45 very sharp. Thanks.
11 PETER OSBORNE: Perfect, thank you.
12 10:45. Thank you.
13 --- BRIEF RECESS
14 BARRY GANG: Okay. If everybody could
15 take their seats, that would be great. As promised,
16 we're starting right at 10:45 and going until 11:15
17 with Peter.
18 PETER OSBORNE: Thank you, Barry, and
19 thank you to everyone. Lots of questions, as Barry
20 and Rick said earlier. We'll do our best to deal with
21 all of these on the website later. There are a number
22 of questions from our colleagues joining us online, as
23 well as obviously here in the room in Toronto.
24 And just before we move onto some of the
25 other issues, just a couple of points I just wanted to

1 talk about and clarify as a result of a few questions
2 I got during the break which are excellent. One, I
3 mentioned that if you're providing therapy and there's
4 a concern about whether or not what treatment you're
5 providing meets the definition for the controlled act,
6 and I said good practice is to put it in your notes,
7 obviously, where you're a member of this College and
8 therefore authorized to perform the controlled act,
9 it's less of an issue.
10 I'm thinking of circumstances where you
11 may be in a clinical setting and there may be
12 individuals assisting in the assessment process, for
13 example, who are not members of the College, and if
14 what they are doing could potentially be considered to
15 be psychotherapy, it's those folks more than members
16 of the College that I think it's critical to be clear
17 about whether or not they meet the controlled act.
18 Secondly, there were a number of
19 questions and comments about the funding that the
20 provincial government has announced, all good
21 questions. And just to be clear on that, our
22 understanding is at present that the focus of the
23 funding is for those individuals suffering from
24 moderate anxiety and depression, so those are the
25 targeted individuals whom the province is trying to

1 increase access to services through this funding, are
2 intended to be the recipients.
3 But that said, as I say, there are
4 virtually no guidelines or criteria setting out how
5 that funding is to be administered; if it's simply
6 going to be funding made available to CAMH, for
7 example, as it sees fit, consistent with the
8 objectives of the funding program or otherwise, but
9 the short answer is there is no guidance. For me, for
10 example, the obvious question, how does a private
11 practitioner access this funding to provide services
12 to individuals who otherwise may not be in a position
13 to receive it as a result of lack of resources. So
14 lots to - lots to think about.
15 Can we switch gears for a moment and talk
16 about some amendments to two new pieces of legislation
17 that relate to mandatory reporting for vulnerable
18 populations? And I mentioned before the break and I
19 talk about in the materials about elder abuse.
20 Certainly, elder abuse was one of the
21 issues that was receiving a very high profile in the
22 media over the last year or so which brought about a
23 number of these changes. But to be clear, while elder
24 abuse is an issue in one population, elders, to whom
25 the legislation applies, it's really to any vulnerable

1 persons, and particularly it is directed at facilities
2 providing care or where they are residing. So while
3 we talk about this and it often is elders, it is
4 anyone who is vulnerable, and we'll talk about what
5 that means.
6 It is not just elders. It could well be
7 a patient or a client who is 20 years old but who is
8 in need of assistance and, in particular, protection
9 to avoid abuse. It grew out of the inquiry arising
10 after the conviction and guilty plea, many of you will
11 remember a nurse working in a long term care facility,
12 Elizabeth Wettlaufer and her conviction for murder as
13 well as attempted murder and aggravated assault with
14 respect to the administration of various substances to
15 bring about the death of patients in her care and the
16 care of the facility at which she worked. So two laws
17 that require reporting of abuse, let's say that, and
18 the important takeaway I think for us today is that
19 reporting obligation can arise even where the
20 information is confidential or private or privileged.
21 So what does all this mean? As Rick was
22 reminding me, and he is dead right, it's based on
23 facilities and places of residence. That's the focus
24 and target, if you will, of the legislation. So we've
25 got long term care homes and retirement homes,

1 different at least as defined in the legislation, and
2 these will be facilities where many of your clients
3 and patients are resident, long term care or
4 healthcare facilities designed for adults who need
5 24-hour care, and again, 20-year-olds, 80-year-olds,
6 not just elders for sure. The Retirement Homes Act,
7 residential complexes for seniors who are 65 or over
8 who can live independently and may require or not
9 require varying levels of assessment, treatment and
10 care. So Long Term Care Homes Act, so rehab
11 facilities, all sorts of facilities, including again
12 but not limited to elders.
13 What does abuse mean? Physical, sexual,
14 emotional, verbal or financial as defined in the
15 regulations, and there is a lengthy list in the
16 regulations under each Act, but the key takeaway is it
17 certainly can be physical, sexual, but it can also be
18 exclusively emotional, verbal or financial, taking
19 advantage of those vulnerable to access their assets,
20 for example, and try to get them to sign over assets,
21 things like that.
22 How does the mandatory reporting scheme
23 work? Must have reasonable grounds to suspect that
24 one or more of an enumerated list of things has
25 occurred or may occur, and it's mandatory because the

1 language used is "shall immediately report the
2 suspicion and any information upon which it's based to
3 the director" and the director provides that there is
4 a hotline, as we'll come to in a few minutes, as to
5 how the reports can be made.
6 But what is it concerned about? Improper
7 or incompetent treatment or care that resulted in a
8 harm or risk of harm; abuse of a resident by the
9 licensee or staff that resulted in a harm or risk of
10 harm; unlawful conduct; misuse or misappropriation of
11 their money; misuse or misappropriation of funding.
12 The extreme cases we've seen of that are where the
13 patient or client has, in fact, died and there still
14 are government assistance cheques received. We've
15 seen those stories but there are many examples we can
16 all think of with respect to the misuse or
17 misappropriation of funding, but that is essentially
18 the criteria in which there is a positive obligation
19 to report in respect of someone who is in a long term
20 care facility.
21 And as I mentioned a few minutes ago, the
22 duty to report exists, mandatory, even if the
23 information you receive and on which your concern is
24 based is confidential or privileged. So it is no
25 answer to a failure to comply with the mandatory

1 reporting obligation to say that the information was
2 provided to me in extreme confidence, and again, no
3 particular surprise I think here. The idea is to
4 encourage the safe reporting and to effectively reduce
5 the harm or risk of harm however the information comes
6 to your knowledge.
7 It applies to members of all RHPA
8 colleges, so all of you for sure, and that is set out
9 in the legislation, and there is a very similar
10 parallel proceeding under the Residential Homes Act
11 again, and this is so generally for seniors 65 plus
12 who are in a residential care facility but may not be
13 receiving long term care or have cognitive deficits,
14 for example.
15 Abuse is defined broadly the very same
16 way. It includes emotional, verbal or financial
17 abuse. There is a parallel reporting obligation,
18 again, similar although not identical. This is again
19 for those in residential homes, improper or
20 incompetent treatment, abuse, unlawful conduct, misuse
21 or misappropriation of the resident's money. And
22 again, the same duty applies and the same enabling
23 criteria apply; whether or not the information you
24 received was confidential or privileged, the
25 obligation still exists to make that report.

1 So every member of the College is subject
2 to the duty in both of these separate pieces of
3 legislation, long term care and residential
4 facilities. How is that done? There is a 1-800
5 number for the Long Term Care Action Line which we can
6 provide online following this symposium if that's of
7 interest. It's easily accessible online and that is
8 the principal method by which the reports are supposed
9 to be made; and alternatively, there is a retirement
10 homes regulatory authority which is equipped now to
11 receive those reports as well, and either of those are
12 acceptable avenues for reporting.
13 Again, where a report is made, just from
14 a risk management perspective, I would make a clinical
15 note to that effect. If there is an issue ever down
16 the road about whether action or appropriate action
17 was taken or not, I think you want to be able just to
18 say here is my clinical note, I made that phone call
19 on such-and-such a date and therefore complied with my
20 reporting obligation.
21 Inevitably, if unfortunately these issues
22 come to the fore for you when there is an adverse
23 event and then there is a retrospective inquiry about
24 who reported what, when, and it's nice just to have a
25 short note in your file as to whether or not a report

1 was made. And having said that, and this relates to
2 one of the questions and comments I got over the break
3 as well, the mandatory reporting under either of these
4 pieces of legislation -- and so, too, the mandatory
5 reporting in respect of young persons under the age of
6 18 -- it requires some professional judgment; right?
7 There is a mandatory obligation to
8 report, but it still requires that the circumstances
9 be reasonable and meet the criteria in all of these
10 Acts. It's just as it is unprofessional to fail to
11 report where there is a circumstance that requires
12 protection, so too I think it's inappropriate to jump
13 the gun, if you will, and swamp the reporting lines
14 with reports where really there isn't a concern and
15 some significant consequences can flow from that. So
16 as with every single thing you do, professional
17 judgment is required at all times. Barry, yeah, we
18 have some questions.
19 BARRY GANG: Yes, there's some questions
20 coming in. The first one is, does the legislation
21 speak only to staff on resident abuse, or does it
22 cover resident-on-resident abuse? I can take a guess
23 at that based on what I read, and you can let me know
24 if I'm right but both Acts within the things, the list
25 of things that are to be reported, talk about abuse of

1 a resident by anyone or neglect of a resident by the
2 licensee or staff.
3 PETER OSBORNE: Absolutely right. So, if
4 we look at section 24(1)(ii) just in the middle of the
5 page -- and for those online, I'm at slide 23 -- Barry
6 is absolutely right. It's abuse by anyone. So it's
7 not just staff, although it certainly includes staff,
8 resident-on-resident. Really, it's a harm-based
9 approach, so whomever is causing the abuse to occur,
10 the reporting obligation arises. It could be a
11 roommate as well as staff for sure.
12 BARRY GANG: Another question is, is
13 there an obligation to tell your clients when you're
14 getting informed consent that you have a duty to
15 report?
16 PETER OSBORNE: Good question. What do
17 folks think about that? Yeah, I think it's not
18 specified in the legislation, but I think it's good
19 practice for sure, and I know some practitioners have
20 notices in their clinical or office setting saying
21 that, that as a member of this college, a regulated
22 health profession college, I have a mandatory duty to
23 report abuse, and I think it makes good sense.
24 Certainly, the obligation arises and
25 applies to you whether or not you've got consent for

1 sure. That's the whole purpose of the legislation,
2 but I think absolutely that's right. You should tell
3 people that that is a possible consequence.
4 BARRY GANG: Here is another interesting
5 question. I don't think I've seen the answer to it
6 anywhere. Do hospices fall under long term care?
7 PETER OSBORNE: Good question. My view
8 is they do. They are not specifically enumerated in
9 the legislation, but when you look at the definitions
10 -- and they are set out more fully in the material,
11 these are just highlights -- but long term care
12 facilities, healthcare facilities designed for adults
13 who need 24-hour care. Depending on the level of
14 services provided in a hospice, I can foresee many
15 examples where those facilities would fit that
16 definition, and it could be that they also meet the
17 definition for seniors who can live independently but
18 require some limited care.
19 So the short answer is I think you've got
20 to look a little bit at what the services the hospices
21 providing are, but my takeaway, again, if you're
22 absolutely confident that there is abuse that would
23 attract a mandatory reporting obligation and your only
24 concern is whether or not hospice met the definition,
25 I would give some serious consideration to making the

1 mandatory report to protect the resident, even if it
2 were determined down the road that the particular
3 hospice in which that person lived didn't qualify.
4 Good question.
5 Okay. So it covers elders for sure, not
6 limited to elders as I say at all, but lots of issues
7 to think about there and we'll see what happens. To
8 date, there have actually not been all that many
9 mandatory reports. It is expected that those will
10 increase over the next few years and we will see if
11 that, in fact, occurs. I know we have some questions
12 at the back here.
13 PARTICIPANT: Yes, sorry. I just wanted
14 to ask to whom does one report if the abuse is not
15 occurring with any kind of a residence. So for
16 example, if the abuse is at the hands maybe of a child
17 who is taking care of an elderly parent, and
18 especially maybe where it's not something that would
19 be obvious like physical abuse that you would report
20 to the police, but say psychological abuse or
21 emotional abuse, whom would you report that to?
22 PETER OSBORNE: So certainly if the
23 vulnerable person is in facility, I would report it to
24 one of the hotlines there, and that certainly would
25 apply to abuse by a family member or caregiver, a

1 child, often an adult child if the person is elderly,
2 and so too if it's by a parent for a young person who
3 is in a care facility. And my sense would be that,
4 wherever the person were residing, I would report to
5 the hotline and get their advice on whether or not a
6 report should be made elsewhere as well, but certainly
7 it clearly applies to abuse by family members for
8 sure, including their kids.
9 I think do we have one more question back
10 there or no? We're good, okay. Any other questions
11 or thoughts on this? Lots to think about, and it's a
12 difficult decision to make, given the circumstances
13 that can flow from a mandatory report for sure.
14 Barry.
15 BARRY GANG: Here is another one that
16 came in. Do these reporting requirements apply to
17 people who are receiving care at home, as opposed to
18 in a facility?
19 PETER OSBORNE: So that I think ties
20 right into the question being asked at the back a
21 minute ago. Generally, they are care-directed, and so
22 it's a very fair question and one that is the subject
23 of much debate. As you read the technical
24 definitions, it appears not, but it seems to me that
25 if there is a concern of abuse, if it's reported to

1 the hotline and they say we can't do anything about it
2 because this individual resides at home and is cared
3 for there by family members, not our problem, I think
4 if it were me -- and again being confident that abuse
5 was occurring -- I would report it to the police in
6 those circumstances and leave it to them to
7 investigate the matter.
8 But certainly these two pieces of
9 legislation are facilities-based. They are directed
10 to the location where the person resides and it is a
11 very fair point. We can all foresee examples of
12 abuses that occurs outside those facilities for sure.
13 Yes, thank you. Sorry.
14 PARTICIPANT: I see that the wording in
15 the legislation says a person who has reasonable
16 grounds. Does this mean that there is an obligation
17 to report even if one doesn't have a professional role
18 in the situation?
19 PETER OSBORNE: It does. That's a very
20 good point. So even if you are not the treating or
21 assessing psychologist or psychological associate, as
22 a member of the College, the reporting obligations
23 apply to you. So if you are providing treatment, for
24 example, in a facility and you are reasonably certain
25 that abuse is occurring to another patient or resident

1 in the facility who is not your patient, you very much
2 still have the obligation. Good question. Even
3 though you are not involved in their treatment.
4 Okay. Lots to think about there, and if
5 we continue the discussion over the next year or two,
6 again, I would be very interested in seeing after a
7 while and this legislation has been in force for a
8 year or two whether or not it's posing practical
9 difficulties for you and how often you are being faced
10 with those clinical decisions to make.
11 So I'm conscious of time. Let me switch
12 gears if I can just for a minute before we get to Rick
13 and tricky issues. I wanted to talk just for a few
14 minutes about changes to the Regulated Health
15 Professions Act brought about as a result of Bill 87.
16 Again, this is part of the government's initiative to
17 try to strengthen the laws around sexual abuse and the
18 prevention of sexual abuse for all individuals in
19 Ontario.
20 And there was a task force led by law
21 professor Marilou McPhedran, many of you are familiar
22 with, and there has been lots been written about that
23 report. Some of you may have been involved in that
24 task force, but Bill 87 and the legislative amendments
25 are part of the fallout from that report.

1 So again, these changes came into effect
2 last May, end of May 2017, and really what are we
3 talking about here? For some time, as you all know,
4 there has been mandatory revocation in the Health
5 Professions Procedural Code arising out of a finding
6 of sexual abuse that was defined to include a certain
7 number of acts. So in other words, not every finding
8 of sexual abuse results in mandatory revocation of
9 their certificate of registration, but certainly some
10 on the enumerated list do, and that list has now been
11 expanded.
12 There is also an expanded definition of
13 "patient" in the context of sexual abuse, and we'll
14 talk about what that means very briefly, and there are
15 some changes to the interim order powers. What are
16 interim order powers? As some of you may know, there
17 are circumstances under the Code in which the College
18 can impose an interim suspension of a certificate of
19 registration in advance of a finding of professional
20 misconduct and a final finding by the discipline
21 committee and the circumstances in which interim
22 orders, pending an outcome of the hearing can be made,
23 has been expanded.
24 So just quickly what are we talking about
25 here you should be aware of it? Again, there is a

1 mandatory revocation in respect of sexual abuse
2 according to a list set out in the Code. This is
3 slide 32 for those joining us online. And
4 importantly, there are two new additions to the list
5 which relate to expanded circumstances of touching or
6 other conduct which will now attract the definition of
7 sexual abuse and therefore the expanded definition of
8 those circumstances in which mandatory revocation
9 occurs.
10 Again, we have seen a number of media
11 reports over the last year or two where some of the
12 colleges -- and in particular, the College of
13 Physicians and Surgeons -- has been under heavy fire
14 for circumstances in which there has been a finding of
15 sexual abuse but no mandatory revocation, and this
16 expanded list which we've highlighted there is
17 intended to address the broader set of circumstances
18 in which there is no discretion in the discipline
19 committee; revocation must be ordered by the
20 committee.
21 So Bill 87 adds some of the circumstances
22 which we've just talked about, and the second change
23 of which you should be aware is even where a finding
24 of sexual abuse is made but mandatory revocation is
25 not ordered -- there is an inappropriate comment,

1 inappropriate touching, but not the nature of touching
2 that's caught by the list -- there has to be as one
3 term of the order imposed at least some period of
4 suspension.
5 There was a concern that there were too
6 many findings of sexual abuse but where different
7 colleges had ordered various things, including
8 remediation, boundary courses, increased education and
9 boundary awareness, but not a suspension, and the
10 legislature has been clear, hey, if there is a finding
11 of sexual abuse of any kind, at least some period of
12 suspension has to occur.
13 Who is a patient to which these
14 provisions apply? The Act has now changed so that
15 it's clear that it's not just a patient or a client to
16 whom you are providing clinical services. It's an
17 individual who was the member's patient/client within
18 a year or such longer as may be prescribed from the
19 date on which the individual ceased to be the member's
20 patient, or anyone who is determined to be a patient
21 in accordance with the regulations, and we'll talk
22 about that.
23 So this is to address -- and we'll talk
24 about a couple of the cases as well, many cases
25 involving colleges from a number of the regulated

1 health professions where there has been a sexual
2 relationship, often consensual, and the member has
3 defended ensuing professional conduct proceedings with
4 the defence essentially that the counterparty in the
5 relationship was not a patient, not a client at the
6 time the sexual relationship occurred, and therefore
7 they ought not to be prohibited from doing that.
8 And here you've got the baseline period
9 of one year or such longer period of time as may be
10 appropriate in some circumstances, but a minimum of a
11 year between the date on which the individual ceased
12 to be member's patient and the intimate relationship,
13 which again I think makes good sense and we'll talk
14 about these in a minute just when I offer you a brief
15 comment concerning a couple of cases that have been
16 decided over the course of the last year. So this
17 again is all to address candidly the situation where
18 there is said to be a termination of the relationship,
19 if you will, on the way to the hotel and they are
20 trying to ensure that in those circumstances there has
21 to be a significant period of time between the two
22 relationships, and we'll come back to that.
23 A quick comment on interim orders, the
24 old section has been struck out and the new section is
25 here. We've got that at slide 35. I won't spend any

1 time on this. Just my quick takeaway for you on this
2 is, the key is an interim suspension can now be
3 ordered at any time following receipt of a complaint.
4 Previously, it was after there had been an
5 investigation and a referral to the discipline
6 committee. Now, if there is a complaint received that
7 suggests that there is an imminent risk of harm to
8 individuals who may be receiving treatment, the
9 certificate of registration can be suspended right
10 away.
11 Other changes that are just of note for
12 you, interim orders cannot impose gender-based terms,
13 conditions or limitations. In circumstances, a number
14 of the colleges historically have imposed terms where
15 there was a pending allegation of sexual abuse of a
16 patient, for example, or inappropriate sexual conduct
17 that there be a male chaperone or a female chaperone
18 required for certain assessments or treatments, more
19 for physicians than psychologists, but certainly there
20 are circumstances when that could apply.
21 The new legislation says there cannot be
22 any gender-based terms. So there may be a requirement
23 for a third party chaperone, a requirement for a
24 certain subset of examinations, but it can't be
25 defined on a gender basis. Interim orders again can

1 be made any time and they are in force until the
2 matter is disposed of one way or the other.
3 Lots to think about here, and we can deal
4 with this just in the interest of time online and
5 afterwards in the discussion, but it will be
6 interesting to see, I think, whether the expanded
7 definition of sexual abuse that attracts revocation
8 fixes the problems and the abuses that the government
9 is trying to address.
10 A quick note on the privacy legislation,
11 and I'll go through this quickly. I'm conscious of
12 our time and I don't want to spend a lot of time on
13 this, just give you the quick takeaways on this. And
14 again, there haven't been some significant changes
15 this year, but just a quick primer again on privacy
16 and what it means for you in your clinical notes and
17 records.
18 So we've got the federal act that refers
19 to information collected in the course of a commercial
20 activity. It's not limited to health, but the
21 emphasis on the commercial activity, so think IMEs,
22 think psychological examinations, et cetera, and those
23 are the circumstances in which the federal statute
24 PIPEDA, the Personal Information Protection and
25 Electronic Documents Act, will apply. So we'll come

1 to this in a second what it means, but information
2 collected in the course of a commercial activity.
3 And then, as I say, we have of course got
4 what we call PHIPA, the Personal Health Information
5 Protection Act, Ontario only, that applies to all of
6 you, and it is specifically directed towards the
7 collection and use of personal health information,
8 whether or not there is any commercial activity,
9 whether or not you receive a fee, whether or not it
10 was an assessment, a custody and access assessment for
11 which you were paid, an independent psychological
12 examination, anything. And the idea is that there has
13 to be -- any personal information is the takeaway
14 answer, has to be protected and the confidentiality of
15 that information maintained by you in the way in which
16 you keep your records.
17 There is a Municipal Act, just so you're
18 aware of it as well. I know some municipalities now
19 have psychologists and psychological associates on
20 staff, so they in particular would be subject to the
21 municipal freedom of information legislation, and it
22 provides for a protection scheme as well, to again
23 ensure in a consistent way the privacy of the
24 information protected. And there is an enumerated
25 list of facilities to which all of these acts apply,

1 but clearly they apply to all RHPA professionals. And
2 there are exceptions and circumstances in which
3 disclosure can be made, the obvious one being the one
4 we just talked about, the mandatory reporting
5 obligation, and there is a scheme set out when there
6 is an objection to information that is sought to be
7 revealed and the circumstances in which that exception
8 can be sorted out.
9 There is a privacy legislation review
10 ongoing right now. Many healthcare custodians, health
11 information custodians, hospitals, CAMH, long term
12 care facilities are concerned and there is a debate
13 about whether the protection is too broad or too
14 narrow and whether or not the obligations strike the
15 right balance, and that is under review right now, so
16 stay tuned on that and that will come over the next
17 year or so.
18 There is mandatory reporting under PHIPA,
19 so that again is the Health Information Protection,
20 mandatory reporting to the Privacy Commissioner where
21 there has been a breach; a theft or loss or
22 unauthorized use or in disclosure. If you look at the
23 privacy cases that have occurred with the Commissioner
24 in terms of again practical takeaways for you,
25 clinical notes and records, don't leave them in your

1 car. If you go out for dinner to stop at the
2 restaurant on the way home from your clinic before you
3 go home, take them with you. Laptops should be
4 encrypted.
5 Most of the cases I would say are the
6 inadvertent leaving of a laptop in a public place or
7 breaking into a motor vehicle, often which I think the
8 personal health information was probably not the
9 target of the theft, but that occurs and the Privacy
10 Commissioner has come down very hard in circumstances
11 like that. So if you can access remotely your
12 electronic records through your laptop, make sure that
13 the access is encrypted, and if you've got any records
14 on your laptop -- many practitioners don't I know at
15 all, but many do -- make sure that you've got
16 appropriate encryption and protection on your laptop
17 to ensure that it's more than, for example, simply a
18 Microsoft password to access your hard drive if it
19 contains personal information of your clients.
20 The mandatory reporting occurs -- and
21 we're looking at slide 49 -- where the information is
22 sensitive, certainly where it involves many
23 individuals' information. In other words, if you had
24 your notes for all of your clients on your laptop and
25 the Commissioner will take into account whether more

1 one custodian or agent was responsible for the breach.
2 It occurs. Things do happen. The point is that
3 you've got to take reasonable measures to try to
4 protect the personal information.
5 All right. Just to finish up then, can I
6 offer just a couple of minutes just on a couple of
7 cases and these I thought were just interesting
8 clinical manifestations of some of the issues we've
9 talked about earlier this morning and circumstances
10 where there was an issue about, for example, whether
11 or not an individual was a patient.
12 The first one, a case called Clokie, a
13 dentist. There was a finding that the member had
14 committed sexual abuse and the main issue in the case,
15 since there was an admission of sexual relations,
16 whether or not the counterparty was a patient at the
17 time it occurred, which was the main defence of the
18 member. And of course, all of these cases apply to
19 all RHPA members, so us as well in terms of being
20 psychologists.
21 So we've got sexual relations October
22 2006. There had been an appointment about three weeks
23 earlier in September and, indeed, there was a clinical
24 appointment that had been scheduled to take place down
25 the road a few months later in February 2007. There

1 was an email with a clinical purpose on November 2,
2 2006. So again, not a personal or intimate email but
3 one with a clinical purpose, and that's important
4 because that occurred about two weeks after there had
5 been a sexual relationship.
6 And it's interesting, and I thought this
7 might be of interest to you given the fact that I know
8 in many circumstances treating relationships for
9 psychologists and psychological associates can be
10 episodic in nature. So give some thought in your
11 treatment and in your clinical notes and records to
12 when the treating relationship ends.
13 In this case, the professional said,
14 well, the treating relationship was episodic, it
15 started and stopped many times over the course of a
16 number of years, and so the fact that I had a clinical
17 email to my client after there had been a sexual
18 relationship doesn't mean necessarily that the
19 clinical relationship continued throughout and
20 therefore the member is guilty of sexual abuse; but
21 rather, it can be episodic and start and stop as that
22 occurs.
23 Just stopping there, do people here have
24 episodic clinical relationships where you would
25 consider your treating relationship to start and stop

1 with the same individual over time? Anyone do that?
2 I'm seeing lots of nodding. So be careful is the
3 takeaway from this case, and in circumstances where
4 that occurs, you've got to I think document very
5 clearly that the treating relationship has ended and
6 this individual is no longer your client, and if they
7 come back to see you following another bout of
8 depression or a particular circumstance a year later,
9 that a new clinical relationship begins.
10 And this same theme occurs in a couple of
11 cases that arose in the circumstances of our friends
12 at the College of Massage Therapists. There was a
13 sexual relationship in the Edwards case that's
14 consensual, so it's not a case of a non-consensual
15 relationship obviously.
16 The last professional treatment in
17 January 2014. A week later, there is an email in
18 which the client expresses her feelings for the RHPA
19 professional and the discipline committee found that
20 there was sexual abuse of a patient by an RHPA member.
21 So even here where the sexual relationship was after
22 the end of the treating relationship so documented,
23 the discipline can be found that it wasn't sufficient.
24 The client/therapist relationship
25 continued because there was no clinical reason to

1 discharge. The termination of the client/therapist
2 relationship doesn't consist of simply drawing a line
3 after which the professional abdicates their
4 professional responsibilities.
5 This is consistent with the way the
6 courts treat this. So in many of these cases, you
7 have got a circumstance where there is an intimate
8 relationship and the RHPA professional says that's
9 fine because look at my chart, the treating
10 relationship ended a year earlier.
11 My takeaway from these cases, that may
12 very well not be enough. Was there a referral to
13 anyone else? Was there a formal letter or email sent
14 to the client formally terminating the relationship
15 and providing aftercare advice; if your symptoms
16 continue, if there's an issue, you can call my office
17 and we can begin a treating relationship again, et
18 cetera, et cetera. The point being, simply putting a
19 note in the records to the effect that the clinical
20 relationship has ended is not going to be enough.
21 And the very same circumstance arose in a
22 case Tekien, again, a massage therapy case. A sexual
23 relationship began. There was the last treatment a
24 week earlier but no notes in the file at all to
25 indicate that the treating relationship had ended.

1 There were daily near constant phone calls, emails and
2 text messages, and what the committee found -- and
3 many courts have done the same thing -- is that there
4 was a dual relationship.
5 So the client/therapist relationship did
6 not end, even though the therapist had given advice to
7 the effect that, although it wasn't charted, the
8 treating relationship had ended. So just things to
9 think about there, takeaways, and there are
10 circumstances in which I think there may be a personal
11 relationship with a former patient. Be very, very
12 careful in terms of what is happening.
13 The courts have said really from a
14 practical perspective the safest thing, formally refer
15 that patient to another treating professional to make
16 it crystal clear that your treating relationship has
17 ended. And lots of comments in there I think that are
18 self-explanatory and we don't need to talk about.
19 I know there are questions probably about
20 a lot of things we talked about but I wanted -- I'm
21 conscious of the time and I want to turn it over to
22 Dr. Morris to deal with his tricky issues and then we
23 can continue the discussion afterwards if that makes
24 sense and we'll try to deal with all of the questions
25 online as well. Thank you so much. Dr. Morris.

1 DR. RICK MORRIS: Okay. Am I on? Can
2 you hear me? Great. Okay. Good morning, everyone.
3 Many of you have participated in these kind of
4 presentations I've done before, so I'm not going to go
5 through my whole usual set of rules. The scenarios
6 that I provide to you, they are all based on questions
7 or inquiries that have come into the College.
8 On the multiple choice ones, just to
9 remind you, when I'm coming up with the answers that
10 I'm suggesting or putting out there, I don't
11 necessarily worry about whether one is right and all
12 the rest are wrong, because it's not that kind of
13 examination. So if you see one you like, don't
14 necessarily stop and say all the rest must be wrong
15 because that's not necessarily the case.
16 This needs to be, for it to work,
17 interactive but it can really only be interactive in
18 the room. We'll certainly try and answer as many
19 questions as we can, but given the delay, it's really
20 hard to do it for the people who are participating by
21 webinar. So hopefully, if there are questions in the
22 room, those will be exactly the same questions as the
23 webinar people might have wanted to ask.
24 For some of these scenarios, if you look
25 through them, you may recognize them. Others, so

1 those may be refreshers or a review. Other ones might
2 be brand new. Anything we don't get through -- and I
3 don't think we're going to get through all of them --
4 I'll endeavour to write up and put into the next
5 e-bulletin or the one after that. One of the problems
6 in following Peter, and I've done this before, is he
7 sometimes gives away the answers to some of the
8 questions that I've provided or some of the suggested
9 answers that I've had, but that's just the way it goes
10 and it will probably get us through it maybe a little
11 bit quicker.
12 So having said that, okay, here is the
13 first one: My 17-year-old client reported that she
14 had been abused in her home and is worried it may
15 happen again. I thought I was familiar with my
16 mandatory reporting obligations but then I began to
17 second-guess myself. Just to be sure, I consulted
18 with a colleague.
19 My colleague was correct in telling me,
20 okay, what? I have an obligation to report the abuse
21 as the client is under 18; or I do not have an
22 obligation to report the abuse as the client is over
23 16; or I may have an obligation to report the abuse as
24 my client has two younger siblings living at home; or
25 I may report to the CAS if I wish, but it's not

1 mandatory; or I have an obligation to report if a
2 client of any age tells me about being abused as a
3 child. So I'm turning to the people in the room, give
4 me some guesses.
5 PARTICIPANT: I think number three is
6 probably the best plan.
7 DR. RICK MORRIS: Okay.
8 PARTICIPANT: If there is any risk of
9 abuse to the younger children, that has to be
10 reported.
11 DR. RICK MORRIS: Okay. So we have a
12 vote for number three; if there is a risk, the
13 legislation would expect, according to what you're
14 saying, that if there is a risk to other children,
15 even though it's not this client, then you would have
16 reason to report. Okay. So people like that answer,
17 people don't like that answer?
18 Okay. What about any of the others? As
19 I say, there may be more than one. Give me a number.
20 PARTICIPANT: One.
21 DR. RICK MORRIS: Number one? Number
22 one, I have an obligation to report abuse as the
23 client is under 18. Agree or disagree?
24 PARTICIPANT: Agree.
25 DR. RICK MORRIS: Agree, the client is

1 under 18, so I have an obligation to report. All
2 right. You were saying number two, which is opposite
3 from -- which is opposite or contradicts number one.
4 So we have a little bit of a disagreement on whether
5 number one or number two, and that's the whole age
6 thing and that relates to some of the stuff that Peter
7 had talked about.
8 Okay. So we've had some conversation on
9 one, two and three. What about four and five, where
10 do they fit? Are they -- would you say those are true
11 or false if this was -- if we look at it that way?
12 PARTICIPANT: Number four.
13 DR. RICK MORRIS: Number four you like?
14 PARTICIPANT: Between 16 and 18 is
15 voluntary.
16 DR. RICK MORRIS: Okay. So number four,
17 you would like, pick that out as a reasonable option
18 that if you consulted your colleagues and they told
19 you that, that would be one that you would certainly
20 consider. Okay. What about number five, if you were
21 told that by your colleagues that, listen, you had
22 better report because a client of any age tells you
23 that when they were a child they were abused, that's
24 reportable to the CAS? True or false? False?
25 Okay. Let me run through them as I see

1 it. So I would have chosen -- if I'm looking for
2 things that are possible alternatives, I would have
3 chosen not number one, not number two. I would have
4 chosen three and I would have chosen four.
5 If a person is over 16, there is no
6 obligation to report, and "obligation" is a really
7 important word and that's one of the things that Peter
8 was stressing. So there is no obligation to report.
9 The reporting, there certainly is an obligation if the
10 person is under 16, but if they are over 16 -- and the
11 timeframe we're talking about is one day over 16 and
12 one day younger than 18 -- then there is no obligation
13 to report, however, number four would kick in, and
14 that's the new piece of legislation.
15 The new section, the bill that Peter was
16 talking about, it has amended the Child and Family
17 Services Act, section 71 that talks about reporting,
18 to indicate that if you believe that one of the
19 conditions -- and if you look through the CFSA, it has
20 got like 10 or 11 things that you have to worry about
21 if you're thinking about reporting child abuse. If
22 one of those conditions exists and the individual is
23 between 16 and 18, then the legislation now gives you
24 the permission, I guess it is, to report.
25 Beforehand -- it not only gives you the

1 permission to report, it also gives the CAS some
2 authority to do something with that, because
3 previously if you went to report the abuse of a
4 17-year-old, the CAS really didn't have anything in
5 their authority to do anything with your report.
6 Well, now they do. Now they have authority to do
7 something with it, but as we stressed, it's not a
8 mandatory, it's an optional. It's certainly still
9 mandatory under 16, nothing has changed, but the over
10 16 to 18 definitely is now an optional kind of thing.
11 Yes?
12 PARTICIPANT: When you say mandatory as
13 opposed to optional, does that mean that an individual
14 who is over 16 but under 18 that even if the person
15 doesn't give permission for the information to be
16 released that there is still the permission to release
17 that confidential information to the CAS?
18 DR. RICK MORRIS: Yes, that's my
19 understanding that the conditions, the authority to
20 breach confidentiality and the safeguards which we
21 have when we breach confidentiality under the
22 legislation, those would all apply. So no, you
23 wouldn't require the individual's thing.
24 The other one that was chosen, and
25 certainly this is one that I would agree with, is

1 number three. The legislation talks about reasonable
2 grounds to suspect that a child may be abused, may be
3 in danger, that sort of thing, and it doesn't
4 necessarily relate only to the individual who is
5 talking to you. So if you have reasonable grounds to
6 suspect that there are other siblings at home who may
7 be in danger or in need of protection, that becomes a
8 mandatory reporting obligation. And so it doesn't
9 matter what the age, and it doesn't matter what the
10 age is of the person who gave you that information.
11 They could be an older individual where there isn't
12 any question about whether you would report, but what
13 they're telling you leads you to be concerned about
14 children under 16 who are still at the home somewhere.
15 And number five is not correct, there is
16 no obligation, if none of the other things apply and a
17 35-year-old tells you, explains to you that when they
18 were a child they were abused, if number three doesn't
19 apply or some variation on number three doesn't apply,
20 then you wouldn't have the reporting obligation.
21 Okay. All right. The next one, call
22 this one "Duty to Offset Harm". You have serious
23 concerns that your client may be self-hurtful. You'd
24 like to let someone know about these concerns but are
25 worried about the negative impact this will have on

1 your therapeutic relationship which has been quite
2 difficult to establish. The client has expressly
3 forbidden you to speak with anyone about any aspect of
4 his therapy.
5 You consult your colleagues -- once
6 again, we do that -- and you get a variety of advice,
7 which is often characteristic of consulting with
8 colleagues, so you get a variety of advice. Based on
9 these consultations, you decide it would be
10 appropriate for you to do what?
11 Is it appropriate for you to ignore his
12 wishes and inform the police of your concerns as
13 PHIPA, Personal Health Information Protection Act
14 requires that in such a situation one must inform the
15 police to eliminate or reduce the significant risk of
16 serious bodily harm; or would you maintain the
17 client's confidentiality as he has requested and
18 continue to work with him in an effort to reduce his
19 self-hurtful behaviour; or ignore his wishes and tell
20 his family about your concerns as PHIPA permits you to
21 do this in order to eliminate or reduce a significant
22 risk of serious bodily harm; or would you indicate to
23 the client that you're very uncomfortable keeping this
24 secret and unless he provides consent, you'll have to
25 terminate your therapy. Or possibly would you keep

1 this concern confidential, although you'd like to
2 inform someone about your concerns, your hands are
3 tied as you did not mention this possibility as part
4 of your list of limits of confidentiality at the
5 outset of therapy?
6 Do we have some takers? One, two, three
7 four? I often say one, two, three, four and/or five,
8 but there are some that are mutually exclusive. So
9 one, two, three, four, five, who wants to take a
10 guess? Twenty percent chance of getting it right,
11 maybe more because there's more than one. Yes?
12 PARTICIPANT: Three, if you're concerned
13 that there's a serious risk of self-harm.
14 DR. RICK MORRIS: Okay. So we have one
15 person who likes number three, if you're concerned
16 about the harm, then you're permitted under PHIPA to
17 tell the family, for example. If we had a show of
18 hands, would people agree? Agree, agree, agree? Do
19 we have disagree? Can I see disagree? Is there lots
20 of disagree? There's a few disagrees. Okay.
21 All right. So we had somebody that said
22 number three. If you didn't like number three, is
23 there anything that you do like, or any others even if
24 you like number three that you do like? Number two,
25 maintain the confidentiality as requested and continue

1 to work with them in an effort to reduce his self-
2 hurtful behaviour. Is that a reasonable and possible
3 alternative? Is that a legal alternative? I guess
4 that's another way of putting it in terms of PHIPA and
5 what it requires or what it suggests.
6 PARTICIPANT: It depends how serious the
7 risk is.
8 DR. RICK MORRIS: It depends how serious
9 the risk is. Okay. What part of it -- what part of
10 it -- let's say it's a very serious risk. Could you
11 still do number two? Do you have the option of doing
12 number two should it be -- even if your clinical
13 judgment is that it's a serious risk? Do you have
14 that option, because that's what this would suggest?
15 PARTICIPANT: Maybe if this person was at
16 risk for suicide.
17 DR. RICK MORRIS: Sure, yeah. So do you
18 have the option to do number two?
19 PARTICIPANT: I don't think so, no.
20 PETER OSBORNE: Okay. You would say you
21 wouldn't have the option to do that. Okay. What
22 about number four? You don't want to breach his
23 confidentiality but you also don't like the idea of
24 the secret, so you're going to just terminate his
25 therapy? Hopefully not, hopefully you didn't like

1 that.
2 What about number five? Before we go
3 back to the other ones, what about number five? Do we
4 have an obligation to let them know prior to -- at the
5 outset of therapy? Yes, we have an obligation. I
6 won't ask the question. Yes, we have an obligation to
7 let clients know at the outset of therapy what our
8 limits of confidentiality are. If we miss one in
9 going through our list, does that mean that they get a
10 pass on that because that's what this would suggest?
11 I forgot to tell them one of these, so
12 obviously since he didn't have fair warning, my hands
13 are tied and I can't do anything about it, and it
14 would apply to this or child abuse reporting or
15 anything else. Have I convinced anybody that number
16 five is a good answer? No, good, I'm glad because it
17 doesn't really matter, and I think Peter mentioned
18 this in passing that whether or not a person is
19 informed of the limits of confidentiality, if they are
20 legal limits of confidentiality, if the legislation
21 says in this circumstance you must do such-and-such,
22 then, you know, you must do that.
23 Certainly, you'll have a clinical problem
24 because your client is going to feel betrayed and
25 complain to you that they never would have told you if

1 they had known and all that sort of thing. None of
2 that would matter in terms of this.
3 Okay. So I can tell you, let me just run
4 through. Number one, I see number one as being an
5 incorrect response, and the part of it for me -- does
6 anybody see what part of it I would have a problem
7 with? The part that I have a problem with in terms of
8 knowing PHIPA is this suggests that PHIPA requires --
9 "requires" means that the law says you have to do it
10 -- requires that in these situations you have to
11 inform the police.
12 There's two problems with that. One is
13 that PHIPA does not require, and two, PHIPA does not
14 suggest who you might express your concerns to. So
15 that then moves us basically to number three, which is
16 an acceptable answer under the law in that you can
17 ignore this person's express concerns about
18 maintaining his confidentiality because PHIPA permits
19 you -- and I think that's an important distinction to
20 make, there's a permission versus a "requires".
21 The legislation says the health
22 information custodian may disclose. It doesn't say
23 "must", it doesn't say "has to"; it says "may". It
24 doesn't say "is required to". It says "may". So if
25 you decide that the risk is serious enough, the

1 legislation permits you to breach confidentiality with
2 all the protections that the legislation can provide
3 in terms of you're doing that in good faith, and tell
4 in this case the family about your concerns in order
5 to eliminate or reduce significant risk of harm.
6 One of the reasons that the legislation
7 doesn't suggest or it doesn't specify who you tell --
8 and it has to do whether it's self-hurtful behaviour
9 of a client or aggressive behaviours, hurtful
10 behaviour, a threat of your client against somebody
11 else, is it doesn't tie your hands in terms of who it
12 is that you should tell. That's really left to you.
13 The purpose of breaching confidentiality
14 using this particular section of PHIPA, the purpose is
15 to eliminate or reduce the significant risk of harm,
16 and so who you tell, whether you tell, but then also
17 who you tell should be someone who you believe is in
18 that position to eliminate or reduce that risk. In
19 some circumstances, it might very well be the police.
20 It might very well be an outward, an aggressive or a
21 threat kind of thing, there may be an intended victim.
22 It may be any of those people.
23 In the case of someone who is self-
24 hurtful, it may be the family. In the case of an
25 older adolescent or a young adult, it may be parents,

1 it may be a spouse, it may be a clergyman. I mean,
2 there's a lot of things that a lot of individuals that
3 could be the people to talk to or the person to talk
4 to, but that's really part of what you have to decide
5 in terms of this is that, if I'm going to breach
6 confidentiality, which is obviously a very significant
7 thing, if I'm going to make that decision, I'm going
8 to do it in a way that is going to meet the purpose of
9 the legislation.
10 Now, having said that, you can also,
11 having made the case that this is permissive
12 legislation, that PHIPA says that you may release --
13 may disclose personal health information, it makes
14 number two a legitimate answer. Now, it may not be
15 one that you want to do. Most of our members are
16 pretty conservative when it comes to not reporting if
17 they're very concerned about somebody's self-
18 hurtfulness or someone's threats towards another
19 person, but the legislation gives you the permission
20 to make that decision clinically what's the best thing
21 to do in this situation.
22 So if you felt that there was really no
23 one to tell in number two, or if you felt that if I
24 tell someone about this, that's going to make it worse
25 rather than making it better, and you've have to be

1 able to -- you know, you would obviously want to be
2 sure of that, as sure as you can be, and you would
3 want to document your discussion about that. But you
4 might decide that I need to -- it's better for me and
5 it's better for the client to maintain the
6 confidentiality.
7 I'm going to work out a self-hurt,
8 suicide prevention plan. I'm going to up the number
9 of times I see them from once a week to four times a
10 week. There's a whole raft of things that I'm going
11 to introduce in order to try and move him back down
12 from the level of self-hurt that I'm currently
13 concerned about, and I think I can do that, and I
14 think that will be a better move on my part as the
15 clinician than telling somebody.
16 Now, I mean, there's obviously a risk
17 going along with that and that's a very important
18 thing to keep in mind. Often when I'm talking about
19 this with people, I talk about the fact that if you
20 make that decision, you are definitely going to have
21 this severe knot in your stomach and that knot in your
22 stomach is going to sit there for a long time because
23 you're going to wonder, like, you know, did I make the
24 right decision.
25 I have a decision to make, I've made my

1 best clinical decision, but you still have this knot
2 in your stomach, hoping that you won't get a phone
3 call that says -- gives you the news you don't want.
4 Okay. Are there any questions about that? It's just
5 important to separate the "may disclose", which is
6 very different from say the wording about child abuse
7 reporting. There is no may's involved at all. Child
8 abuse reporting is most definitely a must.
9 Okay. True or false: A member of the
10 College may practice outside of his or her area of
11 competence if being supervised by another member.
12 True or false? True. You know, that's what we would
13 expect that a member who is outside of their area of
14 competence, if they're doing clinical, if they're
15 counselling, psychologists or a psychological
16 associate and they're doing clinical work, they are
17 not authorized to do that, they can and should be
18 supervised.
19 A school board principal may disclose
20 personal health information from the OSR, the Ontario
21 Student Record, without consulting with the
22 psychological associate who prepared the psychological
23 report. True or false? Reports in the OSR, true,
24 false? True, true, true. There was a false over
25 here, but I think the peer pressure caused some

1 reconsideration.
2 Actually, that is a true statement. I
3 mean, with the consent of, I suggest the parents, the
4 report went into the OSR. Once it's in the OSR,
5 that's the principal's domain and it has its own set
6 of rules, but the principal gets to decide what
7 happens to the information that's in the OSR. So
8 giving it to the principal to put in the OSR is the
9 same as sending it to a family physician.
10 I mean, once it's outside, once it's
11 legally disclosed and outside of your control then,
12 well, basically you lose control over it and they can
13 do whatever they wish with it and hopefully, you know,
14 they will deal with it appropriately.
15 Number three: Under PHIPA, raw data from
16 standardized psychological tests or assessments is
17 protected from a summons or court order, true or
18 false? That was a good one. Definitely false. There
19 is nothing -- none of our information in terms of our
20 profession is protected from a court order, summons,
21 search or seizure warrant, coroner's warrant, any of
22 those kinds of things.
23 Certainly, if the situation comes up, you
24 will have the opportunity to argue as to why the
25 information should not be provided and that will be

1 with a judge, but then it becomes up to the judge for
2 her to decide whether or not the information can be
3 turned over. You can't sort of say I'd really like to
4 comply with this court order but PHIPA says I don't
5 have to give you my raw data. You can't do that.
6 One may accept funds in advance to pay
7 for services provided the funds are held separately
8 from ones, operating or personal funds, until the
9 service is delivered. True or false? True? Yeah,
10 that one is true.
11 Some people confuse payment in advance
12 for services, which is not okay, with this kind of
13 thing. There are many circumstances where it makes
14 sense to get the payment up front. If you haven't
15 delivered the service, you can't use that money to go
16 and buy yourself a new iPhone. That money needs to be
17 sitting somewhere else because, if halfway through the
18 session, halfway through the anticipated number of
19 sessions the person leaves, you have to be able to
20 give them back the rest of that money.
21 So we're not suggesting -- the old
22 standard suggested or said you had to hold it in
23 trust. Once you say those kind of words, it gets into
24 all kinds of complicated banking and/or legal things,
25 and we're not suggesting it has to be in trust. It

1 just has to be separate. It has to be designated as
2 their money because it's still their money, and then
3 as you provide the service, the therapy for example,
4 you can take out one session's worth.
5 They get a receipt, but the remainder,
6 the remaining sort of nine-tenths, if it was a ten
7 session amount, is sitting there, and should they not
8 come back, it's sitting there and you are able to
9 provide it, to give it back to them. There is not a
10 concern that you won't have that money available for
11 them. So it's still their money. You're just holding
12 onto it in a sense for them.
13 Okay. The last one, the new standards of
14 professional conduct remove the prohibition against
15 fee splitting. Therefore, one is now permitted to
16 offer a small stipend to a lawyer for clients he
17 refers to you. True or false? False? True?
18 So it is -- the whole number six is
19 false. The first part of it is actually true. The
20 first statement in there is true. There is no longer
21 a prohibition against fee splitting, but fee splitting
22 does not mean that you can pay someone for referrals
23 or receive any kind of a benefit for referrals. That
24 part of the professional misconduct reg is still in
25 place.

1 Fee splitting is a different type of
2 thing. It has to do with splitting fees around rent,
3 around people you're working with or people working
4 for you. That's what fee splitting is. It's
5 different than making -- than accepting a benefit or
6 giving a benefit to get referrals from other
7 colleagues or from, in this case, a lawyer.
8 Barry, what time is it? How are we doing
9 for time? All right. Let's do the next one then.
10 Collection of outstanding fees: A colleague has a
11 client who owes her a considerable amount of money.
12 She has sent numerous statement of accounts and
13 offered the client the opportunity to discuss any
14 issues that may be interfering with his ability to
15 pay.
16 Your colleague is aware the client has
17 already submitted the invoices to his insurance
18 company and the claims have been paid to him but he
19 has not used this money to pay her. She has a few
20 ideas about what she might do which she wants to
21 discuss with you. Which of her ideas would you tell
22 her she can pursue?
23 Would you tell her that it's okay to
24 pursue: That she could notify the client that she
25 plans to turn the account over to a collection agency

1 if payment is not made or other payment arrangements
2 made -- payment is received or payments arrangements
3 made; or would you contact the insurer and discuss how
4 she or you might go about settling this account?
5 Would you write it off? Could you write it off as a
6 bad debt at tax time?
7 What about notifying the client that she
8 intends to take him to Small Claims Court and just let
9 a judge settle the matter? What about having her
10 lawyer send the client a strongly worded letter
11 demanding money? Or, but what about letting this one
12 go, but in future require Mastercard or Visa payments
13 from clients where are concerns about their ability or
14 willingness to pay for services?
15 What are we going to do with our huge
16 outstanding debt that we have for our private
17 practice, one, two, three, four, five and/or six?
18 One, we have a couple of votes for number one. Any
19 others that are legitimate things to do? Three?
20 Others? Anything else? Go with four? Five, too?
21 Five as well; right?
22 What about two? I mean, because here is
23 a situation where I provided the invoice, the invoice
24 was sent to the insurance company and the insurance
25 company paid the client? You know, what about my

1 telling the insurance company that this is what is
2 going on? Is that okay? Not okay? All right. What
3 about requiring Visa or Mastercard payments as in
4 number six? Also not okay.
5 All right. So you've got the ones. I
6 mean, number one, in terms of a collection agency;
7 number three, writing it off; number four, Small
8 Claims Court; number five, have your lawyer send a
9 really nasty, strongly worded letter, those are all
10 okay kinds of things. The important thing is to make
11 sure that the client is given fair notice that that's
12 going to occur.
13 But you know, we're talking about the
14 business of psychology. If you want, you can write it
15 off, off the loss, I'm assuming as a bad debt at tax
16 time. But since you have rent to pay and you have all
17 kinds of other expenses as a private practitioner, you
18 probably can only do so much of that until you are no
19 longer a private practitioner. So you know, you can
20 do so much of it.
21 A lot of people have trouble sort of with
22 those particular options because we see ourselves as a
23 helping profession, make people feel better, don't be
24 the cause of problems for them. And obviously, if
25 you're going to take somebody to court, that's going

1 to cause them a problem but that's kind of the way it
2 is. I mean, we have to be able to be appropriate in
3 terms of business procedures. So any of those kinds
4 of things, with appropriate notice, is certainly an
5 acceptable way of dealing with a bad debt.
6 Okay. Let's do this one. Okay. You
7 conduct an assessment of an individual's need for
8 special accommodation with respect to university exam
9 taking. At the outset, you obtain consent to conduct
10 the assessment and share the findings with the
11 university. To the client's dismay and disbelief, the
12 assessment results did not support the extent of the
13 accommodations he felt he needed.
14 The client indicated he was going to get
15 another and more accurate assessment from a more
16 experienced clinician. He was concerned that your
17 assessment might find its way to the university, so he
18 demanded that you give him the complete original file
19 and any copies which he planned to shred.
20 Your response to this request was to:
21 Retain the file, but offer him a copy if he wanted it,
22 and reiterate that it will only be released with his
23 consent unless otherwise required by law; or revise
24 the report in a manner that is more acceptable to the
25 client as it is important that a psychological report

1 be accurate and complete in the client's view; give
2 the original complete file to the client as requested
3 but privately keep a copy for your records in order to
4 comply with College retention rules; agree to destroy
5 the file rather than give it to the client in order to
6 protect the security of the raw test data; send the
7 report to the university based on the consent obtained
8 prior to beginning the assessment, but add a note of
9 disagreement outlining the client's concerns.
10 What are we going to do with the --
11 number one, okay. Number one. Okay. I see a lot of
12 nods for number one. Anything else that might be an
13 appropriate and ethical way of dealing with this?
14 I've got to make sure I don't say something that's not
15 there. Yeah, I mean, basically number one is it.
16 Some people jump -- when I've used this
17 before, some people go look at number five and say,
18 well, you know, they referred the person, the person
19 gave consent, I still have an obligation to send it to
20 the university, which is not the case because as you
21 know, an individual can rescind their consent. Unless
22 there is something in the law that says different, but
23 in this case in this private assessment, they can
24 rescind their consent at any time. So just because at
25 the beginning their agreement was, sure, do the

1 assessment, send it off to the university, once they
2 get the results, they are perfectly within their right
3 to say I don't want this going to the university.
4 But that doesn't give them the right to
5 tell you how to write your report, as in number two,
6 or to give them the right to have the whole file
7 because you have obligations with respect to record
8 retention. So, yes, number one.
9 Okay. I know there are a couple more,
10 but in the interest of time, I am going to hold off on
11 -- there is one on the correction of a record, release
12 -- there is two left. What I'll do with those ones is
13 I will write them up in the next bulletin. I've done
14 that in the past when I've not been able to cover all
15 the things that we received. So we'll do that the
16 next bulletin, hopefully the next bulletin; if not,
17 the one after that. I want to hedge my bets here. So
18 good, thank you.
19 BARRY GANG: I want to thank our two
20 speakers. It's too bad we have to give up the room in
21 about three minutes because they are both people we
22 could listen to for a lot longer. Peter, I can't see
23 him but I know he's here, it's a challenge for people
24 whose job it isn't to keep up with legislation and
25 jurisprudence and, you know, you help us on a regular

1 basis and I'm sure the membership really appreciates
2 your being able to help them directly too now. You
3 have a great skill in making the complex
4 understandable and also very interesting.
5 Rick, it's no secret why everybody at
6 every evaluation demands that there is more tricky
7 issues and more time allocated to it. For me from
8 where I sit, I think not only is it entertaining and
9 really interesting, you also give everybody the very
10 clear message that it's okay if you don't instantly
11 know the right answer, that there are grey zones and
12 it's perfectly legitimate to sort of parse out all the
13 different things and, you know, dig deep sometimes for
14 the answers. Here is a plug for our practice advice
15 service. When you get into these kind of situations,
16 please give us a call or send us an email and we will
17 help.
18 Thank you to all of you for participating
19 here and online. We hope to see you again in about
20 six months. We're doing this twice a year now. Thank
21 you to all the staff who organized this and made it go
22 very smoothly I think this time. You're going to get
23 evaluation forms emailed to you very shortly. We read
24 them, we take them very seriously and they really do
25 help us. So thank you all.

1
2 *********
3
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