The *e*-Bulletin

THE COLLEGE OF PSYCHOLOGISTS OF ONTARIO
L'ORDRE DES PSYCHOLOGUES DE L'ONTARIO
Regulating Psychologists and Psychological Associates

January 2019 **Volume 10, Number 1**

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Barbara Wand Seminar in Professional Ethics, Standards and Conduct - January 2019
Thank you to everyone who joined us for the live event. The recorded Seminar is now posted to the website.

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The second quarter report for the ICRC - September 1, 2018 to November 30, 2018 is available for download.

VIEW ICRC REPORT

Council Meeting Materials Available for Download

The College posts the materials which support the items for discussion at the quarterly Council meetings. These materials are available one week prior to the meeting and are maintained, along with the approved minutes, in the Resources section of the College website.

Changes to the Register

Since October 2018, there have been many changes to the College Register as new Certificates of Registration were issued or members retired or resigned.

VIEW CHANGES TO THE REGISTER

Upcoming Council Meetings

March 29, 2019
June 21, 2019

We welcome observers. Materials are posted to the website one week in advance. Please advise the College of your wish to attend by calling 416-961-8817 or emailing cpo@cpo.on.ca

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President's Message

Winter – who needs it or wants it? But, because the New Year starts in the winter and we are often 'hiding' from the weather during this season, it sometimes promotes us to reflect. I was recently reminded of the power of, and necessity for, reflection in my professional life at the Barbara Wand Seminar, which focussed on cultural sensitivity. I encourage any of you who did not participate either by webinar or in-person to access the archive of the morning. It is worth the time, and is offered at no cost to members.

Since the last *eBulletin*, a number of College events have occurred, including the December Council meeting. This report provides you with an overview of those activities.

In November, I attended the mid-year meeting of the Association of Canadian Psychology Regulatory Organizations (ACPRO) together with Dr. Morris, Registrar & Executive Director. Considerable time was spent learning about the development of a pan-Canadian website to offer prospective international registrants a single portal for information. This is being developed with the support of a federal grant. There were also discussions about jurisdictional issues as well as the recently developed competency exam (EPPP2).

The Executive Committee held a Member Reception on November 1st in Windsor. The reception was very well-attended, which was partly due to the large number of clinical graduate students who participated. Dr. Morris provided information about the College and encouraged questions in a 'town hall' format. Participants gave positive feedback about the reception and the town hall component. The next Member Reception is planned for May 2019 in Thunder Bay.

In the first week of December, the College conducted the oral exams with the involvement of many professional members. Interestingly, the group of 90 candidates was the highest number of examinees that the College has ever had at the oral exams. As always, it was a pleasure to interact with and learn from these individuals who are joining the profession.

The Discipline Committee held a plenary session on the day prior to the December Council meeting. The morning included discussions of internal processes such as the Committee's rules of procedure, the plea inquiry process, and the policy regarding the recovery of discipline costs. In the afternoon, Ms. Rebecca Durcan from the law firm of Steinecke, Maciura, LeBlanc provided a training session on best practices in conducting disciplinary hearings with self-represented members.

The agenda for the December Council meeting included a range of policy and business issues. The Council approved some policy changes and discussed the process for the broad consultation being planned regarding the September motion to permit the use of the title 'Psychologist' by all members of the College. The Council received reports from the fall meeting of the Director's of Clinical Training and about the newly implemented integrated risk management system. In addition, Mr. David Lamb, from the Ministry of Health and Long-Term Care, Health Workforce Planning

Branch, met with Council to discuss the work of this area. He provided information on the work the government does to understand the needs of the public with regards to healthcare, including psychological services, and the capability of the workforce to respond to these needs.

Unfortunately, the Council learned that Mr. D'Arcy Delamere was not reappointed as a Public Member of Council. Mr. Delamere's experience and wisdom, especially his contributions to governance matters and financial acumen, will be missed by Council. Since Mr. Delamere was both the Vice-President of the College and a Public Member of the Executive Committee, two elections were held to fill these positions. I would like to congratulate Dr. Elizabeth Levin, Professional Member, on her election as Vice-President and Ms. Judy Cohen, Public Member of Council on being elected to the Executive Committee.

Respectfully submitted,

Lynette Eulette Ph.D., C. Psych.
President

Continuing Professional Development- Lessons from a "Mock Audit" of Member CPD Records

The end of the first two-year cycle of the College's mandatory Continuing Professional Development (CPD) program is approaching. In approximately six months, at the end of June 2019, members with "odd" registration numbers will be required to make a declaration that they have fulfilled all of the requirements of the program over the previous two years.

As decided by the College Council, the College will conduct a compliance audit at the end of each two-year cycle. In the summer or fall of 2019 therefore, some members of the College with odd registration numbers will be selected at random for participation.

For the purpose of planning the audit process, the Quality Assurance Committee sought volunteers from the membership to participate in a "mock audit". These volunteers, who made early declarations that they had completed all of the mandatory CPD requirements, were asked to provide copies of their CPD materials and documentation to help the Committee formulate questions and design a fair and consistent process. This was a 'no risk' experience for participants who were provided with specific detailed feedback, for their own information.

The Committee reviewed materials provided by 17 members. Based on this information, it appeared that 12 of the volunteers either met or exceeded all of the program requirements. If this had been an actual audit, more information would likely have been sought from some. Two members appeared not have satisfied all of the requirements and three did not provide sufficient information for the Committee to decide one way or the other.

The exercise provided a great deal of information that will help to structure the process when the first actual audits are conducted. It also provided helpful information for all members to assist in planning and recording their CPD activities.

For the most part, volunteers were proficient at determining the correct categories in which to count their credits. Some of the Committee's observations in conducting the mock audit, even with those who appeared likely to have satisfied the requirements, are summarized below:

<u>The Need for Specific and Objective CPD Goals</u>

The Self-Assessment Guide (SAG) and the CPD program are integrated components of the Quality Assurance program, with the setting of CPD goals being the final stage within the self-assessment process. In setting CPD goals, it is recommended that goals should be SMART (specific, measurable, achievable, realistic and time bound). Although this has not been set out as a requirement, a SMART goal is a good way to actively manage progress.

The Need for Alignment between SAG Goals, Current Practice and CPD Goals

While interesting opportunities to learn about things that might not be in a learning plan can arise and provide serendipitous benefit, one's choice of CPD activities should also fill identified gaps in knowledge and skill and be expected to further enhance services currently provided.

Calculating the Total of 50 Credits Using Only the Maximum Number Permitted within Each Category

Category maximums have been established because the mandatory CPD program is based upon the understanding that members will learn more effectively if they engage in a variety of different learning experiences. Members are likely to exceed the maximum number of credits permitted within some categories and those credits which exceed the maximums may not be used towards the total of 50 required credits. The College's on-line tracking tool automatically accounts for excess credits and members who do not use this tool must take care to count only the maximum allowable number of credits in each category when declaring that they have satisfied the requirements of the program.

Using Correct Activity Dates

If using the online tracking sheet, the date upon which the activities were undertaken must be manually entered, otherwise the form will automatically show the date the information was entered on the form.

Using Credits Only for Activities Occurring Within the Current Two Year Cycle

Only those activities conducted within the two years before the end of the cycle are eligible for credit. While the on-line tracking tool will account for events which are not within the cycle, those who choose not to use the on-line tool are advised to check the beginning and end dates of their current cycle when choosing and reporting their CPD activities. These dates are available at:
http://www.cpo.on.ca/Continuing_Professional_Development.aspx

Including Sufficient Detail about Activities

In determining how much detail to record in a CPD tracking sheet or other record, members should consider what information an auditor would need to understand what may have been learned and how that could be independently verified should the Quality Assurance Committee see a need to corroborate the reported activity.

For example, more information is required than the simple declaration that "supervision" or "reading" had occurred. If reporting credit for supervision, identifying the supervisee as well as the date and length of each meeting, as well a general description of the nature of the supervision, will make it easy to understand what had occurred. It would also facilitate verification should that be necessary. If reporting credit for reading, the name of the book or article, author, journal, as well as the web addresses and the length of time spent should all be recorded.

If using acronyms to record and report activities, consideration should be given to how widely known the acronym is. Although it may be expected that acronyms like "WISC" or "CBT" may be recognized by most within the profession, the full names of local associations, organizational committees and less widely known tools and techniques should be used.

Retaining and Providing Documentation of Activities

Documentation that verifies registration or attendance at an event or involvement in an activity should be collected, retained and provided in the event of an audit. This may include certificates of completion or, if certificates are not provided, registration documents or program agendas. Correspondence confirming events like Committee meetings, Professional Interest Groups or Grand Rounds would also be acceptable.

Documenting Relevance to Professional Ethics

The content of at least 10 of the 50 mandatory credits reported must be focused on the ethical practice of psychology.

Unless the name of the activity makes it clear that the activity related directly to professional ethics, it is recommended that a note be made explaining how the activity satisfied this requirement. This could then be provided in the event of an audit. While there would be no need to explain the relevance of workshop titles like "Informed Consent with Children in Care" or "Developments in Privacy Legislation", it would be necessary to explain how, for example, a webinar about scoring a new test would satisfy this requirement.

Summary

Members are encouraged to keep these issues in mind throughout each CPD cycle as this will provide ease of reference and reporting in the event one is selected for an audit. As well, it is hoped that this information will help in the planning and monitoring of an effective CPD plan that will assist in filling identified gaps in knowledge and experience and ensure preparation for best practice.

Sexual Abuse and Boundary Violation Prevention

The Health Professions Procedural Code, being Schedule 2 of the *Regulated Health Professions Act, 1991* requires Colleges to have a patient relations program that includes the following measures for preventing and dealing with sexual abuse of clients:

(a) educational requirements for members;
(b) guidelines for the conduct of members with their patients[1];
(c) training for the College's staff; and
(d) the provision of information to the public

In fulfilling this mandate, the College's Client Relations Committee regularly reviews and enhances the information and programs provided to members and the public. In 2018, as part of its review, the Committee considered information about the 47 cases containing allegations of sexual abuse referred to the Discipline Committee between 1980 and 2018. These cases involved 36 members whose behavior was categorized as follows:

- Boundary Violations were a feature of cases involving 25 (69%) of those individuals referred to Discipline; within this group, substance abuse was a evident with respect to four members and mental health problems were noted with respect to two;
- Predatory Behaviour was identified with respect to 10 members (28%); and,
- Inappropriate Intervention (behavior or remarks of a sexual nature not appropriate to the service provided) was the underlying concern with respect to one member.

Boundary violation stood out as a precipitant of problems involving the majority of these individuals. This finding led the Client Relations Committee to focus its work on the preparation of a Discussion Guide designed to enhance members' reflection on the College's existing resources relating to the prevention of such events. The Guide is comprised of a set of hypothetical scenarios and questions. Members need not examine all of the scenarios but should choose those that they believe would like useful to explore further. Ideally, the scenarios will be used in discussion with colleagues so that, in addition to facilitating self-awareness and reflection, members may become more comfortable in seeking guidance and support when uncomfortable situations arise in relationship based professional activities.

Member resources for Preventing and Addressing Sexual Abuse and Boundary Violations, including the Discussion Guide are available on the College website. Members may choose to anonymously share their thoughts and ideas about the scenarios through the survey found in the Member section of the website. Responses will be summarized and made available at a future date.

For members who wish to make consideration of this information a part of their Continuing Professional Development, the time spent reviewing the materials and scenarios are eligible for CPD credit within category B3: *Self Directed Learning*. If using the scenarios in discussion with peers, members may also claim credits under A1: *Professional Consultation/Interaction*. These credits may also be used to fulfill the ethics requirement of the CPD program.

We wish to acknowledge the hard work and thoughtfulness of the Client Relations Committee over the past year in preparing the Discussion Guide and encourage all College members to utilize the materials provided.

[1] "patients" are referred to as "clients" by the College of Psychologists of Ontario

Report of the Domestic Violence Death Review Committee

The College receives information from the Office of the Chief Coroner reporting on the results of reviews by the *Domestic Violence Death Review Committee (DVDRC)* when the reviews make recommendations relevant to members of the College of Psychologists. The letter accompanying the Report states that:

> *The purpose of this Committee is to assist the Office of the Chief Coroner in the investigation and review of deaths of persons that occur as result of domestic violence, and to make recommendations to help prevent such deaths in similar circumstances.*
>
> *By conducting a thorough and detailed examination and analysis of facts within individual cases, the DVDRC strives to develop a comprehensive understanding of why domestic homicides occur and how they might be prevented. Information considered within this examination includes the history, circumstances and conduct of the abusers/perpetrators, the victims and their respective families. Community and systemic responses are examined to determine primary risk factors and to identify possible points of intervention that could assist in the prevention of similar deaths in the future.*

In September 2018 the College received a *Report on the matter of the death of (name removed)* which occurred in December 2014. A copy of this Report is reproduced below.

The Report contains two recommendations directed at the College of Physicians and Surgeons, the College of Nurses, the College of Psychologists and the Ontario Psychiatric Association. The recommendations state that:

1. *Mental health professionals are encouraged to review the common risk factors for intimate partner homicide that have been identified in the annual reports of the Domestic Violence Death Review Committee. The presence of risk factors such as access to firearms and depression should trigger efforts for risk assessment, safety planning and risk management with patients as potential perpetrators/victims.*

2. *When an individual is diagnosed with depression, efforts should be made by the mental health professionals to encourage families to remove the individual's access to firearms.*

In keeping with these recommendations, and the Committee Comments and Rationale provided with them, the College of Psychologists is providing a copy of the Report to all members. In doing so, we wish to remind members of their obligation to provide services only within their authorized areas of practice and within the boundaries of their competence. As well, it is necessary for members to ensure ongoing maintenance of competence and continuing professional development in areas in which they provide services. Members working in the areas addressed by the attached Report especially should ensure they are familiar with and up to date on relevant and recent information related risk assessments, risk management and safety planning as well as the links between depression and domestic homicide.

Rick Morris, Ph.D., C.Psych.
Registrar & Executive Director

Domestic Violence Death Review Committee

Office of the Chief Coroner

Report on the matter of the death of:

OCC File : 2014-14222
(DVDRC 2018-12)

Details of Deceased:

Date of Death:	December 29, 2014
Age:	63 years
Sex:	Female

Overview:

This case involved the homicide of a 63-year-old woman by her 60-year-old husband. The perpetrator had physical and financial challenges which lead to depression. The perpetrator had access to firearms. There were seven risk factors for intimate partner homicide identified.

History of Victim:

The victim was the 63-year-old wife of the perpetrator. She worked full-time as a receptionist and was planning to retire, but she was also concerned about possibly losing her job. Due to the perpetrator's health issues and financial concerns, the victim was experiencing anxiety and depression for which she was prescribed medication. Approximately seven years prior to her death, she had also been diagnosed with breast cancer.

The victim was described as a kind person who was very supportive of the perpetrator, her children and grandchildren.

History of Perpetrator:

The perpetrator was the 60-year-old husband of the victim. He had a close relationship with his father and six siblings. Following high school, he completed an automotive mechanic apprenticeship and was also employed part-time as a Special Constable in the 1970's. He owned and operated a business until experiencing a serious injury in 2011.

In 2011, the perpetrator struck his head on a metal beam and required medical attention. Shortly after returning to work, he experienced a seizure and was found unconscious by the victim. He was hospitalized and continued to experience seizures, dizziness and would "pass out." Over the next several years, he was the subject of numerous consultations with medical specialists, but they were unable to determine the root cause of his condition. He was also unable to drive and had to depend on others. He indicated that he used to be the guy everyone came to, but over the past few years he has been "nobody" and that's when he began to experience depression. He spoke with his family doctor and was prescribed medication. Due to his health difficulties, the perpetrator was unable to sustain his business and was forced to sell.

The perpetrator owned at least 30 firearms consisting of long guns and approximately 14 handguns. He was a member of a local gun club and a hunt camp. He was described as an avid hunter and had been involved with firearms all his life. He was also attempting to start a gunsmith business and had been working as a gunsmith out of his garage since losing his business.

Over time, due to his illness, the perpetrator was unable to engage in any activities and stopped attending the gun club and no longer went hunting with his friends, despite their encouragement.

History of Children:

The victim and the perpetrator had two adult children together and three grandchildren. Both of their children lived in the same area and appeared to have a close relationship with their parents. Following their father's diagnosis, they were both supportive and involved in caring for him.

History of relationship:

The victim and perpetrator lived together for five years prior to getting married 40 years prior. The perpetrator reported that they had an "awesome" relationship and that the victim was the glue that kept the family together.

Family and friends reported that the couple appeared to have a good relationship and they were never witnessed to have arguments or difficulties in their marriage. They were both very active and enjoyed the outdoors. They were described as being supportive and patient with each other.

After the perpetrator experienced the injury in 2011 and selling his business, the couple was supported by the victim's income and they began to experience financial difficulties.

Following the homicide, relatives divulged that just prior to the homicide, the perpetrator had disclosed to them that he had attempted to kill the victim by mixing her drinks with medication. When that did not work, he reportedly sought out stronger medication from the relative. The information from the relatives was not confirmed.

Synopsis of events leading up to death:

In August 2014, the perpetrator was found unconscious in his home and was hospitalized for several months. Throughout this period, he continued to be the subject of several tests and numerous consultations with specialists from various hospitals. The perpetrator and his family expressed frustration with the medical system and their inability to ascertain what was wrong with him. The perpetrator continued to experience hopelessness, anxiety, depression and low moods. He was involved in counselling and received support from various health professionals.

Sometime in September 2014, the perpetrator had a conversation with one of his children about removing the firearms from his residence as he felt a little depressed. The perpetrator thought it might be a good idea to remove the guns from the house. Following the conversation, the perpetrator's doctor changed his medication prior to being discharged from the hospital and it "seemed okay to leave the guns."

On September 5, 2014, the perpetrator was advised of a possible diagnosis of a neurodegenerative disorder. Following this, the perpetrator continued to experience feelings of hopelessness and depression.

On September 15, 2014, the perpetrator reported to the nursing staff that he had attempted to commit suicide.

Medical professionals documented that the perpetrator had expressed little hope for the future. The loss of his business had been difficult and his main concern was that he couldn't do anything. He was upset that he might be confined to a wheelchair for the rest of his life. As a result of a psychiatric assessment/consultation, he was diagnosed with major depressive disorder due to his current mental state and a history of depressive symptoms.

On September 19, 2014, the perpetrator was informed that he was cleared of all neurological diagnosis and that he was likely suffering from conversion reaction (a psychiatric condition).

On September 23, 2014, the perpetrator indicated that he had a much better outlook on life given he was not facing a life-threatening illness. The previous few weeks had left him traumatized and suspicious of the medical system. He continued to have anxious thoughts and fears around the prospect of being in a wheelchair.

On November 7, 2014, the perpetrator returned home from hospital. The discharge plan involved various organizations that were able to assist in modifying the residence to accommodate the perpetrator's disabilities and his use of a wheelchair. The perpetrator was also to receive follow-up with psychiatry, neurology and attend an outpatient neurological rehabilitation program. Friends indicated that both the perpetrator and the victim were excited that he was coming home.

Throughout this period, the victim expressed concern about losing her employment and they both expressed concern about having to sell their home if the perpetrator's condition did not improve. The perpetrator and the victim were both devastated about all the changes to the residence and getting someone into help was overwhelming for them.

A friend/co-worker of the victim reported that the victim was afraid that the perpetrator was going to "drop dead." She was aware that the perpetrator was depressed and he had said that he did not want to live in the condition he was in.

Two or three days prior to Christmas, the victim was calling home all the time and was spoken to at work about tying up the telephone lines. She admitted that she was concerned that the perpetrator was going to commit suicide. The victim's friend asked if she was concerned about the guns and told her if she observed the perpetrator with a gun to leave the residence and call the police. The victim had also spoken to her employer about her concerns for the perpetrator.

Throughout the Christmas holidays, the perpetrator's father and other family members stayed at the residence. Both the perpetrator and the victim described the holidays as "good" and did not express any concerns. One of the couple's children indicated that they felt that the perpetrator was overwhelmed by Christmas.

On December 28, 2014, according to the couple's children, the victim and the perpetrator appeared to be fine and they did not have any concerns.

On December 29, 2014, a friend/co-worker of the victim spoke to her that evening and the victim indicated that she had a great holiday and they were going to have dinner and watch a movie.

The perpetrator reported that they shared dinner and a movie, then went to bed. The victim assisted the perpetrator into bed as she did ever night and then retired to her room. Due to his use of the wheelchair, the perpetrator slept in the spare bedroom.

Later that night, the perpetrator contacted the police to report a home invasion. When police attended the scene, they discovered the victim deceased in her bed with injuries to the face and head. The perpetrator denied any involvement in the death of the victim.

The perpetrator was charged and convicted of second degree murder.

Risk factors identified:

There were seven risk factors for intimate partner homicide identified:

- Perpetrator unemployed
- Depression – professionally diagnosed/professionally diagnosed
- Other mental health or psychiatric problems – perpetrator
- Prior threats to commit suicide by perpetrator
- Prior suicide attempts by perpetrator
- Access to or possession of any firearms
- Victim vulnerability (financial challenges, depression, care provider)

Recommendations:

To the College of Physicians and Surgeons, College of Nurses of Ontario, College of Psychologists of Ontario and Ontario Psychiatric Association:

1. Mental health professionals are encouraged to review the common risk factors for intimate partner homicide that have been identified in the annual reports of the Domestic Violence Death Review Committee. The presence of risk factors such as access to firearms and depression should trigger efforts for risk assessment, safety planning and risk management with patients as potential perpetrators/victims.

2. When an individual is diagnosed with depression, efforts should made by the mental health professionals to encourage families to remove the individual's access to firearms.

To the College of Physicians and Surgeons, College of Nurses of Ontario, Ministry of Health and Long Term Care (Local Health Integration Networks – Home and Community Care):

3. Healthcare providers should emphasize or discuss the importance of care options or mechanisms for couples experiencing declining health or disabilities and work with their families to identify appropriate mechanisms when one partner is being treated for depression or other related mental health issues and, in particular, if there is evidence of depression, suicidal ideation, previous suicide attempts and access to firearms.

Tricky Issues in Professional Practice

At the *Barbara Wand Seminar in Professional Ethics, Standards and Conduct*, held on January 21, 2019 in Toronto, I presented *Tricky Issues in Professional Practice*. Due to time constraints, one scenario provided to participants in the handout was not reviewed. Below is the scenario and multiple-choice answers from the handout, followed by a discussion of this situation. The discussion only speaks to the various options presented in the scenario, so the answers indicated as "correct" are the right options of those given. There may be other options, not mentioned, for addressing this scenario.

Please note that the comments provided are intended as general information. The circumstances of an individual client and the details of a specific situation may influence how one handles an actual matter. As always, members are encouraged to seek consultation and/or independent legal advice if they are unsure of the best approach to an individual situation.

Consent to Service

A colleague was about to undertake an assessment. As was her practice, she discussed both the limits of confidentiality and the service to be provided. She then asked the client to sign her usual Consent Form indicating he understood and agreed with what was discussed.

The client reported that his lawyer told him that, while it was OK to participate in the assessment, he was not to sign anything. Your colleague was satisfied that the client understood what had been discussed but she felt she was unable to continue as she believed that a signed Consent Form was required. That is, verbal consent was not good enough. She asked for your input on this dilemma.

Of the following, which correct advice would you provide to her?

1. *Your colleague acted appropriately in discontinuing the assessment as written confirmation of an understanding of the limits of confidentiality and consent to service is required.*
2. *Your colleague acted appropriately in discontinuing the assessment, although she didn't need written confirmation of an understanding of the limits of confidentiality, such confirmation is necessary regarding consent to service.*
3. *If your colleague was satisfied that the client understood the limits of confidentiality and the nature of the service to be provided, she could accept the client's verbal consent.*
4. *Both the Personal Health Information Protection Act, 2004 (PHIPA) and the Health Care Consent Act, 1996 (HCCA) specifically require written confirmation of informed consent.*
5. *The Standards of Professional Conduct, 2017 anticipate the appropriateness of verbal consent as it permits "documentation of the process of obtaining verbal consent related to the member's service to the client".*
6. *Since there is a lawyer involved in the matter, the assessment will probably end up before the courts; therefore, as a potential court matter, written consent is required.*

Discussion

There is no legal requirement that one obtain written consent to document a client's understanding of the limits of confidentiality or informed consent to service. This is anticipated by the *Standards of Professional Conduct, 2017* which, in describing the contents of the clinical file states, "The record shall include the following: "a copy of every written consent and/or documentation of the process of obtaining verbal consent related to the member's service to the client;" [9.2(2)k)]. While there is no restriction on obtaining written consent to document the consent process, and it is generally accepted as "best practice", there is no legislative requirement to do so.

In reviewing the choices provided to this scenario, only options 3. and 5. are correct. While a colleague may certainly decide not to proceed without written consent, both options 1. and 2. state that written confirmation is required and discontinuing the assessment is necessary. This is not the case. Rather, the decision not to continue is one to be made by the practitioner, if deemed appropriate. Similarly, option 4. is not correct as neither *PHIPA* nor the *HCCA* require written consent. As with options 1. and 2., option 5. is incorrect as the potential for court involvement does not automatically necessitate written consent. Given that the situation may become litigious, a practitioner may decide to require a signed consent form, however this would be a matter of professional judgement rather than a legislative requirement.

In summary, obtaining written consent is generally viewed to be good clinical practice, but it is not a legislative requirement. Rather, the requirement is that a member be satisfied that the consent obtained was informed and fully understood by the client. A member may find there are circumstances in which accepting a client's verbal consent is necessary or appropriate. In such situations, one is expected to document the process undertaken to obtain verbal consent as per Principle 9.2 of the *Standards*.

Note: this scenario does not address the matter of consent when one wishes to include a client's name when making a mandatory report of sexual abuse. In this situation, the client's written consent IS necessary. The Health Professions Procedural Code being Schedule 2 of the *Regulated Health Professions Act, 1991 (RHPA)* specifically states, "The name of a patient who may have been sexually abused must not be included in a report unless the patient, or if the patient is incapable, the patient's representative, consents in writing to the inclusion of the patient's name." [85.3(4)]

For those who could not join us in person or by webcast for the January 2019 Barbara Wand Seminar, it, along with several previous Seminars, is available in the Archive of Past Barbara Wand Seminars on the College website.

Rick Morris, Ph.D., C. Psych.
Registrar & Executive Director

Council Highlights – December 14, 2018

Policy Issues

Policies

The Council approved revisions to the following policies:

- *Policy I-10: Authority to Speak on Behalf of the College*
- *Policy I-12: Registrar's Performance Review*

The Council approved the following new policy*:*

- *Policy III A-6: Integrated Risk Management*

A copy of the Briefing Notes and draft policies considered by Council may be found in the Council Materials in the Resources section of the website.

Business Issues

Election of the Executive Committee

The term for Mr. D'Arcy Delamere as a Public Member of Council expired in October 2018. Mr. Delamere was both Vice-President of the College and a Public Member representative on the Executive Committee. With his leaving Council, elections were held to fill these two positions. Dr. Elizabeth Levin, Professional Member, was elected as Vice-President and Ms. Judy Cohen, Public Member of Council, was elected to the Executive Committee.

Election to Council

The date of March 29, 2019 was approved for election to Council for Districts 1, 2 and 3.

Other Business

The next meeting of Council will be held on March 29, 2018.

Inquiries, Complaints and Reports Committee (ICRC) Report to Council

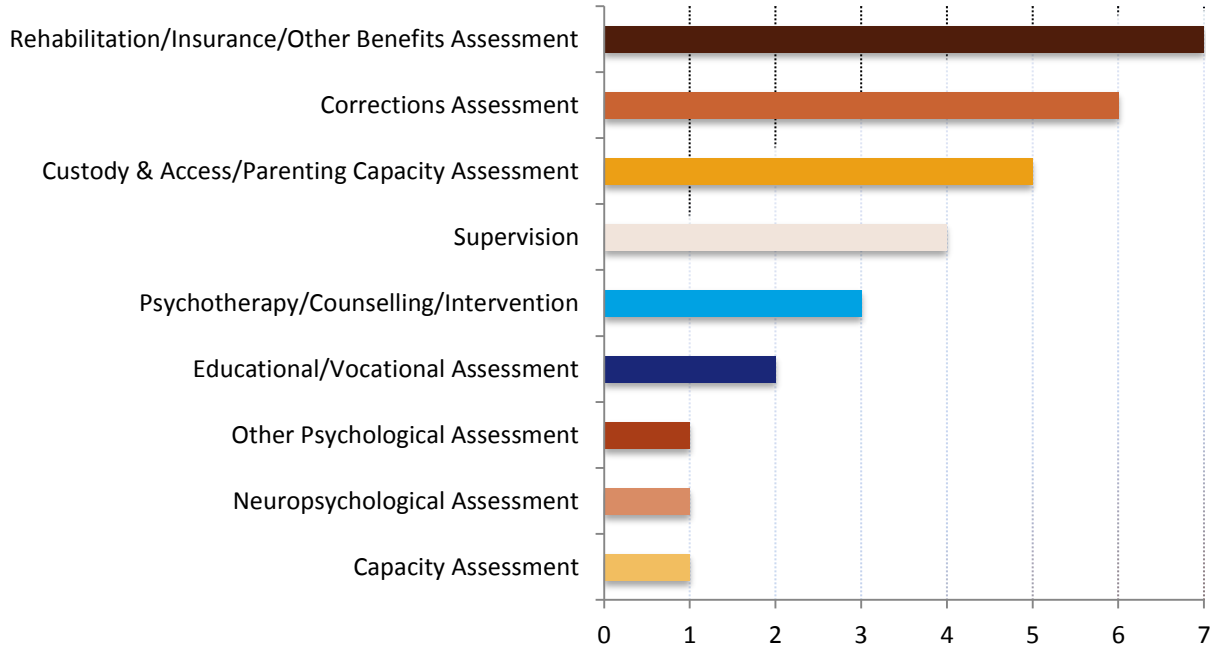
Second Quarter, September 1, 2018 – November 30, 2018

Committee Members:

Sara Hagstrom (Chair)	College	Lynette Eulette	Council
Diane Addie	College	Emad Hussain	Public Member
Ruth Berman	College	Elizabeth Levin	Council
Kristin Bisbee	Public Member	Donna McNicol	Public Member
Gilles Boulais	College	Melanie Morrow	College
Jason Brown	College	Rana Pishva	College
Judy Cohen	Public Member	Fred Schmidt	College
Dorothy Cotton	Council	Laura Spiller	College
D'Arcy Delamere	Public Member		

New Complaints and Reports

In the 2nd Quarter, the College received 29 new complaints and opened one new Registrar's Investigation for a total of 30 new matters. The nature of service in relation to these matters is as follows:



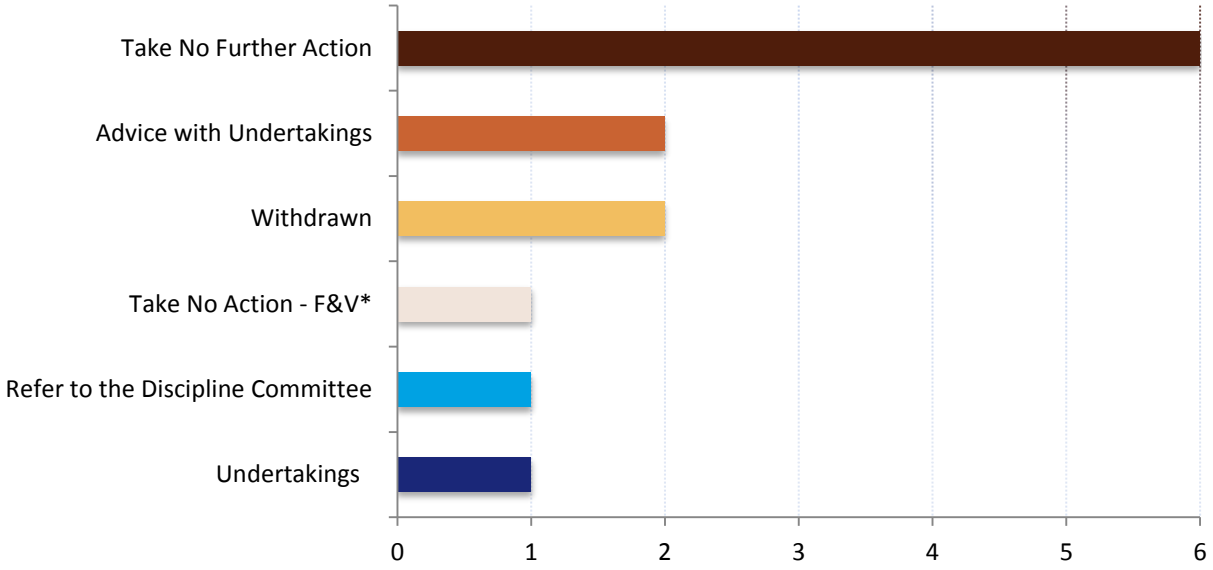
ICRC Meetings

Panels of the ICRC met on September 17, October 9 and November 6, 2018 to consider a total of 20 cases as well as nine teleconferences held to consider 11 cases. In addition, the ICRC also met in a Plenary session on November 5, 2018.

The first ICRC meeting of the 3rd Quarter took place on December 5, 2018, with the panel considering nine cases.

ICRC Dispositions

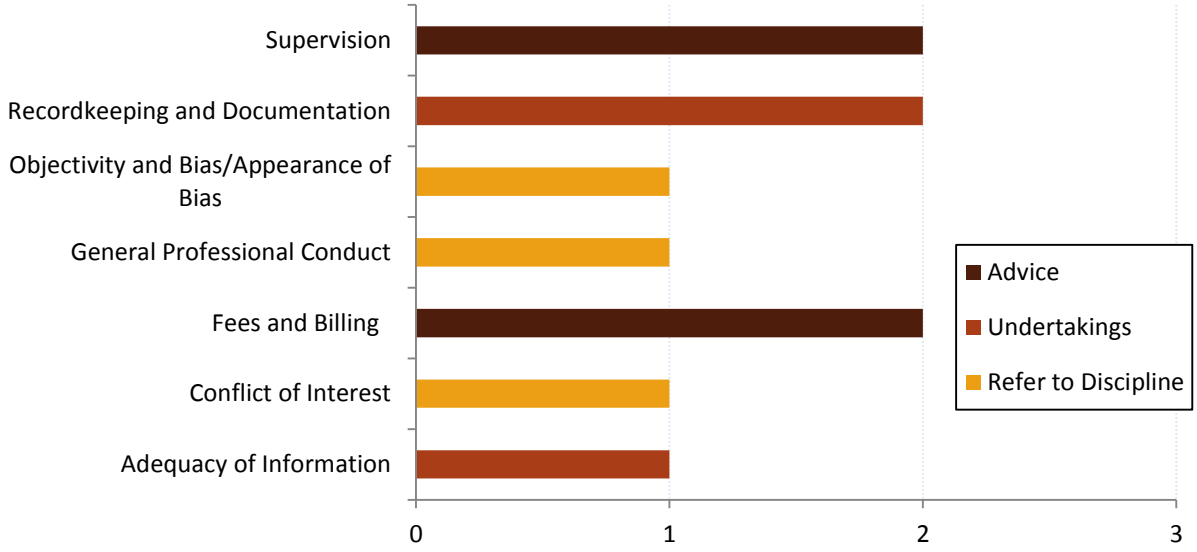
The ICRC disposed of 13 cases during the 2nd Quarter, as follows:



*F&V: Frivolous, vexatious, made in bad faith, moot or otherwise an abuse of process, pursuant to s.26(4) of the Health Professions Procedural Code

Disposition of Allegations

In the 2nd Quarter, the 13 cases disposed of included the consideration of 31 allegations. The ICRC took some remedial action with respect to 10, or 32%, of these allegations.



Health Professions Appeal and Review Board (HPARB)

In the 2nd Quarter, three HPARB reviews of ICRC decisions were requested. Two HPARB decisions were received, both confirming the ICRC decisions.

Changes to the Register

Certificates of Registration

The College would like to congratulate the ***Psychologist*** and ***Psychological Associate*** members who have received Certificates of Registration since October 2018.

Psychologists - Certificate of Registration Authorizing Autonomous Practice

Immaculate Arunthathy Antony
Alexandra Gilda Basile
Renée Katherine Biss
Joshua Michael Boden
Katelyn Elizabeth Boersma
Kerri Michelle Bojman
Jessica Elizabeth Borushok
Emily Gail Bryntwick
Madelaine Clair Burley
Tatijana Busic
Angela Caron
Jacqueline Chin
Caitlin Alexandra Claggett Woods
Cassandra Jessie Crangle
Emilie Crevier-Quintin
Emma Elizabeth Dargie
Wendy Bernadette den Dunnen
Leandra Katrine Rosina Desjardins
Esther Yona Direnfeld
Farah Dobani-Budhani
Fiona Dyshniku
David Alexander Eisenach
Kailey Pearl Ennis
Julie Dorothy Ann Erickson
Breanne Marie Ruth Faulkner
Sabrina Freund
Katelyn Marie Gomes
Leah Iris Hartman
Sabrina Hassan
Nicola Hermanto
Katherine Holshausen
Kristine Nicole Iaboni
Leah Allison Sarah Keating
Christine Klinkhoff
Angela Marie Lachowski
Denise Ma
Clarisa Markel
Marc Martineau
Justin Martin Massey
Hilary Marie Maxwell
Tracy Anne Mewhort-Buist
Bryce Patrick Mulligan
Jordanna Jade Nash
Leorra Meira Newman
Kevin Louis Noble
Julie Margaret Norman
Sarah Nicole Nowak
Constance Elizabeth Oates
Marianne O'Byrne
Erin Leigh O'Farrell
Pamela Elaine Percy
Syb Pongracic
Heather Joan Prime
Levi Riven
Anne-Rose Robbins
Jennifer Robin Rouse
Lyndall Anne Schumann
Magali Segers
Matthew Jacques Shanahan
Kimberley Lynn Shilson
Rebecca Stead
Oona Elizabeth Rain Tiplady
Christina Tomei
Ghia Althia Townsend
Lianne Jill Trachtenberg
Mechtild Uhe
Brandon Paul Vasquez
Julie Anne Marie Wallis
Eamon Roy James Wilson
Nikita Yeryomenko

Leann Kimberly Lapp
Stephanie Lindsey-Marie Lavoie
Christian Lepage
Karen Michelle Zhang Yao
Yue Zhao

Psychological Associates - Certificate of Registration Authorizing Autonomous Practice

Nicole Bennie
Allison Caldwell
Laura Evelyn Cousineau
Alexandra Stephanie Erika Cowie
Hallie Melody Farrow
Niyati Anis Gandhi
Jennifer Eve Kellerstein
Parvati Sonia Khan
Michael Andrew Kong
Cristina Carolina Magrina Sanchez
Vincenza Mancuso
Andrya Racquel Mauro
Laura McDougall McGill
Patricia Ann Molnar
Erin Kimberley Mullings
Christopher Anthony Rodrigues
Regieve Kumar Roopa
Jessica Spape
Pasquale Veleno
Karey Lyn Wilson

Psychologists - Certificate of Registration Authorizing Interim Autonomous Practice

Afshan Afsahi
Julie Ayotte
Mary Patricia Beaudoin
Karine Bertrand
Diana Vivian Waltho Cassie
Jennifer Ellen Curry
Alex Drolet-Dostaler
Leah Nicole Enns
Rebecca Lisa Fraccaro
Jason Blake Keller
Mélanie Amélia Paulette Léger
Kerry Lee Spice

Psychological Associates - Certificate of Registration Authorizing Interim Autonomous Practice

No new certificates were issued

Psychologists - Certificate of Registration Authorizing Supervised Practice

Touraj Amiri
Olivia Evelyne Beaudry
Stéphanie Camille Boyer
Dillon Thomas Browne
Melissa Lauren Button
Andrew Jonathan Carlquist
Nicole Rosanna Carson
Ken Andrew Colosimo
Eli David Sidney Cwinn
Alexander Robert Daros
Marina Simone Dupasquier
Petrice Gentile
Maryam Gholamrezaei
Natalie Margaret Elizabeth Hazzard
Casey Shigeo Iwai
Nalini Maria Iype
Jenna Brooke Jones
Marta Janina Kadziolka
Genevieve Mary Hirst Monaghan
Michelle Monette
Marisa Murray
Shayna Hannah Nussbaum
Dragana Ostojic-Aitkens
Jeffrey Luc Perron
Gauthamie Poolokasingham
Stephanie Rose Price
Jennifer Sarah Rabin
Elyse Kerry Reim
Erin Lynn Romanchych
Lianne Avril Rosen
Emily Safronsky
Cynthia Sing-Yu Shih
Victoria Kar-Yan Sit
Susan Laurie Sprokay
Erin Sulla
Jenna Michelle Traynor

Alexa Lynn Kane
Jean Kim
Samantha Kayeon Longman-Mills
Nidhi Luthra
Jasmine Claire Mahdy
Sasha Ameeta Mallya
Lee David Unger
Yunqiao Wang
Sarah Elizabeth Wootten
Mengran Xu
Dora Marta Zalai
Wenfeng Zhao

Psychological Associates issued with certificate authorizing supervised practice

Carol Anne Susan Austin
Souha Hassan Bawab
Lauren Patricia Dolente
Julie Elizabeth Gamboz
Aubrey Carolyne Gibson
Lital Rachel Grinberg
Lynn Denise Laverdiere-Ranger
Gabriela Najman
Michele Leanne Palk
Jasmine Christine Peterson
Jennifer Leigh Post
Jill Ann Schroeder

The College wishes to thank those members who generously provided their time and expertise to act as primary and alternate supervisors for new members issued Certificates Authorizing Autonomous Practice

Retired Certificate of Registration

Lott Makhudu Mamabolo
James Ernest Sweeney
Mary Catherine Tierney

Resigned

Philip Francis Carney
Ellen Greenberg
Margaret Peggi Janet Liswood

Deceased

The College has learned with regret of the death of the following members and extends condolences to the family, friends and professional colleagues of:

Hans J Breiter
Laura Anne Chambers