The *e*-Bulletin

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

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Tricky Issues in Professional Practice
At the *Barbara Wand Seminar in Professional Ethics, Standards and Conduct*, held on June 14, 2018 in London, I presented some *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.

READ MORE

Barbara Wand Seminar - June 2018
The Barbara Wand Seminar in Professional Ethics, Standards and Conduct was held in London on June 14, 2018. Members may view the recording of this and other past Seminars on the College website.

Council Highlights
Highlights from the Council meeting held on June 22, 2018 are now available.

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Oral Examiner Thank You
The College would like to thank the following who acted as oral examiners in June 2018.

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Inquiries, Complaints and Reports Committee Activities
The fourth quarter report for the ICRC - March 1, 2018 to May 31, 2018 is available for download.

DOWNLOAD 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 April 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

September 21, 2018
December 14, 2018
March 29, 2019

We welcome observers. Materials will be 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

At the Council meeting in June, the Council elected the Executive Committee for the coming year. Re-elected are Public Members Ms. Kristin Bisbee and Mr. D'Arcy Delamere, and Professional Members Dr. Michael Grand and Ms. Christine DiZazzo. Dr. Elizabeth Levine, Professional Member, was newly elected to the Executive. Mr. D'Arcy Delamere, was elected Vice-President and I am pleased and honoured to have been acclaimed to serve again as President. Two new Professional Members were welcomed to Council at this meeting – Dr. Janice Currie and Ms. Melanie Morrow.

Every year there is a very positive response from members to the call for volunteers for the College Statutory and Non-Statutory Committees, though the number of vacancies is limited. As a way of being able to include more of the membership, the Council decided to limit the number of terms that any one professional member could serve on College Committees. I want to thank the Professional Members who will be involved in Committee work this coming year, and express my appreciation to the College members who put their name forward but were not appointed this year.

Council voted to adopt a formal 'Code of Conduct' for anyone participating on Council or a Committee. This 'Code' sets out expectations for preparation and involvement in Council and Committee work, and it provides a process for working through difficult situations in a way that is respectful and fair should they arise. Other items on the Council agenda included a variety of policy changes as well as consideration of the external audit reports for the Client Relations and Finance and Audit Committees which were formally reviewed this past year.

Council was pleased to welcome representatives of the Association of State and Provincial Psychology Boards (ASPPB) to discuss the proposed changes to the Examination for Professional Practice of Psychology (EPPP) that are targeted towards evaluating the competencies of applicants. This session was helpful as Council members were able to gain important information about the proposed changes and to ask questions directly from those working on the project. Council also continued discussions of the 'Shaping the Future' Council motion from March 2013 pertaining to the closure of Master's level registration as well as title. No decisions were made at this meeting and discussions will continue at the September Council meeting.

The Executive Committee held a members' reception in Kingston in early May. The reception was well-attended by members from both the public and private sectors. Dr. Rick Morris, Registrar & Executive Director, fielded questions during a Q and A session. Most of the questions concerned the controlled act of psychotherapy and supervision of non-registered practitioners and those already registered with other Colleges. It was a lively session with good dialogue and problem-solving. Looking forward, the Executive will hold two members' receptions in the coming year, one in fall and one in the spring. The locations for these receptions will be determined at the summer meeting of the Executive Committee.

Summer is simply the best season of the year! And, because we live in a 'four-season' country, it's all the more precious because it doesn't last that long! I encourage you to make the most of the summer days by relaxing and connecting with those who are most important to you.

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

CONSULTATION

Amendments to *By-law 5: Selection of Committee Chairs and Committee Members* and *By-law 21: Committee Composition*

At the meeting of the Council of the College of Psychologists held on June 22, 2018, a motion was passed to circulate proposed amendments to *By-law 5: Selection of Committee Chairs and Committee Members* and to *By-law 21: Committee Composition*. According to the Health Professions Procedural Code being Schedule 2 of the *Regulated Health Professions Act, 1991 (RHPA),* amendments to some By-laws must be circulated to members 60 days before it is approved by Council. If you wish to comment on the proposals, we would appreciate hearing from you by Tuesday, September 4, 2018 so your feedback can be included in the Council discussions at its next meeting.

There are a number of changes to *By-law 5: Selection of Committee Chairs and Committee Members*, many of which are 'housekeeping'. The most substantive change relates to delineating the role of the Chair of the Committee and the introduction of a Vice-Chair position. Close communication between the Committees and the Council is very important. As not all Committee Chairs are necessarily members of Council, the role of Vice-Chair was introduced with the requirement that at least one of the Chair or Vice-Chair must be a member of Council. In this way, each Committee will have a direct line of communication to the Council.

The change to *By-law 21: Committee Composition* is relatively minor. In describing the composition of the Registration Committee, the Council wished to emphasize the need for the Committee to have members who are familiar with the psychology training programs. While not a strict requirement, the change to the By-law would suggest that Registration Committee membership should include members with "academic involvement".

Copies of both By-law 5 and By-law 21, showing the amendments, with an accompanying explanation of the proposals are below. Additions are shown as underlined in blue with deletions marked as ~~strikeouts in red~~.

The College Council will be discussing these amendments at the September 2018 meeting. If you wish to provide any comments we would appreciate hearing from you by Tuesday, September 4, 2018.

Please submit your feedback to: bylawconsultation@cpo.on.ca

To ensure transparency and to encourage engagement from College members, the public and other stakeholders, the feedback received will be posted on the website as part of the Council Materials for the September meeting. The College will make reasonable efforts to remove personal identifiers and information that may identify a third party prior to posting but will not review submissions for grammar, spelling or accuracy.

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

BY-LAW 5: SELECTION OF COMMITTEE CHAIRS AND COMMITTEE MEMBERS

[Approved by Council on June 11, 1994; amended on March 4, 1995, December 2002, March 14, 2003, September 2007, March 27, 2009, September 2018]

This by-law is made under the authority of the Regulated Health Professions Act, 1991 as amended, and the Psychology Act, 1991 as amended.

5.1 The Council may, by resolution, establish Committees additional to those established through Section 10 of the Health Professions Procedural Code being Schedule 2 under the Regulated Health Professions Act, 1991 (Code).

Addition made to properly reference the Code

5.2 At least two months prior to first meeting of Council following the annual election, College members will be notified of the opportunity to put their names forward for possible appointment to a Committee of the College. In addition to other information, College members interested in appointment to a Committee are required to submit a ~~resume~~ statement of qualifications pertaining to the mandate of the Committees in which they wish to participate.

The submission of a statement regarding one's qualification and how these relate to Committee choices indicated is more valuable than simply a resume.

5.3 At the meeting of Council preceding the annual election prescribed in the Bylaws, the President will advise the Council of the process for Committee appointments and for indicating their Committee preference. At least one month prior to first meeting of Council following the annual election, all Council members will be notified of the opportunity to submit their preferences for appointment to Committees of the College.

5.4 The Nominations and Leadership Development Committee will prepare a list of suggested appointees from the College membership to the Committees of the College. This list will be provided to the Executive Committee at the first meeting of Council following the annual election.

5.5 ~~During, or in the 24 hours immediately following~~ Immediately after the first meeting of Council following the annual election, the Executive Committee shall appoint the Chairs and the members of the Committees identified in subsection 5.1 as well as those designated in section 10 of the Code.

This is in keeping with current practice.

5.6 Committee Chairs:

a. Each Committee will have a Chair and each Statutory Committee will have a Vice-Chair, one of whom is a Council member.

b. The Committee Chair reports to Council on behalf of the Committee

i. The Vice-Chair will be elected or appointed by the Committee at the earliest opportunity.

ii. If the Chair of a Committee is not a Council member, the Vice-Chair will report to Council.

c. The duties of the Committee Chair, or of the Vice-Chair in the Chair's absence, include:

i. Chairing Committee meetings;

ii. Approving meeting agendas prepared by College staff;

iii. Determining whether Committee members have the resources and

This new section delineates the role of the Chair and introduces a Vice-Chair position. To ensure close communication between the Council and the Committees, the By-law requires that one or both must be members of Council.

training to effectively perform the Committee's work; iv. Working with the Committee and College staff to establish, monitor and execute Committee goals; v. Providing effective leadership for the Committee and facilitating Committee Meetings; vi. Liaising with Council and the Executive Committee on the affairs of the Committee; and, vii. Any other duties determined or assigned by Council. 5.15.2 ~~The Executive Committee~~Committee appointments will be announced ~~will advise Council of the committee appointments~~ within five business days of the first meeting of Council following the annual election. ~~5.2~~5.3 A majority of the members of a Committee, other than a Committee prescribed in section 10 of the Code, constitutes a quorum. ~~5.3~~5.4 Where one or more vacancies occur in the membership of a Committee during the year, so long as the number is not fewer than the prescribed quorum, the Committee may continue to conduct its business. ~~5.4~~5.5 The Executive Committee may, if necessary for a Committee to achieve its quorum, appoint members of the Council, or of the College where required, to fill any vacancies which occur in the membership of a Committee to take effect immediately and to be reported to Council at its next meeting. ~~5.5~~5.6 Every appointment to a Committee automatically expires at the first meeting of Council following the annual elections unless otherwise prescribed in subsection 3(d) of By-law 21: Committee Composition; or any provision to the contrary in the Code, the By-laws or the policies of the College. ~~5.6~~5.7 Both registration titles will be represented on all statutory committees.	While the Executive Committee makes the final appointments, Council notification is generally done through the office of the Registrar.

BY-LAW 21: COMMITTEE COMPOSITION

[Approved by Council December 1999; amended March 2001 and June 2002, December 2006, September 2007, March 27, 2009, June 2009, September 2017, September 2018]

This by-law is made under the authority of the Regulated Health Professions Act, 1991 as amended, and the Psychology Act, 1991 as amended.

21.1 (1) The Executive Committee shall be composed of:

(a) four members of the Council who are members of the College;
(b) both titles shall be represented among the members in section (a); and,
(c) two members of the Council appointed to the Council by the Lieutenant Governor in Council.

(2) The President and Vice-President of the Council shall be members of the Executive Committee and the balance of the members shall be elected to complete the composition of the Executive Committee as set out subsection (1).

(3) The President of the Council shall be the chair of the Executive Committee.

21.2. The Registration Committee shall be composed of:

(a) at least three members of the Council who are members of the College; normally two of whom have academic involvement;
(b) at least two members of the Council appointed to the Council by the Lieutenant Governor in Council; and
(c) at least two members of the College who are not members of the Council.

Emphasizes the desirability and importance of having Committee members with academic experience on the Registration Committee

21.3. The Inquiries, Complaints and Reports Committee shall be composed of:

(a) at least two members of the Council who are members of the College;
(b) at least three members of the Council appointed to the Council by the Lieutenant Governor in Council; and
(c) at least two members of the College who are not members of the Council.
(d) a member of a panel who would otherwise cease to be a member of the Inquiries, Complaints and Reports Committee after an investigation of a matter has been commenced by the panel shall continue, for the purposes of concluding that matter, to remain a member of that panel and of the committee until the final disposition of the matter by the committee.

21.4. The Discipline Committee shall be composed of:

(a) at least six members of the Council who are members of the College;
(b) at least four members of the Council appointed to the Council by the Lieutenant Governor in Council; and
(c) at least two members of the College who are not members of the Council.

21.5. The Fitness to Practice Committee shall be composed of:

(a) at least two members of the Council who are members of the College;
(b) at least one member of the Council appointed to the Council by the Lieutenant Governor in Council;
(c) at least two members of the College who are not members of the Council.

21.6. The Quality Assurance Committee shall be composed of: (a) at least two members of the Council who are members of the College; (b) at least one member of the Council appointed to the Council by the Lieutenant Governor in Council; (c) at least two members of the College who are not members of the Council. 21.7. The Client Relations Committee shall be composed of: (a) at least two members of the Council who are members of the College; (b) at least two members of the Council appointed to the Council by the Lieutenant Governor in Council; (c) at least two members of the College who are not members of the Council.	

Results of the Consultation on *By-law 25: The Register and Related Matters*

The College wishes to thank those members who took the time to respond to the recent consultation on *By-law 25: The Register and Related Matters*. The College received 25 responses to the consultation. While most of the changes were positively received, significant concern was expressed regarding the unintended consequences of the section which proposed that the public register include *the full name of every direct supervisee, who is not a member of the College*.

The feedback questioned the public protection value of this additional requirement. It also noted the significant increased burden it would place on supervisors. Members noted the variety of settings and circumstances in which supervision is undertaken which can include supervision of many research assistants and students in clinical training programs. Feedback suggested that while supervisees within a small private practice may be somewhat stable over time, in many settings supervisees may change with some regularity as research projects are completed or training program terms end. Many members felt the paperwork necessary to keep such a required list up-to-date would pose significant issues without an offsetting public protection/interest value.

The Standards of Professional Conduct, 2017 require that clients be directly provided with information about the supervisory arrangement. Specifically,

> ***4.1 Informing Clients***
> *Supervising members must confirm that clients have been informed of the following at the onset of service provision:*
> *a) the professional status, qualifications, and functions of the individual providing the service;*
> *b) that all services are reviewed with, and conducted under the supervision of, the supervisor;*
> *c) the identity of the supervisor and how the supervisor can be contacted;*
> *d) that meetings with the supervisor can be arranged at the request of the client, supervisor, and/or supervisee; and,*
> *e) with respect to the limits of confidentiality, that the supervisor must have access to all relevant information about the client.*

This requirement ensures that clients have the contact information of the supervisor and would be the way in which the public would know who to contact directly in the event of a question or concern regarding their service.

The Council carefully considered the feedback received regarding *By-law 25: The Register and Related Matters* and approved the proposed amendments except for the section requiring that the public register include t*he full name of every direct supervisee, who is not a member of the College*. Based on the feedback received, the Council determined that such a requirement would have significant unintended consequences and therefore not be in the interest of the public or the members, at this time.

The amended *By-law 25: The Register and Related Matters* may be found on page 39 of the College By-laws available on the website at: www.cpo.on.ca/WorkArea/DownloadAsset.aspx?id=445.

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

Public Consultation for the 6th Revision of the Canadian Psychological Association (CPA) Accreditation Standards

The CPA Accreditation Panel for Doctoral Programs and Internships in Professional Psychology has begun a process of public consultation for the purpose of revising the *Accreditation Standards and Procedures for Doctoral Programs and Internships in Professional Psychology*. The last revision took place in 2011. The CPA Accreditation requirements are referenced in the College Registration Regulation and are an integral part of the College registration process, at all levels.

The CPA Accreditation Panel is currently seeking feedback from all members of the community regarding the Standards through a Public Consultation Survey.

This survey is part of a multi-step revision process. Once this survey closes, the results will be integrated into a draft revision of the Standards by a committee overseen by the CPA's Accreditation Panel. That draft will then be circulated to the training community for further feedback which will be integrated into a second draft. The feedback process will continue until both the Panel and majority of the training community are satisfied with the revisions. Once this occurs, a final draft will be submitted to the CPA Board of Directors for approval; the Board may then approve it as proposed or request further revisions. The Accreditation Panel anticipates that the 6th revision will be completed by June 2020.

Further information about the survey or the Accreditation Standards review process may be obtained from Dr. Stewart Madon, CPA Registrar of Accreditation at accreditation@cpa.ca or 1-888-472-0657 ext. 333.

- Download the current revision of the Accreditation Standards (2011)
- Survey Link English

Information and Update: Quality Assurance

The College's Quality Assurance Committee has responsibility under the Health Professions Procedural Code (Code) being Schedule 2 to the *Regulated Health Professions Act, 1991* for assuring the quality of the practice of the profession and promoting the continuing competence among the members.

Under the *Act,* a Quality Assurance Program must include: continuing education or professional development; self, peer and practice assessments; a mechanism for the College to monitor members' participation in, and compliance with, the quality assurance program; and on a day yet to be named by proclamation of the Lieutenant Governor, promotion of interprofessional collaboration.

All members, except for those who hold Retired Certificates of Registration, must engage in Self-Assessment and Continuing Professional Development activities as required by the legislation and the Quality Assurance Regulation. Fewer members will have had direct experience with the Peer Assisted Review process.

Peer Assisted Review
Each year, some members of the College are selected to undergo a Peer Assisted Review (PAR).

A member is required to participate in a PAR if they have not completed their Self-Assessment Guide and Continuing Professional Development Plan (SAG) before the date required, unless they have received a deferral due to exceptional circumstances. A member is also required to participate if selected for review by either a random or stratified random selection. Stratified random selection allows the College to focus on a particular subgroup of the membership at the discretion of the Committee. The Quality Assurance Committee strives to complete approximately 50 reviews per year.

Under the Code, the purpose of a PAR is to evaluate a member's knowledge, skill and judgment and is not intended to be an investigative procedure. The members conducting the PARs are guided by the College to facilitate a collegial exchange of information regarding the member's practice. Experience has shown that this can be educational and beneficial to both reviewers and reviewees.

If the Quality Assurance Committee determines, based on the results of the PAR, that a member's knowledge, skill and judgment are unsatisfactory, it can require the member to undertake some remedial action. This could include informal educational endeavours or a more formal requirement that the member participate in a specified continuing education or remediation program. In a very serious situation, the Committee could direct the Registrar to impose terms, conditions or limitations on the certificate of registration of the member for a specified period or if the member did not successfully complete the required specified continuing education or remediation program.

In the process of reviewing the PAR report, the Committee could form the opinion that the member may have committed an act of professional misconduct, or may be incompetent or incapacitated. In such cases, according to the Code, the Committee may disclose the name of the member and information leading to the concerns to the Inquiries, Complaints and Reports Committee. It cannot however, provide any other information obtained while administering the Quality Assurance program.

Experiencing a Peer Assisted Review

Reviewers conducting PARs are guided by the College to facilitate a collegial exchange of information regarding the member's practice. This is intended to be educational and beneficial to both reviewers and reviewees and, based on survey results, this is commonly the experience.

The College conducts surveys with those who have participated in the PAR process. The Committee reviews the feedback for ways in which the program can be enhanced. In almost all cases, experiencing a PAR is reported to be a positive opportunity for members to improve the quality of their services and reflect on ways in which to continue growing as a professional.

One question in the survey asks participants whether the review was conducted in a collegial and respectful manner. On a four-point scale, where zero is "strongly disagree" and four is "strongly agree", to date, the average and median rating given in response to this question has been four, "strongly agree". The same average and median ratings have been obtained when respondents are asked if they found the review to be a positive and constructive experience.

Members have commented that:

- *… we exchanged readings and information about useful conferences and forms. The whole thing was done to help each other in our practices and to encourage each other*
- *… In the end, the experience was actually very validating … I would encourage all members to go through the exercise, working through the list of interview questions with a trusted colleague*
- *… I realized the degree of my collegial isolation and I have already taken steps to remedy that, becoming part of an independent professional support group that discusses developments in the field and interesting or troubling cases*
- *… The respectful dialogue with 2 colleagues, whose openness & observations were non-judgmental though evaluative, was refreshing. … It was relieving to learn that the CPO hadn't disclosed to their reviewer my history of investigations…*

The Committee also utilizes constructive feedback in program planning. Some examples include:

- *…I experienced anxiety in waiting between the time of notification of the review and the review and then seeing receiving a copy of the reviewers' report*
- *… The review occurred too late in my professional career and would have been more useful if it had occurred earlier …*
- *…Some things in the process were different than what others I know experienced and it would be better if procedures were more standardized*

Selection for a Peer Assisted Review

All members who have not completed their Self-Assessment Guide and Continuing Professional Development Plan before the date required by the College are required to undergo a PAR. In addition, a number of members are chosen to participate in a PAR based on computerized random and stratified random sampling. The stratum to be sampled is decided on a year to year basis by the Quality Assurance Committee, based upon developments in the field about which members may require assistance and support.

2017-2018 Peer Assisted Reviews

Forty-nine PARs were completed between June 1, 2017 and May 31, 2018. In almost all cases, the PAR reviewers reported that those reviewed practice ethically and competently. Most described the practices of these peers in highly positive terms. Some of the specific comments made by reviewers were about:

- Professional environments which were warm, respectful, and conducive to privacy;
- Security with respect to client files and testing equipment;
- Collegial cooperation and respect for colleagues;
- Active engagement in continuing professional development activities, including regular meetings with colleagues, some utilizing technology for distance;
- Thoughtfulness about the selection of topics and themes for continuing professional development and the relevance to reviewees' professional goals;
- Thoughtfulness about best practices;
- Specific consent procedures which had been developed with respect to anticipated non-mandatory reporting situations like suspected inability to drive safely or protection of clients in high risk populations;
- Active consideration of responsible workload management where members feel challenged by professional and personal demands;
- Self-awareness of the limits of ones' own competence and willingness to consult with others; and,
- Documents members have prepared to provide to clients with respect to confidentiality and consent as well as about their own practice models and what clients and referral sources can expect.

In a limited number of cases, some feedback was provided about areas for improvement. For example, some reviewees were advised about:

- Copyright infringement and the use of photocopied test protocols;
- Need to take greater care regarding confidentiality of client records, both with respect to traditional face to face service models and services provided via technology;
- Enhancing practices with respect to obtaining informed consent for services;
- Practicing only within areas of authorized practice and competence, unless under supervision;
- Reviewing legislation that is relevant to their practices, including mandatory reporting requirements;
- Taking greater care to avoid conflicts of interest;
- Maintaining records for the required retention periods; and,
- Adherence to the Supervision Standards, including augmenting supervision practices.

In those cases where the reviewers made suggestions regarding areas for improvement, all of these were addressed collaboratively without any need for action by the Committee. There was no information to support a belief that there are any commonly occurring problems among the membership.

Greater Focus on Specific Groups of Practitioners

To date, it has been difficult to observe any trends regarding strengths and challenges faced by members or solutions to challenges which could be shared broadly with the membership. It is hypothesized that this is because of the wide variability among members reviewed; that is, a wide

variety of members providing a wide variety of different services in a wide variety of settings. For this reason, the Committee has decided to place more emphasis in its annual selections on specified segments of the membership.

During 2018-2019, the Quality Assurance Committee has decided to select 80% of the random sample from among members who are in solo private practice, where they do not have the benefit of institutional infrastructures providing policies, procedures, records departments or as many naturally occurring opportunities for collegial interaction. It is hoped that this will not only assist the individual members selected for review but may also give the College the ability to provide more detailed and helpful information to those with similar practices who have not been reviewed.

More information about the College's Quality Assurance Programs, is available at:
http://www.cpo.on.ca/Quality_Assurance_Program.aspx

Reporting Privacy Breaches
Update on Amendments to the *Personal Health Information and Protection Act, 2004*

The *Personal Health Information Protection Act, 2004* (*PHIPA*) and its Regulation (O. Reg. 329/04) have undergone several amendments over the past few years. Some of these amendments pertain to reporting requirement by Health Information Custodians in the event of unauthorized disclosures of Personal Health Information.

Amendments to *PHIPA*, previously reported in the July 2016 *eBulletin,* require that:

> *When a privacy breach occurs, in addition to notifying the affected person that this has occurred, the responsible health information custodian is also now required to advise the individual of the right to make a complaint about the privacy breach to the Privacy Commissioner of Ontario. A member who is not the health information custodian but is an agent of the health information custodian is also required to advise the responsible health information custodian of the occurrence of the breach at the first reasonable opportunity.*
> *(*www.cpo.on.ca/Privacy_Breaches.aspx*)*

As of October 1, 2017, *PHIPA* also requires Health Information Custodians to report directly to the Privacy Commissioner the following breaches involving personal health information:

1. Use or disclosure without authority
2. Stolen information
3. Further use or disclosure without authority after a breach
4. Pattern of similar breaches
5. Disciplinary action against a College member resulting from a breach
6. Disciplinary action against a non-College member who acted on behalf of a college member
7. Significant breaches which are not covered by the other 6 criteria listed above

Further information, including a description of these criteria, may be found on the website of the Office of the Information and Privacy Commissioner of Ontario (IPC) in a document: *Reporting a Privacy Breach to the Commissioner: Guidelines for the Health Sector, September 2017*. In addition, the IPC has prepared an on-line *Privacy Breach Reporting Form* for use in reporting.

Additional amendments to *PHIPA* require Health Information Custodians to provide an annual statistical report of privacy breaches to the Privacy Commissioner. The first report is due in March 2019 and must contain statistical information about breaches which occurred during 2018.

The report must include information about personal health information in the custodian's custody or control that was:

1. Stolen
2. Lost
3. Used without authority and/or
4. Disclosed without authority

Detailed information about this reporting requirements may be found in the IPC's online document: *Annual Reporting of Privacy Breach Statistics to the Commissioner: Requirements for the Health Sector, November 2017*.

This statistical report must be made using the IPC's online portal which will be available on the IPC website. Members are advised to track any privacy breaches which may occur to facilitate reporting when the first report is due.

The Office of the Information and Privacy Commissioner of Ontario provides a great deal of helpful information on its website. In the unfortunate event of a privacy breach, members are encouraged to visit the Information and Privacy Commissioner's website to ensure that their knowledge about their legislative responsibilities is up to date. In addition to information about *PHIPA*, the website also provides information about the *Freedom of Information and Protection of Privacy Act, 1990* (*FIPPA*), and the *Municipal Freedom of Information and Protection of Privacy Act, 1990* (*MFIPPA*). Members are encouraged to contact the Office of the IPC (info@ipc.on.ca) for assistance with any specific questions about their obligations with respect to privacy of personal health information and breaches of privacy.

Information about Federal Privacy Laws, including the *Personal Information Protection and Electronic Documents Act, 2000* (*PIPEDA*), as well as information about the applicability of various privacy laws across Canada may be found on the website of the Privacy Commissioner of Canada.

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 February 2018 the College received a *Report on the matter of the deaths of (names removed)* which occurred in February 2014. In April 2018 a second Report was received regarding deaths which occurred in March 2016. Copies of these reports are attached.

The Report received in February 2018 contains a recommendation (#1) directed at the College of Social Workers and Social Service Workers, the College of Psychologists and the College of Physicians and Surgeons. This recommendation states that:

> *Social workers, psychologists and physicians are reminded of the importance of ongoing training on risk assessment, risk management and safety planning in the prevention of domestic homicides. Special emphasis should be given on the impact that depression has on domestic violence and domestic homicide*.

The second Report received in April 2018 contains a recommendation (#3) directed toward the College of Physicians and Surgeons, College of Nurses, Ontario Psychiatric Association and the College of Psychologists. This recommendation states that:

> *Health and mental health professionals who are involved with vulnerable patients involved in domestic violence should complete risk assessments focused on domestic violence and reach out to the police and justice system for advice on potential lethal circumstances with a documented history of concern*.

In keeping with these recommendations, and the Committee Comments and Rationale provided with them, the College of Psychologists is providing a copy of the Reports 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.[1]1 As well, it is necessary for members to ensure ongoing maintenance of competence and continuing professional development in areas in which they provide services.[2] Members working in the areas addressed by the attached Reports 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.

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

[1] Ontario Regulation 74/15, Registration, s.7
[2] Ontario Regulation 209/94 General (Part III Quality Assurance), s 10.(1)

Domestic Violence Death Review Committee

Office of the Chief Coroner

Report on the matter of the death of:

OCC File : 2014-1470
(DVDRC 2017-16)

This document was produced by the DVDRC pursuant to section 15(4) of the Coroner's Act. R.S.O. 1990 c. 37, on the basis that it is to be used for the sole purpose of a coroner's investigation, and not for any litigation or other proceedings unrelated to the coroner's investigation. Moreover, the opinions expressed herein by the Committee do not necessarily take into account all of the facts and circumstances surrounding the death. The final conclusions of the coroner's investigation may differ significantly from the opinions expressed herein.

Details of Deceased:

Date of Death:	February 3, 2014
Age:	6 years
Sex:	Female

Overview:

This case involved the homicide of a six-year-old girl by the perpetrator who was her 35-year-old father. At the time of the homicide, the child's parents were in the process of separating. There were seven risk factors[1] for intimate partner homicide identified.

History of Victim:

The homicide victim was the six-year-old daughter of the perpetrator. The child's mother, who was the indirect victim, was the 42-year-old wife of the perpetrator. The woman was a stay-at-home mother who cared for the victim, together with three other siblings ages three to seven years.

[1] Risk factors pertain to the relationship between the child's father (the perpetrator) and mother.

The mother was reportedly depressed and stressed over multiple issues including the recent loss of her father and her own health concerns. The woman felt that her husband had a personality disorder.

History of Perpetrator:

The perpetrator was the 35-year-old father of the victim. The perpetrator had a university degree and had been terminated from a previous job due to fraud. At the time of the homicide, he was working for another employer.

The perpetrator's parents were well established in the community and his father worked in the law enforcement field.

As part of a court-related assessment for fraud charges, the perpetrator had been diagnosed with a major depressive disorder two months prior to the homicide. He also reported anxiety and was on multiple psychiatric medications. He had repeatedly reached out for help on a crisis basis when depressed, but there was little indication of ongoing counselling. He was also seeking marriage counselling.

The perpetrator had difficulty finding a place to live after the separation from his wife. He was becoming more depressed and then suicidal. One month prior to the homicide, the perpetrator went to a hospital emergency department to report that he was suicidal. He indicated that he had significant depression and anxiety. He had suffered many recent losses including the death of his father, termination from a good job, and a failing marriage.

The perpetrator was described as being fixated on his wife and always wanted to be close to her. He often ignored his fathering role unless told what to do by his wife.

On the morning of the homicide, the perpetrator had made a court appearance relating to the fraud charges.

History of relationship:

The perpetrator and his wife had been married for 10 years and had been separated on-and-off for two years. The marriage was reportedly filled with conflict and stress over health, finance and child care issues.

There were two previous reported domestic incidents in 2009 and 2012 which resulted in the perpetrator being removed from the home. There were no charges or concerns about suicide reported to the police on those occasions; mental health records however indicated that the perpetrator had discussed suicidal thoughts.

Early in the marriage, the couple moved to another country so that the perpetrator could go to school. They returned to Canada after approximately six months as the perpetrator's wife was homesick.

History of Children:

The perpetrator and his wife had four children together: three-year-old twins, the six-year-old victim and a seven-year-old.

There was a referral to CAS in 2009, but no follow up or action was required.

The children were exposed to parental stress and conflict on an ongoing basis.

Synopsis of events leading up to death:

On the day of the homicide, the perpetrator went to the matrimonial residence and had an argument and physical confrontation with his wife.

At approximately 11:00 a.m., the perpetrator's wife called police to report a domestic violence incident.

Just after noon, police attended the residence and attempted to locate the perpetrator. The wife indicated to police that she was not fearful that the perpetrator would hurt the children.

At approximately 4:00 p.m., the perpetrator's wife called police to report that the children had not returned home from school. The perpetrator had apparently picked the children up at school earlier in the day. He lied to school officials and told them that he was taking the children for a medical appointment.

The perpetrator took his six-year-old daughter and seven-year-old son to a local hotel and administered sleep medication and alcohol to them.

The perpetrator made an unsuccessful suicide attempt and left a note indicating that he was depressed and upset over the marital conflict.

The six-year-old child died from diphenhydramine and ethanol toxicity. The seven-year-old child and perpetrator both survived.

Following the homicide, the perpetrator told a psychiatrist that he wanted to kill his children and himself, so they could "all be together in heaven."

The perpetrator was charged and convicted of second degree homicide and attempt murder.

Risk Factors Identified:

There were seven risk factors for intimate partner homicide identified:

- Actual or pending separation
- Child custody or access disputes
- Depression – in the opinion of family/friend/acquaintance or professionally diagnosed
- Prior threats to commit suicide by perpetrator
- Obsessive behavior displayed by perpetrator
- History of domestic violence - Current partner/victim
- Perpetrator threatened and/or harmed children

Possible Recommendations:

To the Colleges of Social Workers and Social Service Workers, College of Psychologists of Ontario and Ontario College of Physicians and Surgeons:

1. Social workers, psychologists and physicians are reminded of the importance of ongoing training on risk assessment, risk management and safety planning in the prevention of domestic homicides. Special emphasis should be given on the impact that depression has on domestic violence and domestic homicide.

Rationale:

This case involved a perpetrator who had sought help on a crisis basis on numerous occasions including a visit to the emergency department due to suicidal thoughts one month prior to the homicide. The perpetrator was showing signs of desperation resulting from his court appearance for fraud, his father's death, marital conflict and separation, problems accessing housing and a sense of failure. There may have been opportunities to engage the perpetrator's wife in the creation of a safety plan for her and the children and a risk management plan for the perpetrator. There may have been an opportunity for healthcare workers to follow up with the perpetrator on missed psychiatric appointments.

Since the DVDRC began, there have been numerous recommendations about the role of health care professionals in responding to potentially lethal circumstances that may be associated with domestic homicide. Approximately 73% of all cases reviewed by the DVDRC from 2003-2016 involved a couple where there was a history of domestic violence and 67% of the cases involved a couple with an actual or pending separation. Two other top risk factors include a perpetrator who was depressed (50%) and prior threats or attempts to commit suicide (46%); both of these

risk factors are often associated with contacts with mental health professionals. In many of the cases reviewed, mental health professionals did not thoroughly explore or investigate potential risks associated with domestic homicide.

Domestic Violence Death Review Committee

Office of the Chief Coroner

Report on the matter of the deaths of:

OCC Files : 2016-3520 and 2016-3496
(DVDRC-2017-14)

This document was produced by the DVDRC pursuant to section 15(4) of the Coroner's Act. R.S.O. 1990 c. 37, on the basis that it is to be used for the sole purpose of a coroner's investigation, and not for any litigation or other proceedings unrelated to the coroner's investigation. Moreover, the opinions expressed herein by the Committee do not necessarily take into account all of the facts and circumstances surrounding the death. The final conclusions of the coroner's investigation may differ significantly from the opinions expressed herein.

Details of Deceased:

Date of Death:	March 26, 2016
Age:	53 years
Sex:	Female

Date of Death:	March 25, 2016
Age:	44 years
Sex:	Male

Overview:

This case involved the homicide of a 52-year-old woman by her 44-year-old common-law partner. The couple had a long history of mental health and addiction issues. The perpetrator had been charged after assaulting the victim in another province, but the charges were not pursued after the couple moved to Ontario. There were 22 risk factors for intimate partner homicide identified.

History of Victim:

The victim was a 52-year-old woman who was raised in an abusive family. She had a nursing degree and had a successful job in medical sales that she subsequently lost due to alcoholism.

The victim had been married twice – once for 21 years and the second time, for two years. She had two daughters from her first marriage.

The victim had an extensive mental health and addictions history that was documented since 2012. She had been admitted to hospital on several occasions for alcohol withdrawal and the need for detox. She was referred to counselling and Alcoholic Anonymous (AA).

The victim met the perpetrator through AA and became involved in a volatile relationship with him. The victim had been assaulted by the perpetrator on several occasions while the couple lived in both Newfoundland and Ontario. Police had been involved in many instances and the perpetrator had been charged.

While at counselling, the victim did not make reference to the domestic violence and the counsellor was not aware that the perpetrator had been charged. The counselling focused on the victim's addictions and feeling of worthlessness. In the year prior to the homicide, the victim had gone to hospital due to depression.

In 2014, the victim was diagnosed and treated for breast cancer.

The victim's adult daughters reported that in the six months prior to the homicide, the victim was sober and trying to get her life back in order. They indicated that the perpetrator had threatened their mother and that she was frightened of him. Both daughters witnessed the destructive and abusive nature of the relationship.

On two occasions, the victim was hospitalized due to injuries sustained after being assaulted by the perpetrator.

History of Perpetrator:

The perpetrator was the 44-year-old common-law partner of the victim. He was one of seven children and came from a chaotic family background in Newfoundland. Both of his parents died when he was a child.

At age 14, following the death of his father, the perpetrator spent a month in a psychiatric hospital. The siblings, now orphaned, lived like "gypsies" and moved around from relative to relative. There was an extensive history of mental health and addiction problems in his family including a brother who committed suicide, a cousin who was the perpetrator in a domestic homicide-suicide and sisters who suffered from clinical depression.

The perpetrator had a grade 12 education and had difficulty obtaining and retaining employment. He had serious addiction and mental health issues for his whole life. He reportedly smoked two packs of

cigarettes a day and had a 25-year history of daily marijuana use, binge drinking and regular cocaine use.

Between 1996 and 2016, the perpetrator had been violent to at least three other intimate partners.

The perpetrator was described by his psychiatrist as being "co-dependent" and always externalizing blame – including blaming the victim for his drinking and drug use. There were extensive psychiatric records from 2002-2016 from the local hospital and mobile crisis services. Over the years, the perpetrator had been diagnosed with depression, substance abuse disorder, social anxiety, Attention Deficit Disorder and a personality disorder that varied from anti-social, borderline, narcissistic, paranoid, and dependent. He was described as having poor coping skills, anger problems and difficulty remaining employed. The perpetrator's condition seemed to deteriorate after his brother's suicide.

From 2001 – 2016, the perpetrator frequently went to the hospital emergency department when at a point of crisis for being suicidal to receive immediate counselling and medication. He had multiple hospitalizations and was well known to many psychiatrists. He made extreme suicide attempts over the years including threatening to jump off a bridge and lie down on the railroad tracks. He was often on drugs and alcohol upon admission, but when he was sober, he seemed more insightful. He tended to not follow through with counselling appointments or compliance with medication. He struggled with living arrangements and employment. When not living with one of his victims or sisters, he often stayed at a men's shelter and different residential treatment services for addictions.

Between September 2011 and March 2016, the perpetrator had been admitted to hospital seven times for suicidal behaviour. He was admitted to the hospital three days before the homicide for depression/suicidal thoughts and signed himself out against medical advice. The day before the homicide, he contacted his sister and asked her to apologize to the family for all the things he had done in the past.

The perpetrator had multiple convictions for assault (including against strangers during road rage incidents), impaired driving and careless driving. The perpetrator was reportedly seeking a judicial pardon to improve his ability to find work.

History of relationship between Victim and Perpetrator:

The victim and perpetrator met at an AA meeting and lived common-law (on and off) for three years. They were separated for six months prior to the homicide, but there was evidence that they were still in contact.

In June 2013, the couple moved to Newfoundland. In September of that year, the perpetrator was charged with assault causing bodily harm after he repeatedly kicked the victim in the face causing her to go unconscious. The assault took place in public and there was a witness. The charges were dropped after the perpetrator and victim left the jurisdiction and returned to Ontario; the victim did not return calls from the crown attorney in Newfoundland involved with the case.

The couple returned to Ontario and began to live together again. The perpetrator was charged with threatening to kill the victim after holding a knife to her throat. The local police service was aware of the charges laid against the perpetrator for the domestic assault in Newfoundland.

In June 2015, the perpetrator was charged with domestic violence offences against the victim, released on bail and served a month in jail for the offences. At the time of his arrest, there were 11 domestic violence occurrences against the perpetrator investigated by the local police service.

In the months leading up to the homicide, the victim and perpetrator lost their support systems due to their addictions and abusive relationship – neither family wanted contact with them. They both had been admitted to hospital because of overdoses and depression and suicidal behavior in the weeks before the homicide.

In January 2016, the perpetrator had been admitted to hospital for an overdose of antipsychotic medication after he displayed bizarre behaviour and slurred speech.

In the month prior to the homicide, the perpetrator's behavior was described as more manic and bizarre.

Issues Involving Children:

The victim and perpetrator had adult children from previous relationships – all estranged at the time of homicide due to their addictions. The perpetrator's 23-year-old son had a pervasive developmental disorder and had previously been in foster care.

The victim's adult daughters tried to be supportive, but the victim's alcohol abuse and problems with the perpetrator limited their contact.

Synopsis of events leading up to death:

At the time of the homicide, the victim was renting a room in a townhouse and the perpetrator was residing in a rented room close by.

On March 25, 2016, the perpetrator killed the victim by slitting her throat. He then took the victim's car and veered into the path of an oncoming vehicle. The perpetrator was killed in the collision. It could not be determined if the perpetrator intentionally steered his car in front of the other vehicle.

The victim's body was found the following day.

Risk Factors Identified:

There were 22 risk factors for intimate partner homicide identified:

- Perpetrator was abused and/or witnessed DV as a child
- Perpetrator exposed to/witnessed suicidal behavior in family of origin

- Victim and perpetrator living common-law
- Actual or pending separation
- Perpetrator unemployed
- Excessive alcohol and/or drug use by perpetrator
- Depression – in the opinion of family/friend/acquaintance or professionally diagnosed
- Other mental health or psychiatric problems – perpetrator
- Prior threats to commit suicide by perpetrator
- Prior suicide attempts by perpetrator
- Failure to comply with authority
- Prior destruction or deprivation of victim's property
- History of violence outside of the family by perpetrator
- History of domestic violence - Previous partners
- History of domestic violence - Current partner/victim
- Prior threats to kill victim
- Prior threats with a weapon
- Prior assault with a weapon
- Escalation of violence
- After risk assessment, perpetrator had access to victim
- Victim's intuitive sense of fear of perpetrator
- Victim vulnerability

Recommendations:

To the High Risk Team in the jurisdiction where the incident occurred:

1. This case should be reviewed by the high risk team involved for a lessons learned case review about collaboration and information sharing. The team involved is encouraged to share the lessons learned with other high risk teams in the province.

   Committee comments: This case had many different sectors involved including police, courts, probation, addiction services, psychiatry and health care that did not appear to share information on a timely basis. It would be of benefit to have local agencies come together to review what might have been done differently with hindsight in order to identify gaps in collaboration that might help those involved, as well as other jurisdictions.

To the Ministry of Community Safety and Correctional Services:

2. Police services across Ontario should be reminded that domestic violence risk assessment is only the first step of a longer process that should include safety planning and risk management.

Committee comments: In this case, there was a police risk assessment that highlighted the level of risk as well as prior history of domestic violence. There was no documentation for any victim safety planning or risk management of perpetrator despite serious charges in Ontario as well as a history in Newfoundland that resulted in the victim's hospitalization.

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

3. Health and mental health professionals who are involved with vulnerable patients involved in domestic violence should complete risk assessments focused on domestic violence and reach out to the police and justice system for advice on potential lethal circumstances with a documented history of concern.

   Committee comments: Both the victim and perpetrator were seen at the same hospital over several years with a documented history of addictions, depression and suicidal ideation. Any assessments completed on the perpetrator were focused on behavior in the hospital (i.e. Proset Violence Checklist) rather than a structured risk assessment tool dealing with domestic violence. The homicide took place shortly after their last attendance at the hospital.

To the Ministry of Community Safety and Correctional Services, Ministry of the Attorney General and Newfoundland Department of Justice and Public Safety:

4. Police services and crown attorneys should be aware of, and reinforce, the National Framework for Collaborative Police Action on Intimate Partner Violence which speaks to the importance of collaboration and information sharing across jurisdictions. (https://cacp.ca/index.html?asst_id=1200)

   Committee comments: In this case, the perpetrator had been charged after a witnessed assault of the victim in Newfoundland. The victim's injuries were so serious that she was hospitalized. The charges were dropped when the victim left the jurisdiction (with the perpetrator) to return to Ontario and she was reluctant to testify. There was no warrant issued for the perpetrator's arrest.

   The following year, while back in Ontario, the perpetrator assaulted the victim with a knife; this information did not appear to be considered in the risk management of the perpetrator or the subsequent court action. The homicide happened shortly thereafter.

   The crown should proceed with prosecutions in which they have a reasonable prospect of conviction even in the absence of the victim as this would be in both the public interest and personal interest of the victim. Reasonable prospect of conviction and public interest are the two guiding principles in Ontario when the decision is made by the crown as to whether to proceed with charges. In this case, based on the severity of the assault, it would have been in

the public interest to proceed in Newfoundland as well as share this information with the police and crown in Ontario.

To the Ministry of Community Safety and Correctional Services:

5. Probation officers should rigorously explore relationship and domestic violence history with the perpetrator, victim and police collateral contacts during the initial assessment phase. Once the domestic violence flags are identified, action must be taken to address those risks early and consistently regarding ongoing risk assessment, safety planning and risk management.

   Committee comments: In light of the lengthy abuse history with the victim and perpetrator, a thorough assessment of their relationship, including accessing collateral sources of information, may have triggered an earlier intervention by probation services and the courts.

Tricky Issues

At the *Barbara Wand Seminar in Professional Ethics, Standards and Conduct*, held on June 14, 2018 in London, I presented some *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. Note that the discussion only speaks to the various options presented in the scenario so the one indicated as "acceptable" is the best option of those given. There are other options, not mentioned, for resolving this scenario.

Please note that the comments provided are intended as general information. The circumstances of an individual client and the details of the specific situation will influence how one handles an actual scenario. 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.

Dual Relationship

Your colleague saw a client for a few sessions about five years ago and terminated service when both he and the client felt the therapy goals had been met. Recently, your colleague began to see the former client's sister. The former client has now asked to return for a few sessions. Since their issues are unrelated, your colleague is thinking about seeing the former client while continuing to see his sister. Your colleague asks for your advice and so you tell him. . .

1. *To see these siblings at the same time would constitute a prohibited conflict of interest and therefore the original client should be referred out.*
2. *While it could be difficult, it would be unethical to refuse to see a former client who requires service.*
3. *While it could be difficult, this dual relationship may be manageable, allowing both clients to receive the service they need.*
4. *It would be appropriate to discuss this dilemma with the current client to see if she's OK with it as it would be her therapy that potentially could be affected.*
5. *The best solution is not to see either of them which avoids any issues.*

Discussion

This scenario addresses the question of providing services in a situation in which one must consider the implications of working, within a dual relationship, with one or more clients. According to Ontario Regulation 801/93 Professional Misconduct, *one cannot practice the profession while one is in a conflict of interest (10)*. Neither the Regulation nor the Standards of Professional Conduct, 2017 address dual relationships. The Canadian Code of Ethics for Psychologists, 4th Edition (2017), which has been adopted by the College, does set an expectation that*, one will avoid dual or multiple relationships that are not justified by the nature of the activity, by cultural or geographic factors, or where there is a lack of reasonably*

accessible alternatives' (III.30). If avoidance is not possible, one *would 'manage dual or multiple relationships entered into in such a way that bias, lack of objectivity, and risk of exploitation or harm are minimized' (III.31)*. In considering the *best* option pertaining to the scenario, it is important to keep these concepts in mind.

Answer 1 does not appear to be accurate. While it is an accurate statement that providing service while in a conflict of interest is prohibited, it would not appear that working with both clients at the same time, even though they are siblings, would constitute a conflict of interest. This scenario instead raises issues of dual or multiple relationships. Conflict of interest situations generally refer to those in which the practitioner has a personal stake e.g., financial gain/loss; moral/religious position. While it could be argued that the practitioner would financially gain from seeing the second client, if this were the case, then every private practitioner could be seen to be in a conflict with every referral they consider.

Answer 2 is not correct. There is nothing in the Regulations, Standards or Code of Ethics that would suggest a practitioner is required to provide service to a former client. It is quite possible that one may feel a professional obligation to do so based on one's past relationship. If however, a careful consideration of the situation suggests it may not be in the client's best interest, it would not be unethical to refuse.

Answer 3 is an acceptable action. Although the Code of Ethics suggests that one try to avoid dual relationships, this is not a prohibition. While entering this situation may pose a number of potential problems or issues, one may decide to "manage" the dual relationship, not avoid it. As the Code of Ethics anticipates one may find there are there cultural, geographic or access to services, etc., factors which must be considered.

Should one decide to see both clients one should anticipate, and be prepared for, potential issues. The main issues would appear to relate to confidentiality. For example, it is quite likely that the clients, as siblings, would share with each other that they are both seeing you. This need not be a problem but it is not something you are able to confirm or deny. Similarly, one client may indicate that, "my sister told me that you said. . ." The content of the alleged statement may be something of great concern to the client but you could have difficulty addressing the concern keeping in mind your obligation not to discuss either client's therapy and what may or may not have been said.

Some other potential concerns can arise from inadvertently using information obtained in one client's session in that of their sibling. Even if you are very careful about this, it may be a concern held by the client. You could also find that there are challenges to the therapeutic relationship with the client being distracted by what they think may be going on in their sibling's sessions. The client may be concerned about the impressions you have of them based on what they worry you may be learning from their sibling. Or, the client could be hesitant to relay the details of a conerning event wondering how it compares to what they think you may or may have learned from the other client.

While dual relationship issues will not necessarily arise, it is important to consider and anticipate such possibilities so that if they do arise, one will not be caught off guard.

Answer 4 is not an appropriate action. To speak with either individual, the current or the returning client, about this situation would constitute a breach of the individual's confidentiality.

Answer 5 does not appear to be an acceptable. While seeing neither client would solve the practitioner's issue, it would, by its very nature, mean the termination of a client who continues to need service. According to the Professional Misconduct Regulation, it is an act of professional misconduct to 'discontinue professional services that are needed' for other than one of the listed reasons. None of the listed reasons appear to include the current situation. It would be hard to argue that the request by the former client, and a desire not to say 'no' or to see both, is an acceptable reason for terminating a current client.

For those who could not join us in person or by webcast for the June 2018 Barbara Wand Seminar, it, along with several previous Seminars, are available in the Archive of Past Barbara Wand Seminars on the College website.

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

Council Highlights – June 22, 2018

New Council Members

The Council welcomed new Council members, Dr. Janice Currie, District 5 (GTA East) and Ms. Melanie Morrow, Psychological Associate Non-Voting.

Executive Committee

As the first order of business, the Council held elections for the Executive Committee for 2018-2019. We congratulate the following individuals, both professional and public members of Council, and thank them for their willingness to serve on this year's Executive:

Dr. Lynette Eulette - President	(Professional Member)
Mr. D'Arcy Delamere - Vice-President	(Public Member)
Ms. Kristin Bisbee	(Public Member)
Ms. Chritine DiZazzo	(Professional Member)
Dr. Michael Grand	(Professional Member)
Dr. Elizabeth Levin	(Professional Member)

Policy Issues

Consultations

Two new consultations were approved for circulation. The proposed amendments to *By-law 5: Selection of Committee Chairs and Committee members* and *By-Law 21: Committee Composition* have been distributed to members and, as well, are posted to the College Website.

By-laws

Council approved amendments to *By-law 25: The Register and Related Matters* after reviewing feedback received during the consultation period. This feedback is included in the Council Materials found the Resources section of the website. An article describing the changes made to this By-law may be found in this issue of the e-Bulletin. As well, the amended *By-law 25: The Register and Related Matters* may be found on page 39 of the College By-laws available on the College Website.

The Council approved revisions to the following policies:

- *Policy I-2 – Council & Committee Orientation and Training* to now include the *Code of Conduct for Council and Committee Members;*
- *Policy II-8(i): Finance and Audit Committee: Terms of Reference/Role;*
- *Policy II-9(i): Nominations and Leadership Development: Terms of Reference/Role.*

In addition, two new policies were approved:

- *Policy II – 5(ii): Peer Assisted Review: Criteria for Exemption or Deferral;*
- *Policy II-3(iv): Responding to Requests for Extensions to Make Written Submissions.*

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

Business Issues

Committee Audits

As part of the College's continuous review and improvement of its processes, the Council agreed that the Nominations and Leadership Development Committee as well as the Inquires, Complaints and Reports Committee will undergo a process audit in 2018-2019.

Other Business

The next meeting of Council will be held on September 21, 2018.

Oral Examiner Thank You

The College would like to thank the following who acted as oral examiners in June 2018:

Cheryl Alyman, Ph.D., C.Psych.
Patricia Behnke, Ph.D., C.Psych.
Ruth Berman, Ph.D., C.Psych.
Laura Brown, Ph.D., C.Psych.
Ian D.R. Brown, Ph.D., C.Psych.
Clarissa Bush, Ph.D., C.Psych.
Angela Carter, Ph.D., C.Psych.
Dorothy Cotton, Ph.D., C.Psych.
Mary Susan Crawford, Ph.D., C.Psych.
Janine Cutler, Ph.D., C.Psych.
Jenny Demark, Ph.D., C.Psych.
Angela Digout Erhardt, Ph.D., C.Psych.
Christine DiZazzo, M.Ps., C.Psych.Assoc.
Deanna Drahovzal, Ph.D., C.Psych.
Lynette Eulette, Ph.D., C.Psych.
Donna Ferguson, Psy.D., C.Psych.
Robert Gauthier, M.Sc., M.Ed., C.Psych.Assoc.
Sara Hagstrom, Ph.D., C.Psych.
Maria Kostakos, M.A., C.Psych.Assoc.
Lewis Leikin, Ph.D., C.Psych.
Elizabeth Levin, Ph.D., C.Psych
Bruno Losier, Ph.D., C.Psych.
Maggie Mamen, Ph.D., C.Psych.
Lise Mercier, Ph.D., C.Psych.
Karin Mertins, M.A., C.Psych.Assoc.
Denise-Lotte Milovan, Ph.D., C.Psych.
Michelle Moretti, Ph.D., C.Psych.
Elissa Newby-Clark, Ph.D., C.Psych.
Linda Reinstein, Ph.D., C.Psych.
Philip Ricciardi, Ph.D., C.Psych.
Francine Roussy Layton, Ph.D., C.Psych.
Frederick Schmidt, Ph.D., C.Psych.
Karen Shue, Ph.D., C.Psych.
Mary L. Stewart, Ph.D., C.Psych.
Wanda Towers, Ph.D., C.Psych.
Peter Voros, Ed.D., C.Psych.
Mark Watson, Ph.D., C.Psych.
Tammy Whitlock, Ph.D., C.Psych.

Public Members of Council:

Jaffar Hayat
Cory Richman

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

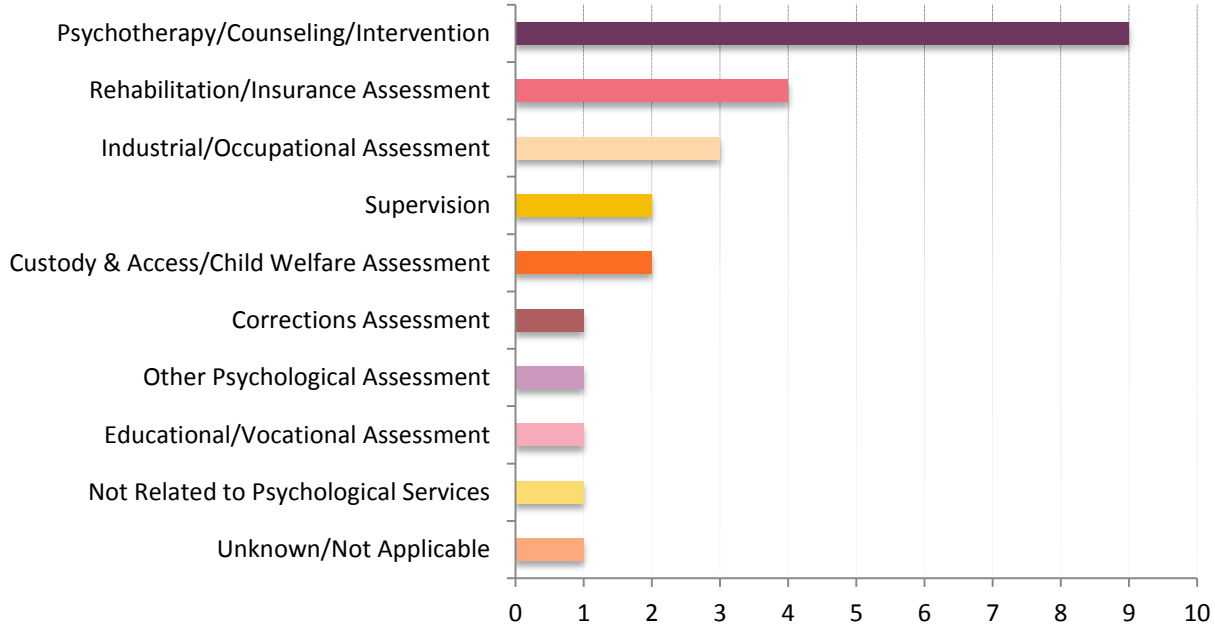
Fourth Quarter, March 1, 2018 – May 31, 2018

Committee Members:

Sara Hagstrom (Chair)	College	Lynette Eulette	Council
Diane Addie	College	Emad Hussain	Public Member
Ruth Berman	Council	Elizabeth Levin	Council
Gilles Boulais	College	Donna McNicol	Public Member
Jason Brown	College	Fred Schmidt	College
Judy Cohen	Public Member	David Smith	College
Dorothy Cotton	Council	Laura Spiller	College
D'Arcy Delamere	Public Member	Joanne Taylor	College

New Complaints and Reports

In the 4th Quarter, the College received 25 new complaints. The nature of service in relation to these matters is as follows:



ICRC Meetings

The ICRC met on March 22, April 13 and May 11, 2018, to consider a total of 26 cases. Also, 12 teleconferences were held to consider 24 cases, in addition to 2 standing teleconferences held on March 2 and April 20, 2018, to consider 4 cases. A plenary meeting was also held on April 20, 2018 for all ICRC members.

ICRC Dispositions

The ICRC disposed of 25 cases during the 4th Quarter, as follows:

Disposition	Number of Occurrences (in 25 cases)	Percentage (out of 25 cases)
Take No Further Action	10	40%
Take No Further Action – F&V†	3	12%
Advice	4	16%
Undertaking	3	12%
Caution	2	8%
SCERP‡	3	12%
Referral to Discipline	2	8%
Total*	**27**	**108%**

*Percentage and number values reflect an overlap of dispositions in some cases. One case was disposed of by way of both Caution and Undertaking, another case by way of Caution and SCERP.

† 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.

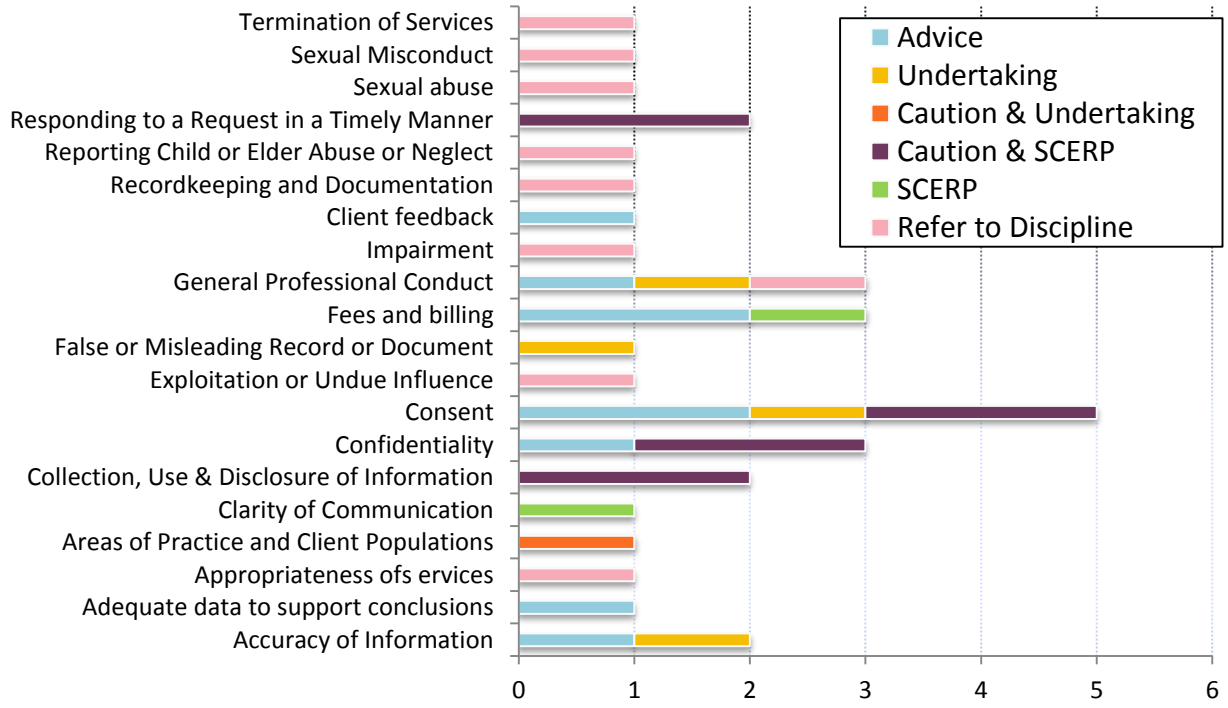
‡ SCERP: Specified Continuing Education and Remediation Program

Disposition of Allegations

In the 4th Quarter, the 25 cases disposed of included the consideration of 81 allegations.

The most common allegations related to: General professional conduct (14); Consent (7); Accuracy of information (6); Confidentiality (6); Collection, use and disclosure of information (5); Objectivity and bias/appearance of bias (5); conflict of interest (5); and fees and billing (4).

The ICRC took remedial action with respect to 33 allegations. The substance of these allegations is illustrated below.



Health Professions Appeal and Review Board (HPARB)

In the 4th Quarter, 10 HPARB reviews of ICRC decisions were requested. One HPARB review was concluded, with the ICRC decision being confirmed.

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 April, 2018.

Psychologists - Certificate of Registration Authorizing Autonomous Practice

Jenna Jacqueline Albiani
Narmeen Ammari
Diana Rose Audet
Alison Carlisle Blakely
Kelly Alexis Blanchette
Janet Marie Bone
Ann Marie Borthwick
Sara Michelle Caird
Colin Andrew Campbell
Suzanne Elizabeth Chomycz
Julie Shiri Cinamon
Laura Anne Cuttini
Beverley Mari David
Ilana Judith Davine
Eleanor Donegan
Joseph Vincent Enright
Gayle Melissa Goldstein
Lezlie Colette Gomes
Petra Dawn Tapper Gyles
Sarah Horowitz
Narges Hosseini-Sedehi
Parasto Jamshidi
Iwona Kaczmarzyk-Kozlowski
Nikki Wendy Kennedy
Lindsey Rachel Keyfitz
Kristine Knauff
Ashley Nicole Legate
Catherine Marie Leite
Simon Levy
Andrea Maria Librado
Angele Marie MacTavish
Ashley Christian Major
Gregory Mendelson
Natalie Michel
Susan Maria Minardi
Cassandra Ashley Lynne Pasiak
Theone Sofia Elektra Paterson
Mandisa Viola Peterson
Danielle Pigon
Anna Polotskaia
Danielle Christine Ransom
Matteo Renelli
Tal Singer
Héloïse Sirois-Leclerc
Laura Elizabeth Smith
Jill Marie St. Denis
Kathleen Elizabeth Staz
Lauren Jessica Sangster Steinhart
Tajinder Uppal Dhariwal
Dragica Visnjevac Fink
James Eliot Watson-Gaze

Psychological Associates - Certificate of Registration Authorizing Autonomous Practice

Fiana Patrice Andrews
Katherine Hollerer
Elizabeth Anne McCague
Heather Lesley McDonald
Dennis David Isaac Mularickal
Natalie Cheryl Parnell
May Ann Garo Santiago

Psychologists - Certificate of Registration Authorizing Interim Autonomous Practice

Jennifer Anne Bossio
Christopher Ian Brown
Annabelle Hélène Marie-Anne David
Michel Dugas
Martin Guimond
Jacqueline Maria Linder
Craig William Martynuck
Rebecca Elisabeth Nemiroff
Cheryl Lynne Roffe
Julia Carole Santo
Shanna Mary Williams
Ya Fang Xue

Psychological Associates - Certificate of Registration Authorizing Interim Autonomous Practice

No new certificates were issued

Psychologists - Certificate of Registration Authorizing Supervised Practice

Malak Abu Shakra
Lisa Nicole Alli
Immaculate Arunthathy Antony
Sahar Bhaloo
Dale Victor Bricker
Lila Elkhadem
Nicole Estella Elliott
Deborah Anne Slack Kanter
Rachel Leung
Victoria Lishak
Jennifer Mary Lyons
Preeyam Parikh
Julie Anne Marie Wallis
Sarah Reanne Yachison
Rebecca Elyse Young

Psychological Associates issued with certificate authorizing supervised practice

Audrey Aiken
Shiri Bartman
Basem Gohar
Daniella Sarah Ivonne Goldberg
Erika Rae Hilderley
Somayyeh Sabet Ghadam

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

Sandra Jean Alexander
Dawne Marie Bergsteinson
Marie-France Boudreault
James Charles Broad
Lina Charette
Sheila Ann Clyne
Robert Eric DeVries
Barbara Joyce Dydyk
Bertha Mook
Ronald Peder Myhr
Wayne Peter Nadler
Katalin Nathan
Warren Robert Nielson
Ross M.G Norman
Anne Parent
Julie Perkins

Tina Immacolata Ferrari-Oryshak
Margaret Mary Flintoff
Zulfiqar Hussain Gilani
Martin Joseph Girash
Elizabeth Ann Grant
Bertrand L. Guindon
Anne Marie Johnson
Frances Khanna
Herb Koplowitz
Mario Lajoie
Lisa F. Mary Larocque
Marianne LoPresti
Alistair William MacLean
Walter Petryshyn
Edward William G Pomeroy
Joseph Levis Georges Ramsay
Reginald Melville Reynolds
Donna Lynn Scher
Cara Anne Settipani
Lynne Stewart
Eugene Peter Michael Sunday
Jo-Anne Margaret Trigg
Michael Hing-pui Tsang
Vibeke Neuweiler Vaerum
Connie Rutherford Valeriote
Gerald Carl Young

Resigned

James Edward Belfrage
Barbara Bresver
Elizabeth de Grace
Susan Elizabeth Dotzenroth
Kenneth Dunn
Jennifer Dunn Geier
Mary Lorna Gick
Neil Hildebrandt
Margaret Kirk
Nicholas Ahlrich Kuiper
Cynthia Bernadette Lanigan
Elaine Ruby Moroney
Janet Munson
Paul Allen Munson
Heather Anne O'Halloran
Pamela Ann Olfert
Sharna Olfman
L. Joan Olinger
Catherine Ann Pink
Marie Piskopos
Janet Polivy
Joseph Steven Rallo
Douglas Reberg
Alan Christopher Rowntree
August Bernard Scheid
Ann Elizabeth Sims
Julie Elizabeth Skadorwa
William G Snow
Larry Saul Snyder
Mona Manwah Tsoi
Nicole Sonya Vellet
Kenneth Ray Welburn
Natasha Whipple
Maxine Ann Gallander Wintre
Kiristin Tarikah Yates

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:

Nina Apanasiewicz
Lori Guzzo
Mary Ann Johnston
Geoffrey W Langford