The
BULLETIN
THE • COLLEGE • OF • PSYCHOLOGISTS • OF • ONTARIO

Providing Psychological Services to Victims of Motor Vehicle Accidents: Considerations and Cautions

While this article specifically addresses the provision of services to victims of motor vehicle accidents, much of the information and advice can be applied to the broader delivery of psychological services.

With the changing economic times and increasing career movement, members may become aware of opportunities in various areas of practice, particularly those funded by third party payers such as companies providing automobile insurance. This article, the first of two on work in this area, will explore some of the considerations and cautions with which members should be familiar in deciding whether to provide services to victims of motor vehicle accidents and to insurers.

The College would like to acknowledge with thanks the time donated by several members of the profession to discuss these and other issues. Drs. Sergio Bacal, Neville Doxey, Michelle Macartney-Filgate, Gary Snow and Ann Taylor met with the Registrar on three occasions during 1996 as part of an ad hoc committee on the ethical challenges faced by members in providing services to victims of motor vehicle accidents.

Accidents which occurred on or after November 1, 1996

On November 1, 1996, the Automobile Insurance Rate Stability Act, 1996 (Bill 59), which amended the Insurance Act, and the Statutory Accident Benefits Schedule - Accidents on or after November 1, 1996, were proclaimed. The College corresponded with Mr. Rob Sampson, MPP, Parliamentary Assistant to the Minister of Finance, and communicated with representatives of the Ontario Insurance Commission, the insurance industry and the Ontario Psychological Association to clarify the role of psychologist and psychological associate members of the College in providing services under the amended Insurance Act and the amended Statutory Accident Benefit Schedule.

The College provided clarity on the two classes of registrant: psychologists who are doctorally trained and have been regulated since 1960 and psychological associates who are trained at the masters' level and have been regulated since proclamation of the Regulated Health Professions Act at the end of 1993.

The controlled act authorized to qualified members of the College is the communication of a psychological diagnosis. Most psychologists are considered competent to provide psychological diagnoses within their particular area of expertise. Some psychological associates also have the authority to provide psychological diagnoses; those who

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have received delegation of this authority from a psychologist. This delegation is codified in a formal written delegation agreement between the psychologist and psychological associate. It specifies the area of practice in which the psychological associate may provide diagnoses and the client population for whom diagnoses may be communicated.

Both psychologists and psychological associates are permitted to practice independently, each member within his/her area of competence. Among both psychologists and psychological associates there are individuals qualified to provide psychotherapeutic services to victims of motor vehicle accidents.

General Concerns

1) Competence

The role of the College is to protect the public. Accordingly, the regulations and standards of the College require that members ensure they are competent to provide the services they offer and do not venture beyond their area of competence in offering services to the public. Regardless of the type of practice in which they are engaged, members are expected to ensure that they provide only those services that fall within their area of competence.

Do members entering this area of practice have the competence to provide appropriate and adequate services?

Members are expected to maintain competence in their area of practice and to acquire appropriate competence in any new area of practice being undertaken. The Regulated Health Professions Act requires the College to monitor members' knowledge and skill through the Quality Assurance Program. When completing the self-assessment guide as part of the Quality Assurance program, describing areas of service at the time of annual renewal of registration, or when advertising or promoting professional services, each member is encouraged to carefully consider whether they have undertaken a new area of practice and, if so, what steps they have taken to acquire the competence necessary to practise in that new area. Members entering a new area of practise should inform the College in a manner consistent with the requirements of Principle 3 of the Standards of Professional Conduct, 1995 and be able to support claimed competence in all areas in which services are offered.

Concern has been raised that in these times of greater competition in the marketplace and diminishing opportunities for public funding, some members may knowingly or unknowingly enter into an area of practice for which they have not been adequately prepared. Members are cautioned to carefully assess their competence to provide services to victims of motor vehicle accidents or any client group.

What are the basic competencies/skills/knowledge necessary to do this work?

Members experienced in this area of practice identified key knowledge and skills requirements. They recommended that any member currently providing services or considering providing services to victims of motor vehicle accidents assess his/her clinical training and experience with respect to the following:

a) awareness of the effects of stress and their contribution to presenting symptoms or complaints;

b) knowledge of health psychology;

c) awareness of the possible effects of physical disorders on psychological functioning;

d) knowledge and skill in assessment techniques appropriate to this area of practice;

e) skill in psychological diagnosis: a good knowledge of assessment, both general and specific; study and supervised experience in the appropriate environment to learn the range of possible diagnoses and to acquire skill in differential diagnosis; interpretation of such instruments as the MMPI in personal injury cases;

f) skill in assessment and treatment: training and experience in identifying treatment needs and providing treatment, as appropriate, for such conditions as head injury, post-traumatic stress disorder, psychosomatic disorders, pain, substance abuse, factitious disorders, and malingering.

With respect to neuropsychological assessment specifically, practitioners are referred to the training criteria published by the American Neuropsychology Association.

How can insurers, lawyers and other health care professionals determine which providers possess the relevant competencies?

Psychology is a **self-regulating** profession. This means that members of the profession have undertaken to ensure they

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are competent with respect to the services they provide. Members provide only those services which fall within their areas of competence and, in describing their practices, they accurately represent their competencies to direct recipients of services, referral sources, and third party payers.

Individuals members must be aware of the limits of their competence. Each must assess whether they are knowledgeable and skilled respecting the sequelae of accidents and other factors which may affect recovery; the selection, administration and interpretation of appropriate assessment tools and techniques; and, the selection, application and evaluation of appropriate treatment strategies. For a member to evaluate his/her competence to practice in this area requires current knowledge of the relevant professional literature, successful completion of appropriate workshops or courses, supervised training and experience, and peer consultation.

While being adequately prepared to practice in a given area does not preclude the possibility of a complaint being lodged against a member, it is a critical factor affecting the likelihood the member's practice meets professional standards.

All members of the College are responsible for practising within their limits of competence and to represent their competencies accurately. An insurer could inquire directly of a member whether he/she is able to provide a particular type of service. Confirmation of professional registration and status with respect to communicating a diagnosis may also be obtained from the College.

2) Diagnostic Issues

The range of appropriate diagnoses for a member to make is determined by the scope of practice of psychology, the member's training and expertise and any terms, conditions or limitations on the member's certificate of registration.

With what degree of certainty can a diagnosis be made?

Appropriate cautions should be exercised; a diagnosis should be reasoned through with adequate consideration of alternatives. The member should consider the adequacy of the data base and the weighting or certainty that can be appropriately applied to the information gathered. Practitioners recommend qualifying a diagnosis with a phrase such as "based on the data currently available".

Adequate and appropriate diagnosis will help in avoiding such potentially harmful situations as a missed diagnosis, an incorrect diagnosis or over diagnosis. The member must be competent and objective, be prepared to make appropriate referral to another regulated health practitioner with required expertise and avoid handing over the task of assessment and diagnosis to an unqualified provider.

Professional judgement is necessary in determining what data are required, what testing is appropriate in the particular case and how reliable the data are. Practitioners in the area of neuropsychology particularly cautioned against doing "neuropsychology by numbers".

Other issues identified by practitioners included whether controversial diagnoses such as fibromyalgia were inappropriate and whether members should diagnose causes of symptoms of dizziness or headache. Members must know when to refer to or consult with another health practitioner with appropriate expertise. Members are cautioned about the tendency to attribute any cognitive deficit to head injury; adequate assessment is required to reach such a conclusion.

If the member is working in an area where there is no psychological service provider with the required expertise, and the member has only limited background, the member must be extremely cautious in making any diagnostic statements. The member should describe carefully what was done to assess the client, to obtain the data used in formulating the diagnosis, and state the relative certainty with which diagnosis is made. Once again, members are reminded of their ethical obligation to make a referral to someone with appropriate expertise.

Recommended self-directed questions:

1) Do I have the required expertise to assess this client/a client with this history/these symptoms?

If "No", refer to a health practitioner who has the relevant expertise; if "Yes", proceed.

2) Is a diagnosis required?

If "Yes", take the necessary steps to arrive at a diagnosis.

3) Have I communicated the differential diagnosis and the probability that it is related to the motor vehicle accident?

4) Can I defend this opinion?

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3) Treatment

Treatment requires a proper differential diagnosis and must be appropriate and competently provided. Inappropriate treatment includes mistreatment, "pseudo" treatment, and inadequate treatment.

When evaluating a client for treatment, experienced practitioners recommend giving a probabilistic diagnosis and advising the client of the potential for different professional opinions. Members are encouraged to set realistic expectations by communicating to the client the differential diagnosis and the effects of other factors. This should include a discussion of whether treatment will be ongoing or whether a trial of treatment is proposed as well as a discussion of the likelihood of improvement without treatment.

Members are cautioned against giving a formal psychological diagnosis outside of a professional relationship or based solely on subjective symptoms in the absence of an adequate history, background information or objective assessment.

The new insurance legislation which went into effect on November 1, 1996 requires a therapist to provide a treatment plan unless this requirement is waived by the insurer. The treatment plan may be reviewed by a Designated Assessment Centre. After six weeks of treatment an insurer's examination may be required.

Approved Designated Assessment Centres include both individual practitioners and facilities. Members providing services in a DAC are reminded of their responsibility to ensure services are provided in a manner consistent with professional standards.

4) Multicultural/Multiethnic Population

Members providing services to multicultural and multiethnic populations are reminded to consider the adequacy or limitations of using an interpreter and the importance of sensitivity to and awareness of cultural expectations and differences.§

END OF PART ONE

Quality Assurance Committee Update

The Quality Assurance Committee has now concluded its seven community "roadshows". While the presentations were generally well received, the Program itself got mixed reviews. Reaction to the proposed Quality Assurance Program ranged from, "this is a great piece of work and will be of great value to both members and the public" to "this program is intrusive, controlling and assumes incompetence and a lack of professionalism among members", and everything in between.

At each meeting, "work in progress" was presented affording members the opportunity to hear about the status of the program, offer suggestions and raise concerns. Changes resulting from member feedback influenced subsequent meetings as member input guided the evolution of the program. As the "roadshow" travelled from its starting point in Sudbury in the summer to its recent conclusion in Waterloo, the content was changed and refined as new ideas were incorporated or new concerns raised.

The Quality Assurance Regulation was submitted to the Ministry of Health for approval by the December, 31, 1996 deadline. This regulation reflected the evolution of the program through the consultation process. Some Colleges have received feedback from the Ministry consisting of requests to modify or clarify their regulation to comply, more closely, with Ministry guidelines and principles. We are expecting little change will be required to the final draft submitted. Great effort was taken to develop a regulation which met the requirements of the Ministry while maintaining flexibility in the specific implementation of the program; details to be worked out through further member consultation.

The Quality Assurance Committee will be inviting existing associations and academies to assist in the development of the content and technical details of the Peer Assisted Review process. There will also be an opportunity for individual input. The information gathered will be synthesized into a draft outline for further consultation. The Committee realizes this will be a time consuming process, however we are committed to continuing the positive consultation process which has characterized development to date.

The first step in the implementation of the Quality Assurance program will be the distribution of the Self Assessment Guide to all members later this spring. The Guide has undergone numerous revisions in response to members' suggestions. We anticipate members will find this a valuable tool for personal, candid self-evaluation leading to the development of an individualized learning plan.§

President's Report

President's Report

The College continues to focus on better communication with government regarding regulatory issues affecting psychology. On October 15, 1996; the Registrar, Dr. Yarrow, and public member of Council, Mr. Giffen, and the President met with Ms. Mary Lou Gignac of the Professional Relations Branch of the Ministry of Health. Plans are underway to meet with the Ministries of Community and Social Services, Education and Corrections.

Efforts to maintain open communications with the Ontario Psychological Association also continue and the President, Registrar, and Mr. Giffen met with the OPA executive and their counsel Ms. Linda Bohnen on October 15, 1996 to review issues related to delegation of the controlled act. The College, and specifically the Registration Committee, continues to work toward a resolution and has received written and oral feedback from a number of members respecting the College's Advisory on Communication of a Diagnosis published as an insert to the Bulletin in July 1996 and subsequently distributed to hospital and school boards. The Director of Professional Affairs has also met with groups of members to discuss their questions and concerns about the College's advice. Some members have found the advice helpful and a useful clarification and endorsement of practices which they had already adopted. Others raised concerns about possible implications of the advice in their particular work setting.

All feedback from the members has been noted and Council will be informed of member's views. The feedback will be used to assist in the preparation of a future article clarifying the College's advice.

Following deliberations at the Council of Provincial Associations of Psychologists, and the direction of the Council of the College, the College has begun preliminary discussions with the College of Psychologists of British Columbia to determine whether the two jurisdictions might enter into a Memorandum of Mutual Recognition. Such a memorandum would address the potential for registrants in good standing in one province to become registered in the other. The Association of State and Provincial Psychology boards, through its Certification Committee, is also exploring the development of mechanisms and procedures that could facilitate mobility of psychologists between member jurisdictions. The President has been appointed to the Certification Committee.

During 1996, the College monitored Bill 59 amendments to the Insurance Act and the amendments to the regulation which sets out the Statutory Accident Benefit Schedule (SABS). The College clarified with the Ministry of Finance the eligibility of both psychologists and psychological associates with appropriate expertise to provide treatment to victims of motor vehicle accidents, under the provisions of the SABS.

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President's Report cont'd

The Registrar attended a meeting with the Ontario Psychological Association and representatives of the insurance industry to inform the industry of College standards requiring members to provide services appropriate to the needs of the client and to ensure that needed services are not withdrawn arbitrarily.

These standards together with the statutes, regulations and standards bearing upon the appropriate protection and release of confidential client information have also been the subject of communication with individual insurers and their subsidiaries as opportunities have arisen.

The College participated in consultations with representatives of the Ministry of Labour and of the Ministry of Health on one aspect of the new legislation on workers' compensation dealing with transmittal of the findings of a Functional Abilities Evaluation to the claimant's employer to facilitate a return to work. The College noted the importance of ensuring that the claimant was clearly informed of his or her rights and obligations and that the nature of information to be transmitted was only that clearly relevant to planning for the return to work.

The College is participating in deliberations at meetings of the Canadian Register of Health Service Providers in Psychology respecting possible listing of psychological associates registered to practice autonomously, if they meet the other criteria for listing in the Register.

Along with several of the other Colleges in Ontario, the College of Psychologists has been monitoring government sponsored meetings to discuss Primary Care Reform and possible models of funding. The Colleges will seek active consultation if public interest warrants it. The College also continues to participate in preliminary discussions with the Health Professions Regulatory Advisory Council preparatory to their report reviewing the legislation five years after proclamation. The Regulated Health Professions Act has created a significant change in the regulation of psychology in Ontario. The College mandate of public protection goes well beyond the registration of psychologists and psychological associates. In order to better prepare for the future, the College is now embarking on a strategic planning exercise to develop both interim and long term plans for the next five to fifteen years. This is a necessary step if the College is to carry out its functions in an orderly and continuous fashion.

John T. Goodman, Ph.D, C.Psych.
President

Tricky Issues Feature

Collection of Fees: Use of Collection Agencies or Small Claims Court to Collect Outstanding Accounts; Credit Card Payment for Services

The Issue:

Members have sought direction from the College on two separate yet related issues with respect to the collection of fees for psychological services provided on a fee-for-service basis. Members have inquired about; a) the use of collection agencies or small claims court in collecting outstanding accounts, and b) whether they may accept credit card payments for their services. Members find these types of questions troubling as they balance professional ethics with the business realities of operating their private practice.

The College's Advice:

The question of the use of collection agencies or small claims court was first addressed in the Bulletin, Vol. 7(2) in December 1981. While there have been many revisions to the Regulations and to the Standards of Professional Conduct since that time, the advice remains unchanged.

This issue brings together Ontario Regulation 801/93 on Professional Misconduct and the Standards of Professional Conduct. As stated in # 30 of the Business Practices subsection of the Regulation, it as an act of Professional Misconduct to: *Sell any debt owed to the member for professional services. This does not include the use of credit cards to pay for professional services.* Some members have interpreted the prohibition against *selling any debt owed* as a prohibition against the use of collection agencies, when this is not the case.

There is nothing in this Regulation which prohibits or suggests impropriety in obtaining assistance in the collection of outstanding accounts. What is necessary however, is consideration for the welfare of the client as required by Principle 6 of the Standards of Professional Conduct. This Principle states that, *A member of the College shall respect the user's right to know what fees and charges are to be levied, shall set reasonable fees and collect these with consideration for the welfare of the user.*

The use of the collection agency is permissible as long as members assure themselves that the practices of the collection agency are ethical and they remain under the control of the psychological associate/psychologist. Most large communities have agencies specializing in the collection of professional accounts and will conduct their business in the spirit agreed to with the psychologist/psychological associate.

The use of a collection agency should not be confused with the prohibited practice of *selling any debt owed* to a third party. In selling an account, the psychological associate/psychologist loses control of the methods used in satisfying the debt and in addition, loses control over unidentified factors affecting the welfare of the user. Once the debt is sold to a third party, satisfying the debt becomes a matter solely between the third party and the client.

There is also no reason why members should not avail themselves of small claims court to obtain a legal judgement where other reasonable methods for collection have failed.

With respect to credit card payments, Regulation #30 quoted above notes that, *the use of credit cards to pay for professional services* is not considered to be selling a debt and is therefore permissible. In considering the use of credit cards in one's practice however, members are reminded that Standard of Professional Conduct 6.4 states, *A member shall not require the use of a credit card in payment for services.* This does not prohibit the use of credit card payments but allows a member to offer this payment option to clients. Similarly, members may wish to offer their clients the option to pay through the use of a direct withdrawal system such as Interac. In either case, clients must not be required to use a "plastic" method of payment but members may present these as options clients may find convenient.§

FUNDING OF THERAPY AND COUNSELLING FOR VICTIMS OF SEXUAL ABUSE -- AN UPDATE

Proposed Additional Criteria for Eligibility for Funding of Therapy and Counselling

The Health Professions Procedural Code of the Regulated Health Professions Act, 1991 requires every regulatory College to have a program to fund therapy and counselling for clients who have been sexually abused by a College member [85.7(1)]. The Code specifically defines one category of eligibility: *A person is eligible for funding only if there is a finding by a panel of the Discipline Committee that the person, while a patient, was sexually abused by a member;* [85.7(4)(a)]. It further provides however, that each College may prescribe alternative eligibility requirements [85.7(4)(b)]. In December 1994, the Council of the College of Psychologists acted upon the authority of clause 85.7(4)(b) of the Code to clarify and broaden the eligibility criteria, sending the following to the Ministry of Health for approval. The explanatory notes in the shaded boxes were not part of the submission to the Ministry.

Subject to clause 85.7(4)(b) of the Health Professions Procedural Code, a person may be eligible for funding if,

1. the sexual abuse occurred after December 31, 1993; and,

To be eligible, the abuse must have occurred after December 31, 1993 as this was the date when sexual abuse was defined by amendment to the RHPA.

2. the allegations of sexual abuse, as defined in clause 1(3)(c) of the Health Professions Procedural Code, are addressed and resolved within an Alternative Dispute Resolution mechanism; or

This section broadens the eligibility to include clients who were sexually abused, as defined in clause 1(3)(c) of the Code, by a member where the matter was addressed and resolved through an Alternative Dispute Resolution mechanism rather than requiring a finding of the Discipline Committee. Clause 1(3)(c) of the Code refers to behaviour or remarks of a sexual nature. The term "sexual nature" does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided [1(4)].

3. the person reporting having been sexually abused by a member only served as a witness in a case where the Discipline Committee finds the witness credible and finds the member guilty of sexual abuse of another client as charged in the notice of hearing; or

This section broadens the eligibility to clients who reported being sexually abused by a member but served only as a witness to the Discipline Hearing of the member accused of sexual abuse of another client. The client, who only acted as a witness, is eligible if the Discipline Committee believes the client to be a credible witness and the member is found guilty of sexual abuse of the other client.

4. the person, while a client, was sexually abused by a member and there has been a finding in a criminal court that abuse occurred.

If the member has been found guilty of abuse in criminal court, the client may be eligible for funding for therapy or counselling without having to wait for a finding of the Discipline Committee of the College.

5. The amount of the funding provided for therapy or counselling for clients who were sexually abused by members will be offset by any other funding for which the person is eligible.

If the client chooses therapy or counselling which is funded through OHIP or some other third party payer, the funding provided by the program of the College will be reduced by the amount covered by the other funding source.

Qualifications of Practitioner Providing Therapy or Counselling

In September 1996, eligibility for funding was addressed by Council once again. Within the RHPA, there is no requirement for the therapist or counsellor providing therapy to the victim of sexual abuse to be a regulated health provider. Therefore, to ensure the client is informed of the qualifications, experience and professional preparation of the provider he/she chooses, the Council approved the motion presented below. This motion authorizes the Client Relations Committee of the College to require the client and therapist to sign a statement detailing the therapist's training and experience, and other aspects of the proposed therapy. The motion states:

That the following eligibility requirement regarding funding for therapy or counselling be added to those approved by Council in December 1994 and forwarded to government for inclusion in the regulations.

(1) The Client Relations Committee may require a written statement to be submitted to the College where funding is provided for therapy or counselling funded through the program required under section 85.7 of the Procedural Code.

The Client Relations Committee is charged with the responsibility of determining the need for a written statement to be submitted to the College.

(2) The statement shall contain:

(a) the details of the therapist's or counsellor's training and experience and whether the therapist or counsellor is a member of a Regulated Health Profession;

(b) confirmation that the therapy or counselling is being provided to the client and that the funds received are being devoted only to the therapy or counselling;

(c) a short description of the therapy or counselling to be offered;

(d) the fees to be charged for the service; and

(e) whether the therapist or counsellor has liability insurance.

In providing this statement to the College, the therapist or counsellor will be expected to address the five areas noted.

(3) The statement shall be signed by the therapist or counsellor and by the client receiving the therapy or counselling, or the person who has consented to the therapy or counselling on behalf of the client.

In requiring the signature of the client, the Client Relations Committee is taking steps to ensure the client is informed of the qualifications and experience of the therapist or counsellor, and the nature of the therapy being offered.

Council views this as a very important measure in attempting to ensure the client is well informed of the qualifications of the therapist or counsellor he/she chooses and the nature of the therapy. Due to the length of time it can take to have a regulation approved, Council passed a further motion stating that, until the above regulation was approved, the requirements outlined in the motion would be adopted as policy of the College. The therapist or counsellor will be asked for this information and it will be provided to the client.§

Measuring Client Satisfaction

From time to time, the Quality Assurance Committee will publish advisories and guidelines related to the College's Quality Assurance Program. This advisory on the measurement of Client Satisfaction describes ways in which members may obtain feedback from their clients. The College encourages members to adopt such a practice as one strategy for the assessment of the quality of their psychological services.

The Ministry of Health suggests *Client Satisfaction* as one measure of the quality of care provided by the regulated health professions. This should not come as a surprise since one purpose for regulating health care was to enable clients, the public, to judge how well they are served. The use of consumer satisfaction information, as a measure of quality of care is a contentious issue and one the Quality Assurance Committee has discussed at length. Dr. Christel Woodward, a past Committee member, reviewed recent research on this topic, including information about the design of client satisfaction measures. This article builds on Dr Woodward's work providing an overview of *Client Satisfaction* and offering valuable information for members to review in considering the development of their own Client Satisfaction evaluations. Recent articles in the American Psychologist (October 1996) also provide useful information on this topic.

What Is Meant By "Client Satisfaction"?

Client Satisfaction measures provide a subjective evaluation of services from the clients' perspective. These measures afford clients the opportunity to comment on their experiences with care providers and the benefits they perceive resulting from this involvement. Quality care meets or exceeds clients' expectations in both the process and the outcomes of the service provided.

Can Client Satisfaction Be Measured?

There is growing consensus that client satisfaction can be used as a measure of the quality of care (Cleary and McNeil, 1988), although there is concern that consumers may have difficulty judging the technical aspects of care. Client satisfaction data can be useful in identifying problem areas in service delivery and improving the effectiveness of services. Before deciding whether to assess client satisfaction and how to go about doing this, one must first answer two questions: *Who are your clients? Why do you want to measure client satisfaction?* With these questions answered, one can then decide what dimensions of the services to assess and what measurement strategies to use.

Who Are Your Clients?

When considering who your clients are, it may seem self-evident this refers to those individuals, groups or corporate entities to whom you provide direct psychological service. For the purposes of evaluating client satisfaction, however, you may wish to go beyond this traditional definition provided in the *Standards of Professional Conduct*. In striving to evaluate client satisfaction, one should not forget that *clients* may also encompass those not seen **directly** for assessment or treatment. For the purposes of evaluating satisfaction, you may also wish to include **indirect** clients, for example, referral sources, the courts, teachers, and other agencies. Depending upon the nature of your services, indirect clients may be better able to comment on some aspects of your work, such as usefulness and clarity of reports, promptness in responding to inquiries or accessibility and ease of referral. In evaluating client satisfaction it can be important to consider the information available from both direct and indirect clients.

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Why Measure Client Satisfaction?

Client satisfaction information can provide valuable data about your practice from the perspective of the recipients of service. For example, you may wish to find out what aspects of your services were valued most or least by recent direct clients so that you can enhance service delivery to them. Similarly, collecting information from referral sources may provide valuable feedback regarding their view of your services. In either case, knowing why you are measuring client satisfaction will help you determine what you want to explore and what you want to learn from your different client groups. Without a clear understanding of how you might use the information you collect, gathering client satisfaction data is likely to be a useless exercise that is quickly abandoned.

What Dimensions Of Client Satisfaction Should Be Measured?

Services to clients can be evaluated on a variety of dimensions. Some examples of common *Aspects of Service* evaluated through client satisfaction are outlined in Table 1 and include: accessibility, information provision/communication, provider/client interaction, administrative arrangements, attention to facilities, outcomes of care and overall satisfaction. For each dimension, a number of *Possible Indicators* of service quality are suggested. For example, some possible indicators of *Accessibility of Services* may be the clarity of signs to help clients find your office, the availability of parking and its cost, access to public transit as well as waiting time to get an appointment and office waiting time. Your availability by telephone and promptness in returning calls may be other client satisfaction indicators of *Accessibility of Services*. Clearly, a psychologist/psychological associate might not want to evaluate all of the suggested indicators of *Accessibility* in every client satisfaction measure, however, the table provides useful examples of the kinds of indicators you may wish to consider.

By thinking about possible dimensions of client satisfaction and the accompanying indicators, you can clarify your personal values about client satisfaction and what is important to you. You are able to define what you mean by high quality service provision and set your own targets by asking, *Am I achieving my goals for service delivery to the satisfaction of my clients?*

What Strategy Should Be Used To Measure Client Satisfaction?

The choice of strategy for assessing client satisfaction will depend on the:

- size and diversity of the client group(s) you wish to access
- amount and complexity of feedback you wish to obtain
- frequency with which you would like the information
- resources you are willing to expend to obtain feedback

The Auditor General's Office of the federal government has suggested six principles that should be considered in developing a measurement strategy (Treasury Board of Canada, 1992).

1. The measurement strategy chosen should be tailored to your information needs.

2. It should be as simple as possible, since complex strategies are usually quickly abandoned.

3. If possible, you should aim for a diversity of approaches, so the limitations of any one approach are minimized. Consistency of evidence from several sources makes the information more trustworthy.

4. Your strategy should be cost-effective. The information gained should be worth the resources expended. Carefully selecting the key bits of information to gather and sampling (randomly) rather than including everyone may be appropriate, especially if you have a large number of clients.

5. It is important to assure your measures are reliable and valid indicators of service quality. The measures should be sensitive to important changes in your client's attitudes.

6. Client satisfaction should be monitored in an ongoing or periodic fashion so that changes can be observed and the impact of any planned changes can be assessed.

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TABLE 1. Dimensions of Client Satisfaction and Possible Indicators

Aspect of Service	Possible Indicators
Accessibility	· ease of access to office · availability of public transport · appearance and clarity of signs · wheelchair accessibility · availability and cost of parking · waiting time to make an appointment · ability to reach you in an emergency · ability to contact you by telephone · promptness of returning telephone calls
Information Provision/ Communication	· regarding services offered, cost, hours of availability, etc. · adequacy of information provided regarding services offered, fees, hours of availability, confidentiality, etc. · ease of obtaining information · clarity of written information · openness to discuss services, fees, etc. · ease of filling out forms · adequacy of feedback of results/progress · clarity/readability of reports · timeliness of reports to others
Provider/Client Interaction	· courtesy · helpfulness · empathy, humaneness · amount of time spent · unhurriedness · fairness of treatment · willingness to listen · treated as important · respectfulness · protection of client confidentiality
Administrative Arrangements	· clarity of billing arrangements · scheduling of appointments · handling of requests for information · flexibility in scheduling, accommodating changes
Service Outcomes	· usefulness/helpfulness of services · attainment of goals · value of service to clients · amount of improvement in client situation after service
Overall Satisfaction	· likelihood of recommending service to a friend (who might need similar services) · likelihood of coming back (if needed to) · extent to which service seen as good value for money · overall assessment of satisfaction with service

Adapted from Annex B, Examples of Client Satisfaction Indicators. Treasury Board of Canada. Your Guide of Measuing Client Satisfaction. Ottawa: Ministry of Supply and Services, Canada, 1992, p.10.

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Measuring Actions Versus Measuring Perceptions

It is often more useful to obtain information regarding actions rather than to measure perceptions. For example, rather than asking, *How satisfied were you with time you had to wait to receive an appointment at this office (facility, clinic)?*, you might instead (or also) ask, *How many days after you contacted our office (facility, clinic) was your first appointment?*

The results of these questions may surprise you. You may find that some clients are satisfied with the length of time they waited for an appointment, but that wait is unacceptably long by your standards. Conversely, you may find that clients express dissatisfaction but the wait is within your standards or those agreed upon by your work group. In this way, measuring actions can help determine adherence to service standards and provide a different type of information than that obtained by solely measuring perceptions. To some extent, client perceptions of satisfaction are based on expectations created by prior learning. A client's satisfaction with services often relates to his/her expectations and how well these may have been met. Low client satisfaction ratings may raise questions about the quality of your communication of expectations.

Deciding On Measurement Approaches

Surveys are most commonly used to measure client satisfaction. These may be mailed to the client, completed in the office or by telephone. Sometimes focus groups are useful, especially when you do not know, in advance, which dimensions of service quality are important to your clients. Focus groups with direct clients may pose some problems as one must consider issues of confidentiality, however they may work very well with referral sources. Some agencies or facilities have found complaint, comment or suggestion boxes to be useful, although they usually yield only 'the tip of the iceberg' regarding client feedback. How often have **you** used them when they have been available at your bank, favourite restaurant or hotel?

Thinking About Response Alternatives

It is generally accepted that using five or more response categories produces more reliable data on perceptions than a simple *Yes/No* response alternative (Nenally, 1978). The use of a five point **quality** scale, (for example, *poor, fair, good, very good, excellent*), has been demonstrated to produce more reliable and valid results than a five point **satisfaction** scale, (for example, *very dissatisfied, dissatisfied, neither satisfied or dissatisfied, satisfied, very satisfied)* for a single encounter episode of care (Ware and Hays, 1988). Sometimes the usefulness of information provided rather than satisfaction can be assessed.

Table 2 provides examples of different ways of formatting items. Data from close-ended items, with no written or narrative responses allowed, are easiest to analyze but the quality of the data varies with the quality of the questions posed and response options provided. There are times when partially closed-ended responses or open-ended responses are more useful as when the likely responses are unknown.

Writing Good Questions

If you decide to use a survey approach, you should consider consulting the literature for available client satisfaction scales. A number of references to this literature are cited below. As well, a sample questionnaire used by The Psychobiology and Clinical Trials Research Unit in Anxiety of the Clark Institute of Psychiatry is also included.

If none of these meet your specific needs or if you want to construct a short survey of indicators most salient to your practice, there are some basic rules of question writing which can assist you to produce valid, reliable responses. Woodward and Chambers (1982) provide the following **Checklist for Writing Good Questions**.

1. Are the words simple, direct and familiar to all?
2. Is the question as clear and specific as possible?
3. Is it a double question?
4. Does the question have a double negative?
5. Is the question too demanding?
6. Are the questions leading or biased?
7. Is the question applicable to all respondents? *(If not, use skip pattern to indicate the client should skip to next question or section)*
8. Can the item be shortened with no loss of meaning?
9. Is the question objectionable?
10. Will the answers be influenced by response styles?
11. Have you assumed too much knowledge?
12. Have you assumed too much about the respondent's behaviour and/or the situation?

>>>

TABLE 2. Examples of Alternative Item Formats

Please circle the one number for each item that best describes your opinion

Type A: How satisfied are you with:	Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Disatisfied
time waited to get your first appointment?	1	2	3	4	5
directions given to find this office?	1	2	3	4	5
fee for the services provided?	1	2	3	4	5
written information about services provided?	1	2	3	4	5

Type B: How would you rate:	Excellent	Very Good	Good	Fair	Poor
time waited to get your first appointment?	1	2	3	4	5
directions given to find this office?	1	2	3	4	5
fees for the services provided?	1	2	3	4	5
information provided in advance	1	2	3	4	5

Type C: Please answer the following questions:

How long did you wait for your first appointment, from the time you asked for an appointment until you were seen? __________ days

How useful were the directions given to you on how to find this office (agency)?

Not at all Useful------------------------->Very Useful
1 2 3 4 5

Would you recommend our services to a friend who needed similar services?

Definitely Not-----------------------------> Definitely Yes
1 2 3 4 5

Would you recommend our services to a friend who needed similar services?

1 Definitely not
2 Unlikely
3 Not sure
4 Probably
5 Definitely yes

*** Why?** ______________________________

>>>

Table 1 cont'd

What changes should be made to improve our services? ***Please circle all that apply.***

1 Reduce waiting time for first appointment

2 Reduce waiting time in waiting room

3 Improve waiting area

4 Provide less hurried atmosphere

5 Provide feedback on assessments more quickly

\+ 6 Other (*please specify*)

* This is an open-ended question and requires categorization later.

\+ This type of question is considered "partially open-ended" because an answer can be written in by the respondent.

13. Is an appropriate time referent provided? *(If needed.)*

14. Does the question have several possible meanings?

15. Have you exhausted the response alternatives?

16. Are the response alternatives mutually exclusive?

Analysing And Reporting Your Data

Usually, simple descriptive statistics, tallying the number and percentage of individuals responding to a particular item, can be very useful. Access to computer statistical packages may allow creation of a data base so responses can be examined by client characteristics, (age, sex, type of problem, service(s) received, etc.) or over time (comparison across quarters, years, etc.). Such refinements may be beyond the reach and/or need of many practitioners who may find that simple, descriptive analyses are most productive. A simple way of displaying data is to put the tallies for individual items directly onto a blank questionnaire.

When analyzing results, it is important to know the response rate, that is, how many of those asked to participate actually provided answers to your questions. A low response rate may suggest an overly high *respondent burden*, that is, questions asked were too numerous, too difficult or too intrusive. Low response rate could also indicate that insufficient attention was paid to following through with clients or encouraging them to respond. For example, a low response rate may be anticipated if only one daytime attempt was made to contact clients by telephone when they are likely to be at work. A thank you/reminder, second mailing or repeated attempts to contact a household at different times of the day can greatly improve response rates (Dillman, 1978). Data obtained from a small proportion of potential respondents may be biased and thus difficult to interpret.

Using Client Satisfaction Information

Client satisfaction data that are collected, filed in a drawer and never used are not worth having. The data collected should stimulate your thinking about the services you provide and how you might improve them. Quality improvement philosophy states that, no matter how good our services are, there is always room for improvement! (Deming, 1982) Improvements may include designing a brochure for clients describing your services or a particular type of service, posting better signs to your office, or setting aside a half hour a day to return calls from your answering machine. Such changes, while not earth shattering, may be much appreciated by both your direct and indirect clients and may even lead to greater professional and financial rewards!

Summary and Conclusions

Client satisfaction measures are one of the criteria suggested by the Ministry of Health to assess the quality of health care services. There is a developing consensus that when we ask appropriate questions, clearly and simply, client satisfaction can be reliably and validly evaluated to provide valuable information. Satisfaction questions can be posed to both direct and indirect recipients of our services with different, yet equally useful findings.

The first step in evaluating client satisfaction is to identify your client group and clarify your own goals and standards for service. You should also decide exactly how you will use the data before beginning to develop the client satisfaction questions to be posed. It is important to ask the right questions and offer the clients an unbiased set of clearly worded optional responses. *Always* and *Never* have commonly understood meanings while *Sometimes, Often,* or *Mostly* may mean different things to different people. Open-ended responses may be difficult to score, but can provide useful insights into the client opinions. Different settings

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may be interested in different dimensions to be explored through different questions. Data analysis can be as simple or complex as your needs and resources dictate. Complex statistics may be useful for larger organizations, but should be used with caution when sample sizes are small and response variations large.

Client satisfaction is not the only way to assess the quality of services but, as a follow up with clients to their involvement with you, it can provide a very valuable supplement to other measures or indicators you employ.

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Example of Client Satisfaction Questionnaire
The Psychobiology and Clinical Trials Research Unit in Anxiety
Clarke Institute of Psychiatry[1]

Please help us improve our program by answering some questions about the services you received at the Psychobiology and Clinical Trials Research Unit in Anxiety. We are interested in your honest opinions, whether they are positive or negative. Please answer all questions. We also welcome your comments and suggestions. Thank you very much; we appreciate your help. (Please do not write your name on this questionnaire).

Date:_________________(Day/Month/Year) Gender: Male:______ Female:______ Age:______

Please answer the following questions about the Psychobiology and Clinical Trials Research Unit in Anxiety.

When you first contacted the Psychobiology and Clinical Trials Research Unit in Anxiety, how quickly were you seen?			
Took forever	Some delay	Promptly	Very promptly
1	2	3	4
2. How would you rate the quality of service you received?			
Poor	Fair	Good	Excellent
1	2	3	4
3. Did you get the kind of service you wanted?			
No, definitely not	Not really	Yes, generally	Yes, definitely
1	2	3	4
4. To what extent has our program met your needs?			
None of my needs have been met	Only a few of my needs have been met	Most of my needs have been met	Almost all of my needs have been met
1	2	3	4
5. If a friend were in need of similar help, would you recommend our program to him/her?			
No, definitely not	Not really	Yes, generally	Yes, definitely
1	2	3	4
6. How satisfied were you with the amount of help you received?			
Quiet satisfied	Indifferent or mildly satisfied	Mostly satisfied	Very satisfied
1	2	3	4
7. Have the various services you received helped you to deal more effectively with your problem?			
No, they seem to make things worse	No, they really didn't help	Yes, they helped somewhat	Yes, they helped a great deal
1	2	3	4
8. In an overall, general sense, how satisfied were you with the service you received?			
Quite satisfied	Indifferent or mildly satisfied	Mostly satisfied	Very satisfied
1	2	3	4
9. If you were to seek help again, would you come back to our program?			
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely
1	2	3	4

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The Bulletin

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Call for Participation in Statutory Committees

Under RHPA, the College has seven Statutory Committees. The Executive Committee is elected from the Council who in turn appoint members of the Council and members of the College (who are not members of the Council) to the six other Committees. Each of the titles, psychologist and psychological associate must be represented on each of the six Committees.

Members who are interested in serving on a Committee are asked to provide their name, registration title, preferred Committee (1st and 2nd choice may be given) and a brief statement of background.

Registration:

Meeting an average of one day per month, to review applications referred by the Registrar, to determine whether requirements for registration have been met and to direct the Registrar respecting the issuance of certificates of registration and any terms, conditions or limitations to be imposed. Two members of the College are required.

Complaints:

Meeting an average of one to two days per month, to investigate complaints, the conduct or actions of members and to render a written decision within 120 days of receipt of a complaint. Two members of the College are required.

Discipline:

Meeting as needed (approximately 12 times a year for hearings ranging from one to five days, including resumptions) to hear allegations against members of professional misconduct or incompetence, which have been referred by the Complaints Committee. Two members of the College are required.

Fitness to Practice:

Meeting as needed to hear matters relating to fitness to practice referred by the Executive Committee after receiving a report from the Registrar regarding possible incapacity. Two members of the College are required.

Quality Assurance:

Meeting four to five times per year to continue the development of the Quality Assurance Program, including ongoing member consultation. The Committee will review the initial implementation of the Quality Assurance Program and make recommendations for revision and change. The Committee may appoint assessors for the purpose of a Quality Assurace program which will function under regulations developed by the College for such a program. Two members of the College are required.

Client Relations:

Responsible for advising the Council on the College's client relations program which must include measures for preventing or dealing with the sexual abuse of clients by members. The program must cover educational requirements for members, guidelines for the conduct of members with their clients, training for College staff and the provision of information to the public. Frequency of meetings is undetermined but the Committee may liaise with staff, Quality Assurance, Complaints and Discipline in fulfilling its mandate. Monitoring reporting and advising are major features of the task. One member of the College is required.§

Changes to the Standards, By-Laws, Guidelines and Regulations

In August, 1996 the College was admitted to the Reciprocity Agreement of the Association of State and Provincial Psychology Boards (Bulletin, Vol. 23, No,2, October, 1996)

An amendment to the College's registration regulation, imposed by the provincial government in 1993, added a requirement for citizenship, permanent residency or authorization under the Immigration Act (Canada).

As this is not a "non-exemptible" requirement and could be waived by the Registration Committee in appropriate cases, Council approved guidelines for exempting applicants from this provision.

The following additions to the College's Guidelines on Registration were approved:

Guideline for Exempting Registration Applicants from the Requirements for Citizenship, Permanent Residency or authorization under the Immigration Act (Canada) cited in subsection 3.(1) 3. of Ontario Regulation 878/93: Registration

(1) Respecting those individuals who apply for registration under the Association of State and Provincial Psychology Board's Agreement of Reciprocity, or any similar agreement entered into by the College:

a) Those individuals who are otherwise qualified for registration in Ontario may be exempted from the requirement for citizenship, permanent residency or authorization under the Immigration Act (Canada) as cited in O.Reg. 878/93, subsection 3.-(1) 3.

(2) Respecting those individuals who apply for a Certificate of Registration For Interim Autonomous Practice:

a) Those individuals who are otherwise qualified for registration in Ontario may be exempted from the requirement for citizenship, permanent residency or authorization under the Immigration Act (Canada) as cited in O.Reg. 878/93, subsection 3.-(1) 3.

The following clarification was also approved:

C. Guidelines for completing the requirements of postdoctoral supervised practice

The College requires individuals who intend to become registered as psychologists and who intend to provide psychological services to individuals or organizations, to have completed a total of two years, or 3000 hours minimum, of supervised practice, at least 1500 hours of which must be completed post-doctorally while on the register authorizing supervised practice.

1. To comply with the Registration Regulation, section.......(no change)

By-Law Amendment

With the approval of the integrated Standards of Professional Conduct in December, 1995, the adoption of the Canadian Code of Ethics for Psychologists, published by CPA and the revisions of the College's guidelines, the by-laws needed to be amended to reflect these changes. Therefore, the following motion was passed:

That section 16.1 of the By-laws be amended to read:

As formal bases for the acceptable professional conduct of members, the College has adopted the Standards of Professional Conduct (Revised, 1995); the Canadian Code of Ethics for Psychologists, Canadian Psychological Association (Revised, 1991) and the Guidelines of the College of Psychologists of Ontario (Revised, 1995).

Change to Standards: Principle 10 Delegation of the Controlled Act

The Council frequently receives requests for information regarding the authority of individual psychological associates to perform the controlled act of communicating a psychological diagnosis. It is anticipated that insurance companies will be seeking such information more frequently and may desire a list of those psychological associates authorized to perform the controlled act as appropriate in particular areas of practice. The current standards do not require notification of the College when a delegation agreement exists, therefore the following motion was passed at the Council meeting held in September, 1996. Therefore, it was passed:

That the Standards of Professional Conduct, Principle 10, be amended in the following manner:

(1) Section 10.5 to be renumbered 10.5(1);

(2) A new section 10.5 (2) be added to read as follows:

A copy of the signed delegation agreement shall be forwarded to the College as shall a copy of each review.

Proposed Amendment to the Regulation on Committee Developement

The Complaints Committee reported that the Complaints Committee has a heavy caseload and would benefit from having more Committee members available to prepare decisions. The following is not expected to increase costs, rather to distribute the workload among more Committee members. The proposed amendment would establish the minimum number of Committee members and would provide more flexibility to meet the demands of the caseload by appointing additional Committee members. Therefore, it was passed:

That Ontario Regulation 621/93 be amended as follows:

Section 3. be amended to read:
3. The Complaints Committee shall be composed of,
   (a) at least two members of the Council who are members of the College;
   (b) at lease 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.

Oral examinations were held on December 11, 12 and 13, 1996. The College would like to thank the following people who assisted in conducting these examinations:

James Alcock, Ph.D., Toronto
Maria Barrera, Ph.D., Toronto
Jean-Martin Bouchard, M.Ps., Elliot Lake
Stephen Butler, Ph.D, Toronto
Aurelie Collings, Ph.D., Toronto
Patricia DeFeudis, Ph.D., Mississauga
Brian Doan, Ph.D.,Toronto
Jack Ferrari, Ph.D., London
G. Ron Frisch Ph.D, Windsor
John Goodman, Ph.D., Ottawa
Margaret Hearn, Ph.D., London
Nina Josefowitz, Ph.D., Toronto
Randy Katz, Ph.D., Toronto
Sharon Kennedy, Ph.D., Ottawa
Anton Klarich, Ph.D., Tecumseh
Louise LaRose, Ph.D., London
Jane Ledingham, Ph.D., Ottawa
Maggie Mamen, Ph.D., Ottawa
Howard Marcovitch, Ph.D, Toronto
Ronald Myhr, Ph.D., Toronto
Schrine Persad, Ed.D., Toronto
Janet Polivy, Ph.D., Toronto.
Monique Pressé, M.A., London
Janet Quintal, M.A., Toronto
Rosina Schnurr, Ph.D., Ottawa
Susan Shaw, M.A., Brampton
Gene Stasiak, Ph.D., Oakville
Martyn Thomas, M.A., Toronto
Maxine Gallander Wintre, Ph.D., Toronto

The College would also like to thank the following public members of Council who assisted by observing the oral examinations:

Gilles Gagnon, Hearst
Jane Snyder, Whitby

The Examination for Professional Practice in Psychology was administered on October 16, 1996 in Ottawa, London, Toronto and Sudbury. The College appreciates the assistance of Ms. Connie Learn, Dr. Jane Ledingham, Dr. Rod Martin, Dr. Shawn Steggles, Ms. Mary Aubult, Ms. Dana Wilson-Li and Dr. Alastair Younger.

Corrections

Reinstatements:

The following persons have reinstated their membership with the College and should have been included in the 1996/97 Directory of Members:

Peter Barrett
Merrickville, Ontario
(613) 345-1461 ext. 3113

Gloria Roberts Fiati
Ryerson Polytechnical University
School of Early Childhood Education
350 Victoria Street
Toronto, Ontario M5B K3
(416) 979-5000 ext 7538

The previous issue of the Bulletin incorrectly listed Jeremy Mills as a new addition to the psychologist Temporary Register. This should have read the psychological associate Temporary Register. We apologise for any confusion this may have caused.

Changes to the Register

Admitted to the Temporary Register since October, 1996 - Psychological Associates

Margot Rochester
Sheri Schwartz

Admitted to the Temporary Register since October, 1996 - Psychologists

Jeffrey Abracen
Susan Bryson
Susan Davies
Philip Dodgson
Deborah Fitzpatrick
Cindy Ford
Carole Gentile
Cathy Goldstein-Kerzner
Georgina Gore
Johanne Guay
Ragnheidur Hlynsdottir
David Klassen
Kadri-Ann Laar
Brenda Lowick
Peter Mallouh
Cathleen McDonald
Marta Meana
Robert Muller
Laura Rees
Graham Reid
Kauliss Simmons
Ian Smith
Lori Triano-Antidormi
Diana Velikonja

WEB PAGE

Our new webpage is now underway. You can check it out at
www.cpo.on.ca
(yes, it is under development)

Changes to the Register

Deceased

The College of Psychologists extends its condolences to the family, friends and colleagues of Ms. Violet Head, C.Psych.

The College would like to congratulate and welcome the 34 new psychological associate members and the 34 new psychologists members

Admitted to the Permanent Register since October, 1996 - Psychological Associates

Donna Akman
Gillian Anchel
Bruce Bauer
Christine Beelen
Julie Bishop
Anstice Blom
Rhonda Chaiet
Christine DiZazzo
Laurie Ferguson
Brenda Ferguson
Tina Ferrari-Oryshak
Susan Flood
Pamela Foreht
Catherine Franko
Lisa Garman
Sheri Gordon
Carole Granatstein
Carol Hendra
Timothy Hill
Patricia Hunter
Judy Jackson
Linda Lifshen
Susan Mantle
Edyth McAfee
Michele Meret
Diane Mullane
Alison Murray
Patricia Nugent
Julie Skadorwa
Marcia Sokolowski
Faye Swartz
Ana Sztabinski
Robert Vachon
Delia Wallis

Admitted to the Permanent Register since October, 1996 - Psychologists

Qadeer Ahmad
Lise Bisnaire-Poirier
Pamela Broley
Elaine Clark
Rafaela Davila
John Erdman
Marcus Feak
Jacques Gouws
Robin Hargadon
Kathleen Hicks
Tory Hoff
Mary Hogan-Finlay
Todd Jackson
Josée Jarry
Karen Kaffko
Allison Kennedy
Elizabeth Kerr
Myra Kuksis
Mark Lau
Brian Levine
Nonie Lyon
Shelley McMain
Gail McVey
Joanna Mitsopulos
Keith Nicholson
Michelle Persyko
Denise Preston
Johan Reis
Judi Riches
Zachary Shnek
Mara Silins
Neil Weinberg
Charles Wilson
Mary Wiseman

Disciplinary Hearing - Dr. X: A Clarification of the Issues

The College received many queries requesting clarification of the article entitled **Disciplinary Hearing - Dr. X** reported in the previous Bulletin, Volume 23 (2), October 1996. This article presented an anonymous summary of the proceedings of a disciplinary panel hearing and was published as an educational resource to members. Based on the number of inquiries received, the article does not appear to have been instructive but rather led to some confusion and uncertainty with respect to standards of professional conduct. Without going into the details of this specific case, the following is provided in a effort to clarify the issues raised by this article.

Members consistently asked the same questions:
Does this mean that if I,

- *a) give my client taxi fare, or*
- *b) allow a client to return to my office after the conclusion of his/her regular session, or*
- *c) rub an upset client's shoulders in an effort to console him/her, or*
- *d) share my lunch with a client, or*
- *e) allow my client to use the telephone in my office,*

I will be guilty of professional misconduct in the eyes of the College?

Each of these questions was usually followed by a number of examples of situations in which the member felt it would be quite appropriate to act in the manner indicated.

The answer to these questions cannot be a simple *Yes* or *No* but rather, must be *Maybe*, dependent upon the client and the situation. The issue at hand is that of **Client/Therapist Boundaries**. The question to be asked is not whether a particular behaviour, in isolation, is an act of professional misconduct but rather **whether the practitioner violated the professional boundary** in the course of involvement with the client. The answer to this question is very complex and dependent upon many factors.

The Health Professions Procedural Code is very clear with respect to boundary violations involving sexual abuse where;

"sexual abuse" of a patient by a member means,

- *(a) sexual intercourse or other forms of physical sexual relations between the member and the patient,*
- *(b) touching, of a sexual nature, of the patient by the member, or,*
- *(c) behaviour or remarks of a sexual nature by the member toward the patient.* (Code 1.3)

"Sexual nature" does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided. (Code 1.4)

It is clear that boundary violations involving sexual abuse are always unacceptable and there is zero tolerance for such behaviour within the profession.

There are other forms of behaviour however, which may or may not be considered boundary violations dependent upon a variety of factors. As a member asks, *Does this mean that if I [insert one of the above examples, a-e], I will be guilty of professional misconduct in the eyes of the College?* they must carefully consider many factors which include, but are not limited to: the nature of their relationship to the client; client characteristics that might affect interpretation; the difficulties and/or vulnerabilities of the individual client; the significance of the behaviour; the type of therapy being provided; the circumstances in which the behaviour occurs; and, the reason for the behaviour.

There are circumstances when some behaviours are reasonable and appropriate. There can also be situations and clients with whom similar behaviour would be contraindicated. The task for each member is to evaluate each situation and act in a manner consistent with good clinical judgement and standards of professional conduct. Such an evaluation must respect the particulars of each professional relationship and take into account how the behaviour may be interpreted by each client.

It is not necessarily a specific action, in isolation, that is inappropriate. Rather, it is the actions of the member, within the total context of the client/therapist relationship, that are significant and that may be viewed by the client and by the College as violating appropriate therapist-patient boundaries.

The topic of boundaries and potential boundary violations is very complex. The Client Relations Committee is prepar-

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ing an information brochure pertaining to this very important subject. The brochure will further elaborate on the issues raised in this article and provide additional assistance to members in understanding and evaluating potential boundary violations.

If you have any questions about the issues raised in this article or other matters pertaining to issues of an ethical nature, standards of professional conduct or guidelines of professional practice, please feel free to call Dr. Rick Morris, Director of Professional Affairs at the College.§

Complaints Committee Report

There were fourteen cases on the Complaints Committee's agenda for its September 16, 1996 meeting. The panel dealt with nine new cases and two re-investigations that had been referred back to the Committee by the Health Professions Board. The Committee also dealt with the following types of cases: one case where it was asked only to consider whether a complaint fell within its jurisdiction and mandate, one case where the Committee was asked whether or not it was willing to confirm the decision of a previous panel where a jurisdictional issue had arisen which prevented the previous panel from issuing its decision, and one case where there had been an ongoing process of alternative dispute resolution.

Disposition of Cases

The following summary describes the disposition of these cases:

> In eight cases, the Committee dismissed the complaint.
>
> In three cases, the Committee issued a written caution to the member.
>
> In one case, the Committee drafted an oral caution to be delivered to the member at the behest of the Health Professions Board.
>
> In one case, the Committee determined that it was within its jurisdiction and mandate to investigate the concerns raised by a third party complainant.
>
> In one case, the Committee determined that a final proposal for resolving the matter should be made to the member in the alternative dispute resolution process.

Nature of Cases

The following summary provides a brief description of the nature of these cases:

In one case the Committee considered only the issue of its jurisdiction and mandate to investigate a third party complaint (i.e., a complaint raised by someone other than the individual who actually received the psychological services from the member).

Two cases dealt with the adequacy of the procedures employed to carry out psychological assessments of sexual offenders, including whether adequate consent was obtained.

Two cases dealt primarily with the issues of obtaining consent to treatment and the release of information in the context of assessments of children where one parent has custody and the other has access.

One case dealt with the issue of whether the procedures utilized and the report prepared in the context of a neuropsychological assessment met professional standards.

Two cases involved reinvestigations of previous complaints where the Health Professions Board ordered the Complaints Committee to reconsider certain issues.

One case dealt with the adequacy of the procedures and report produced in the context of a custody and access assessment.

One case dealt with a determination of the appropriate resolution of a complaint that was being dealt with through a process of alternative dispute resolution.

One case dealt with the adequacy of the procedures utilized and the report prepared with respect to a psychological assessment and with the issue of the release of a clinical record held by a hospital.

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Two cases dealt with the issue of whether or not the procedures followed in carrying out an independent psychological assessment in the context of an insurance claim were in compliance with professional standards.

One case dealt with the issue of whether a member properly handled a request received over the phone for psychological services.

Note: In each case where the Complaints Committee investigates a complaint, the member and the complainant receive a written Decision setting out the Committee's findings and the reasons for the Committee's findings. However, as complaints are confidential, no information about a complaint or about the Committee's decision with respect to a complaint can be provided to anyone other than the member and the complainant. The College therefore regrets that it cannot respond to requests for further details with respect to any of the above cases.§

Report of the Complaints Committee Task Force, February 1997

In June, 1995, Council struck a Task Force to examine the entire complaints process and to develop policies and procedures to assist in the investigation and resolution of complaints. The members were Dr. Nina Josefowitz (Chair), Dr. Margaret Hearn, Dr. John Goodman, Ms. Marilyn Norman (Public Member), Ms. Susan Brooks (College staff), Ms. Claire Barcik (College staff) and Ms. Nancy Ferguson (College staff). Ms. Monica Zeballos-Quiben has been providing greatly appreciated administrative support to the Task Force. We would like to take this opportunity to describe the work we have accomplished.

Under the *Regulated Health Professions Act* (*RHPA*), the mandate of the Complaints Committee is to protect the public by investigating complaints by members of the public or the profession. The Task Force defined public protection as ensuring that members of the profession were practising competently. Thus the emphasis is on education and remediation.

1. Outline of the Complaints Process

We developed a flow chart, which we have included in this volume of the Bulletin, which outlines the complaints process and identifies the Committee's options in resolving a complaint. We initiated a problem-solving first step referred to in this chart. This involves informing the complainant that an informal resolution process exists. Part of developing the flow chart outlining the complaints process included developing a document containing guidelines as to which type of outcome (i.e., dismiss, dismiss with advice, caution etc.) may be appropriate in relation to a member's alleged breach of ethics and standards. The flow chart we have developed which describes these guidelines entitled "Complaints Decision Making" will be included in an upcoming issue of the Bulletin.

2. Alternative Dispute Resolution

The Task Force focused a great deal of attention on the use of Alternative Dispute Resolution (ADR) and developed a number of options for resolving complaints where the Committee has concerns about the conduct of the member, with a view to ensuring that only the most egregious cases are referred to the Discipline Committee.

In particular, the Complaints Committee now frequently uses Letters of Concern in cases where the Complaints Committee has serious concerns about a member's conduct, but is of the view that the appropriate solution is remediation or education. In a Letter of Concern, the Complaints Committee identifies its specific concerns regarding the member's conduct and requests an undertaking from the member that is designed to address the concerns. Examples of undertakings include: peer consultation; further training and/or education; supervision of the member with reports to be provided by the supervisor; or an agreement not to practise in a certain area until competence can be demonstrated in that area. If the member agrees to provide certain undertakings, a caution is issued. The caution will be included the decision of the Complaints Committee which is provided to both parties. The College staff monitors the situation to ensure that the member fulfils the undertakings. As well, the Complaints Committee now has the flexibility to consider the facts of each particular case in determining the manner in which information about the undertaking should be provided to the public (i.e. how it should appear on the public Register and how it should be conveyed to clients) in order to ensure that the public is protected and to ensure fairness to the member.

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If a member refuses the resolution suggested by the Complaints Committee, the Complaints Committee reconsiders the case and must decide if it wishes to refer the allegations to Discipline Committee or take other actions (e.g., issuing a caution).

The Task Force also recommended that mediation be used in appropriate cases. The Task Force developed guidelines to assist the Complaints Committee in determining which cases should be referred to mediation, an "Agreement to Mediate" form which will be provided to the member and the complainant, and procedures to be followed by the Complaints Committee and College staff with respect to complaints where mediation is attempted.

3. Investigation Structured Around Issues Raised By Complainant

The Task Force noted that, under the RHPA, an investigation of a complaint must be structured around the specific issues raised by the complainant. The Task Force decided that if, in the course of the investigation, the Complaints Committee has concerns that were not raised by the complainant, the Committee has two options. Option A: If the concerns are of a minor nature, the Committee can, in its written decision, note the concern and recommend that the member change his or her practice. Option B: If the concerns are of a more serious nature, the Committee must refer the concerns to the Executive Committee. The Executive Committee will advise the member of the concerns and provide the member with an opportunity to respond to the concerns. This is a new policy. At present there have not been any referrals to the Executive, thus we cannot report on how the policy is actually working.

4. Policy and Procedures Manual

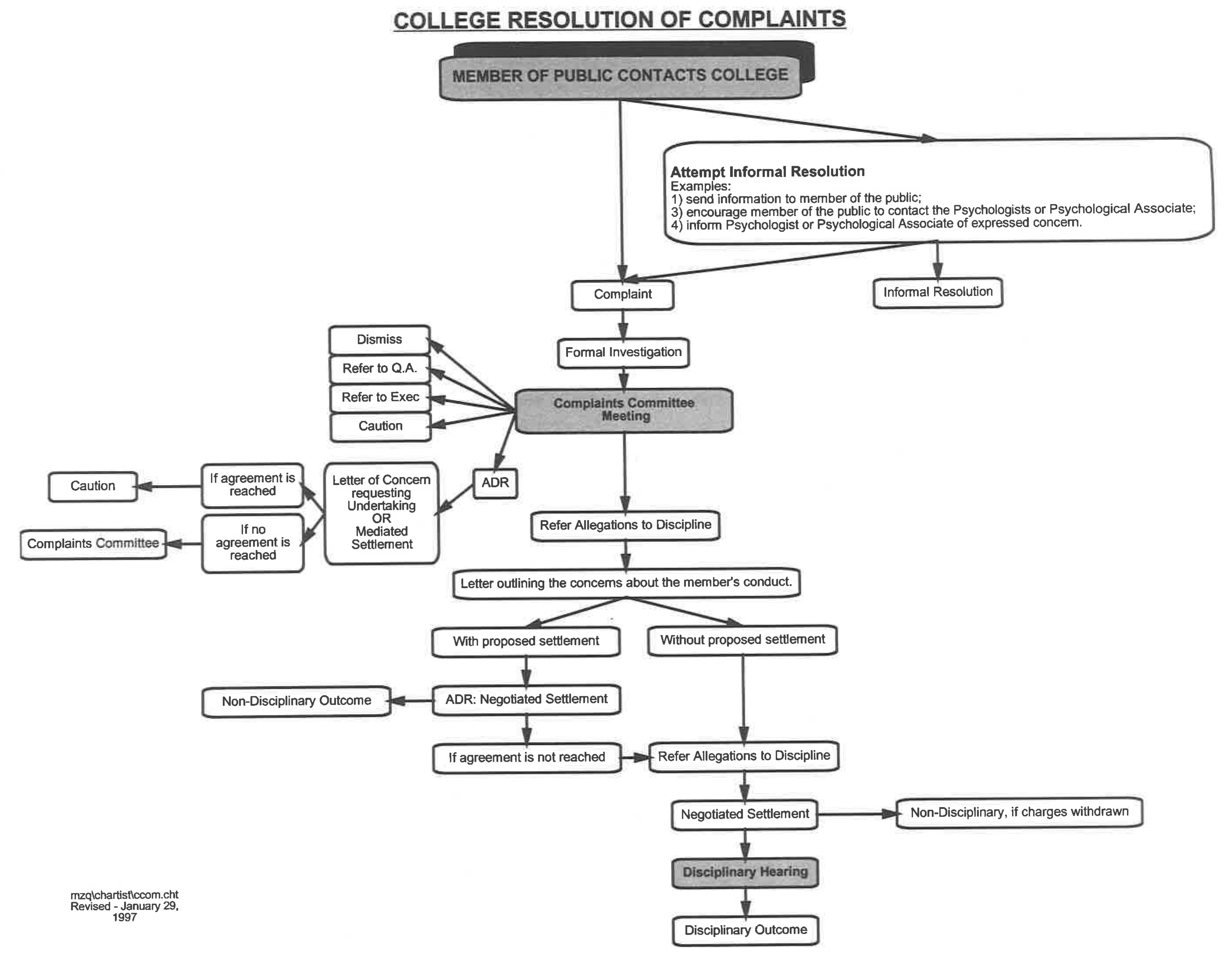
A policy and procedures manual was developed pertaining to the investigation and resolution of complaints. Some of these policies are internal administrative policies that are mainly relevant to the internal administration of the Complaints Committee, such as the duties of the Chair of the Complaints Committee and procedures for voting at Complaints Committee meetings. A number of the policies deal with the procedure for investigating complaints and directly affect members of the College. All policies that directly affect members have been or will be published in the Bulletin. If members are interested in obtaining copies of specific policies, please contact Ms. Monica Zeballos - Quiben at the College. If you request a number of documents, there may be a charge to cover the photocopying costs.

One of the policies developed relates to the use of similar fact evidence. This policy was required by the Health Professions Board and was described in detail in the September 1995 issue of the Bulletin. If the Complaints Committee issues a caution or refers a matter to Discipline, the case will be brought to the attention of a future Complaints Committee in the case where the member is the subject of another complaint and this subsequent complaint meets the requirements of similar fact evidence as set out in the policy.

5. Explaining the Complaints Process

The Task Force was concerned that the complaints process be easily understood by members as well as the public. We published a number of articles in the Bulletin describing the complaints process. In addition, we now have a regular column in the Bulletin describing the types of cases and the disposition. We have developed two documents that explain the complaints process and which are sent to all complainants and members who are the subject of a complaint. One is a short hand out entitled "The Most Common Questions About Lodging a Complaint". The second is a comprehensive document entitled "The College's Procedures for Investigating Complaints". The goal of the second document is to explain fully the process. If you would like a copy of either document, please contact the College or see our web page.

The Task Force is continuing its work and the present members are Dr. Nina Josefowitz (Chair), Dr. Judith Van Evra (Chair of the Complaints Committee), Dr. John Goodman (President of the College Council), Ms. Susan Brooks (Assistant Registrar: Complaints & Discipline); Ms. Claire Barcik (Investigator: Complaints & Discipline); and Ms. Nancy Ferguson (Investigator: Complaints & Discipline). We would appreciate your comments on any aspect of the complaints process. Please send your written comments to Dr. Nina Josefowitz care of the College.§


COLLEGE RESOLUTION OF COMPLAINTS
MEMBER OF PUBLIC CONTACTS COLLEGE
Attempt Informal Resolution
Examples:
1) send information to member of the public;
3) encourage member of the public to contact the Psychologists or Psychological Associate;
4) inform Psychologist or Psychological Associate of expressed concern.
Informal Resolution
Complaint
Formal Investigation
Complaints Committee Meeting
Dismiss
Refer to Q.A.
Refer to Exec
Caution
ADR
Letter of Concern requesting Undertaking OR Mediated Settlement
If agreement is reached
If no agreement is reached
Caution
Complaints Committee
Refer Allegations to Discipline
Letter outlining the concerns about the member's conduct.
With proposed settlement
Without proposed settlement
ADR: Negotiated Settlement
Non-Disciplinary Outcome
If agreement is not reached
Refer Allegations to Discipline
Negotiated Settlement
Non-Disciplinary, if charges withdrawn
Disciplinary Hearing
Disciplinary Outcome
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Revised - January 29, 1997

COLLEGE HIGHLIGHTS

Psychological Associate Registration under the Transition Provisions: The End is Near

Enclosed you will find an insert describing the registration opportunities for persons trained at the master's level in psychology and for those with equivalent graduate training in psychology. For the latter group, the window of opportunity to be registered as Psychological Associates will soon close. Please post, copy, and distribute the sheet of information to any persons you believe may have some graduate level training in psychology. This notice will also be sent to various Ministries and their agencies where individuals with master's or equivalent training in psychology may be employed.

Conflict of Interest Regulation

Thank you to those members who provided their thoughtful comments on the draft conflict of interest regulation. This feedback will be provided to Council for their consideration at the meeting of March 21 and 22, 1997.

Survey on Delegation of the Controlled Act of Diagnosis

Thank you to all 680 members who took the time to respond to the survey on delegation of the controlled act of communicating a diagnosis. This was an exceptional rate of return for a survey. The results have been entered into a database and will be analyzed in time for the next Executive Committee meeting in May. It is anticipated that summary data will be provided to the Council and published in the Bulletin in June.

Barbara Wand Symposium, 1997

Attendance at this year's Barbara Wand Symposium on ethical and legal issues relating to psychological records exceeded 400, nearly one-fifth of the profession. Many thanks to all of the participants. Copies of the video tapes of the Symposium are still available from Audio Archives. If you prefer, audio tapes are also available. An order from is included as an insert to this issue of the Bulletin. Member comments on the Symposium would be welcomed and would assist in the planning of future educational programs.

Red Tape Reduction Act, 1997

The Red Tape Reduction Act, 1997 was introduced in the legislature on February 3, 1997. The Bill would amend the RHPA to move a number of regulation making authorities into by-law making authorities for such procedural matters as College committee composition, appointment of non-Council members to committees, fees, and elections. The Psychology Act would be amended to reflect those changes from regulations to by-laws. Other changes include an amendment to authorize the Registrar of a College to refuse to allow a person to obtain a member's business address and telephone number if the member's safety may be jeopardized. There are also some clarifications relating to the complaints process and provision to merge the Health Professions Board with another review board to form the Health Professions Appeal and Review Board. Printed bilingual copies of the Bill are available from Publications Ontario. §

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