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

COMMUNICATION OF A DIAGNOSIS: A CONTROLLED ACT IN PSYCHOLOGICAL PRACTICE

In September 1995, the Council of the College of Psychologists of Ontario approved for distribution to the membership the consultation paper entitled, *Diagnosis and Delegation: The Controlled Act in Psychological Practice, Discussion Paper and Proposed Guidelines*. This discussion paper was developed to address issues which had arisen with respect to diagnosis and delegation since the introduction of the Regulated Health Professions Act, 1991 (RHPA). The *Discussion Paper* and the limited members' response to it were discussed by the Council at subsequent meetings and work continued on these issues through the spring of 1996.

At the June 1996 meeting, Council reviewed the extensive work done to date and issued the *College Advisory on Communication of a Diagnosis*. This *Advisory* represented College policy on diagnosis and delegation and superseded all previous information distributed on this topic.

Following the distribution of the *College Advisory on Communication of a Diagnosis*, the College received considerable feedback from members, generally pertaining to one of three main issues:

i) the College policy requiring that the communication of a diagnosis be performed personally by the authorized member of the College;
ii) uncertainty with respect to the distinction between communicating a diagnosis and providing feedback from an evaluation;
iii) misinterpretation of the *Advisory* to suggest the College did not consider learning disabilities to be a diagnostic category.

The Council continued to study these issues respecting the communication of a diagnosis taking into account the input of members and the public. At its meeting of March 1997, Council clarified the *Communication of a Diagnosis: A Controlled Act in Psychological Practice: Statutory Requirements and Policy of the College of Psychologists of Ontario*.

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President's Report

Mission

To serve the public interest by ensuring that psychological services in Ontario are effective, safe and accessible.

For the first time in its 37-year history the Regulatory body for psychology in Ontario has a Mission statement. Though still in draft form, the statement embodies the goals and aims of the College. This statement came out of the strategic plan which was developed last July. The strategic plan is currently in the final phases of a consultation process with members and a number of stakeholder groups. Another very important outcome of the plan was the finding that *engagement and involvement of members of the College* was one of the most important success factors in having the College achieve its vision for the year 2000. Member and stakeholder input has already been critically constructive and continued comment is welcomed. In fact, all correspondence to the College on this or other issues is seriously reviewed by College staff and all correspondence on matters of substance is provided to the entire Council. We do want to hear from you.

The operational review carried out by Transitions: HOD Consultants Inc, is also proceeding on time and some of the findings should be available by the time of the Barbara Wand Symposium. All of the Colleges policies and procedures have come under careful and close scrutiny and have included those areas of the complaints and discipline process that have presented concerns for complainants and members.

The Survey on Delegation of the controlled act has been completed with a high level of member participation. The College received 688 responses to the questionnaire, along with over two hundred written comments. The most pertinent finding is that of 64 Psychological Associates who sought delegation, 62 obtained it. While members were, for the most part, abiding by the Standards respecting delegation, it was abundantly clear that neither Psychologists nor Psychological Associates liked the process. It might be more accurate to say both groups disliked it. In order to bring a resolution to this long-standing issue, the Professional Relations Branch of the Ministry of Health arranged a meeting with OPA, OACCPP and the College on December 2, 1997. The College emerged from that meeting with the charge of developing a plan of resolution by mid-February, 1998. The College was further charged with the task of developing a criterion-based measure that, if met, would allow the Registration Committee to grant individual Psychological Associates access to the Controlled Act. Again, we welcome your comments on this endeavour.

Initiatives to foster and enhance relationships with government continue. A meeting with the Hon. Janet Ecker, Minister of Community and Social Services, is in the final planning stages, and a meeting with the Hon.Elizabeth Witmer, Minister of Health, is set for January 12, 1998.

A great deal has been accomplished in 1997, yet as I head toward the end of my term on Council, it feels very frustrating for me to see the huge effort expended by Council, staff and numerous volunteers and yet to realize that in many ways the perception of members has not changed. I am hopeful that, as concrete examples of our efforts reach the members, we will begin to build the collegial atmosphere so essential to serving the public interest. Psychologists and Psychological Associates are nurturant people—either by bent or desire, and with continued efforts we will achieve a more collaborative endeavour to serve the public interest.

See you at the Barbara Wand Symposium, February 18, 1998.

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

COLLEGE HIGHLIGHTS

Strategic Plan

A number of members of the College responded to the College's invitation to comment on the draft strategic plan. As time was short for responding prior to the December Council Meeting, member responses will continue to be accepted until mid January. The Strategic Planning committee who participated in the conference last summer will review all submissions and prepare a report for the Executive Committee of the College which will meet in early February. General response to the strategic plan was favourable, with suggestions being made for refinement.

Organizational Review

Several members of the College have been contacted in connection with the organizational review being carried out on the College's operations. The consultants provided an interim report to Council at its December meeting, and will be providing a final report with recommendations in early February.

Written Jurisprudence Exam

The College field-tested a written Jurisprudence exam on October 8, 1997. After analysis of the results of the examination, a new draft examination will be prepared with a smaller number of items, for field testing in April,1998

Regulation on the Register

The Council of the College has directed that a regulation be drafted to supplement provisions already in the RHPA identifying information to be kept on the register of the College and designating which information is available to the public. Member suggestions are welcome. After a draft regulation has been prepared and reviewed by Council, the regulation will be circulated for further member comment.

RHPA: 5 Year Review

The Health Professions Regulatory Advisory Council will be conducting a review of the effectiveness of the Regulated Health Professions Act and the appropriateness of its various provisions. The College has struck a committee to begin preparing a submission to this review. Members are encouraged to provide their thoughts to the College to inform development of the College's submission. The College may also canvass some members for their views on specific provisions in the RHPA.

Duty to Warn

Several members provided thoughtful responses to the College's consultation on a proposed standard on Duty to Warn. The comments of members, the final report from the Institute for Clinical Evaluative Studies, current case law and steps being taken by other professions were considered by the Council in December. A committee has been struck to make a further recommendation to Council which may include revised wording for a standard on the Duty to Warn. Additional submissions received from members during December and January will be forwarded to the committee for consideration.

Quality Assurance Program

The College's proposed regulation on Quality Assurance has not yet received approval from the government. In the meantime, work continues on the development of the Self-Assessment Guide and on the Peer Assisted Review. There will continue to be focus groups around the province to inform members about the program and to respond to any inquiries. §

COMMUNICATION OF A DIAGNOSIS: A CONTROLLED ACT IN PSYCHOLOGICAL PRACTICE

Statutory Requirements and Policy of the College of Psychologist of Ontario
December 1997

INTRODUCTION

Since the proclamation of the Regulated Health Professions Act, 1991 and the Psychology Act, 1991 on December 31, 1993, there has been considerable discussion throughout the profession regarding the effects of this legislation on the practice of psychology in various work settings. In particular, the inclusion within the statute of the controlled act of Communicating a Diagnosis, has caused confusion with respect to the limitation it places on unregulated individuals who, prior to the RHPA, provided assessment and diagnostic services.

This policy statement addresses the question of what constitutes the controlled act and who may perform it. It also provides some direction regarding what constitutes "diagnosis" and its communication within settings where many psychological services have traditionally been provided by non-registered individuals under the supervision of a psychologist.

The mandate of the College of Psychologists of Ontario is to act in the interests of the public by ensuring that members are appropriately qualified and competent, and that the ethics and standards of the profession are consistently applied and upheld. The College and the public rely on the professional judgement of individual members, as well as on the expectation that members will act in accordance with the legislation, regulation, standards and guidelines of the profession. It is the responsibility of members to ensure they are familiar with the relevant legislation governing not only the profession as a whole, but also the particular setting in which they work.

RELEVANT LEGISLATION, REGULATIONS, STANDARDS AND GUIDELINES

Controlled Acts in Psychology under RHPA

The RHPA, its regulations and the discipline-specific acts permit controlled acts to be performed only by members of specifically authorized Colleges. Members of the College of Psychologists of Ontario are authorized to perform two controlled acts: *communication of a diagnosis (Psychology Act 1991) and applying electricity for aversive conditioning (O. Reg. 107/96).* These are two of the 13 acts that have been given a special status within the legislation as they are deemed to carry substantial risk of harm if improperly performed.

The controlled act of communicating a diagnosis, permitted to members of the College of Psychologists of Ontario, is defined in subsection 27(2)(1) of the RHPA as:

> **Communicating** to the individual or his or her personal representative **a diagnosis identifying a disease or disorder** as the cause of symptoms of the individual **in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.**

If all elements as highlighted are present, this controlled act is considered to have been performed.

The legislation refers specifically to communicating the diagnosis to the "individual or his or her personal representative". Individual practitioners are responsible for ensuring the client has authorized a third party to act as his or her personal representative, unless this is otherwise specified by law. It is particularly important that members be aware of the provision for consent under the Health Care Consent Act, 1996 in determining to whom the diagnosis may be communicated. It should be noted that another professional and/or a multidisciplinary team does not fit the definition of "client" for this purpose.

Definition of the Controlled Act within the Psychology Act

Under the Psychology Act, 1991,

> The practice of psychology is the assessment of behaviourial and mental conditions, the diagnosis of neuropsychological disorders and dysfunctions and psychotic, neurotic and personality disorders and dysfunctions and the prevention and treatment of behaviour and mental disorders and dysfunctions and the maintenance and enhancement of physical, intellectual, emotional, social and interpersonal functioning. (Section 3)

While the controlled act is defined in general terms within the RHPA, the Psychology Act is specific with respect to authorization. Section 4 provides that:

> In the course of engaging in the practice of psychology a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to communicate a diagnosis identifying, as the cause of a person's symptoms, a neuropsychological disorder or a psychologically-based psychotic, neurotic or personality disorder.

The formulation of a diagnosis is usually made in the course of a psychological assessment that takes the observations of an individual's strengths and weaknesses further to identify and integrate causes, antecedents and determinants in such a way as to provide a psychological interpretation consistent with an accepted nomenclature and associated body of knowledge and research.

The controlled act is considered to have been performed when such a diagnosis is communicated according to the conditions described in the RHPA, subsection 27(2)(1), as quoted above. Therefore, a diagnosis, as defined in the Acts, formulated in the course of practice may not be communicated to a client or his or her personal representative except by a member of the College authorized to do so.

WHO MAY PERFORM THE CONTROLLED ACT?

Controlled acts are deemed to carry a substantial risk of harm if improperly performed. Therefore, the RHPA has placed strict limitations as to who may perform the controlled acts. Under Section 27(1) of the RHPA,

> No person shall perform a controlled act set out in subsection (2) in the course of providing health care services to an individual unless,
>
> (a) the person is a member authorized by a health profession Act to perform the controlled act; or
>
> (b) the performance of the controlled act has been delegated in accordance with section 28 to the person by a member described in clause (a).

A Memorandum of Agreement was signed in 1991 by the Ontario Board of Examiners in Psychology, the Ontario Psychological Association, and the Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists. It was agreed that performance of the controlled act would be limited to those entering registration through doctoral level preparation and using the title, *Psychologist*. The possibility also was raised that qualified psychological associates might seek the authority to communicate psychological diagnoses should an appropriate mechanism be established.

With respect to psychologists, it is important to note that the controlled act may only be performed by those who have no limitations on their certificate of registration with respect to communication of a diagnosis and who have the appropriate training and experience to communicate specific diagnoses competently.

With respect to psychological associates, the College has approved Standards of Professional Conduct and Guidelines respecting the delegation of the authority to perform the controlled act by a psychologist to a psychological associate. These include the requirement of a signed delegation agreement between the psychologist and the psychological associate. A copy of the signed delegation agreement must be forwarded to the College. A sample delegation agreement was published in the Bulletin in December 1994.

The psychologist's accountability concerning a delegation agreement rests solely in following the Standards of Professional Conduct and Guidelines to ensure the appropriateness of the delegation. Once the agreement is signed, the psychological associate, as an autonomous member, is entirely accountable for all aspects of her or his professional services. The accountability for the psychologist in delegatory arrangements is very limited and specific, in contrast to supervisory arrangements with unregulated providers in which accountability is global in all respects.

It is essential to note that no controlled act may be performed by or delegated to an unregulated provider. The one exception to this, allowed by the legislation, pertains to a supervisee who is in the course of fulfilling the requirements to become a member of the profession, that is, those individuals who have been admitted to the Temporary Register of the College.

PERSONAL COMMUNICATION OF A DIAGNOSIS BY AUTHORIZED MEMBERS ONLY

The proposed regulation on delegation approved by the Council, as well as the Standards of Professional Conduct and the Guidelines of the College, permit delegation only to another member of the College. Delegation to unregulated persons who are under the supervision of a member of the College is not permitted.

The historical reliance on unregulated providers to provide assessment and diagnostic services within institutional set-

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tings does not fit well with the RHPA's principles of health care providers being registered with a College and all that entails in terms of training, standards of practice, continuous learning and accountability. The Council is well aware of the concerns of some members who work in settings in which a significant amount of service is provided by supervised, unregulated staff. Council believes however, that it would not be in the public interest to support any activity which can be construed as the performance of the controlled act by an unregulated provider, as this is not permitted under the RHPA.

It is the policy of the College of Psychologists of Ontario therefore that **where a diagnosis is to be communicated, the authorized member should be present, properly apprised of all important aspects of the case, and personally communicate the diagnosis**. In this way, the client relying on the information has a true professional relationship with the member and not solely with a supervised, but unregulated, provider.

It is expected that the member communicating the diagnosis will be able to respond directly to the individual receiving the diagnosis with respect to information about the disorder, including etiology, differential diagnoses, signs and symptoms, prognosis, and the various interventions and treatments available, and that the member will be available to respond to any further questions that the individual may have. It is important to note that information must be given in such a manner as to be readily understood by the individual receiving the communication.

TRANSITIONAL IMPLEMENTATION PHASE

The Council recognizes that some settings will have difficulty implementing personal communication of diagnoses, where traditionally, a significant amount of service has been provided by supervised, unregulated staff. Therefore, Council has approved a three-year transitional implementation phase to allow members, within these settings, the time to revise their policies and practices with respect to the use of unregulated providers. The transition period will be in effect until **September 1, 2000** after which time, the College will enforce the provisions which require that a diagnosis be communicated personally by authorized members of the College. The transition period only applies to situations in which unregulated staff are supervised by a member of the College. The College will continue to enforce the RHPA in other situations where unregulated providers are performing the controlled act.

During the transitional phase, a comprehensive process for communicating a diagnosis must be established in settings where the controlled act is not being performed personally by a psychologist, or psychological associate with appropriate delegation. This is in addition to the requirements already in place as outlined in the Standards of Professional Conduct and the Guidelines of the College, including the Standards and Guidelines for Delegation and the Guidelines for Supervision of Non Registered Personnel. The process for communicating a diagnosis where supervised unregulated providers are involved must include:

1. The supervising member of the College will take all reasonable steps to be present to communicate in person to the client or his or her personal representative any diagnosis formulated in the course of a psychological assessment. In this circumstance, the member will be thoroughly familiar with the background and assessment information and will make clear the roles of the individuals involved in the assessment process.

2. In situations where a psychological diagnosis is formulated by a member without delegation or by an un regulated provider in the course of an assessment, but where it is impossible for the supervising member of the College to be present in person to communicate the diagnosis to the client or his or her personal representative, the supervising member will thoroughly review the assessment.

   The diagnosis, along with supporting information and recommendations for further assessment or follow up, will be clearly outlined and integrated into a psychological report. The written report, containing the signature and title of the supervising member and indicating the names and qualifications of those involved in the preparation of the report, will be signed by the supervising member prior to any communication of the diagnosis to the client.

   The report may then be given to the client or his or her personal representative by the individual who conducted the assessment who will interpret the report and recommendations.

3. Upon request, the supervising member of the College will make herself or himself available to the client or his or her personal representative receiving the communication of any diagnosis in order to respond to questions and to provide further clarification or information as required. This will be clearly indicated in any written report or at any oral feedback session.

The steps noted above are provided for members who work in settings in which the transitional implementation phase is nec-

essary due to an insufficient number of providers who are authorized to perform the controlled act. During the three-year transition period, a concerted effort should be made by institutional settings and members to bring all eligible providers into regulation or to hire staff who are registered.

CRITERIA FOR DIFFERENTIATING BETWEEN COMMUNICATION OF A DIAGNOSIS AND FEEDBACK

Given the requirements of the RHPA, it is imperative that a distinction is made between communicating a diagnosis which must be done in person by an authorized member of the College, and feedback, which may be given by unregulated providers.

Criteria for Communication of the Controlled Act

Communication of a diagnosis goes beyond a description of procedures, functioning and management recommendations or intervention strategies as a diagnosis carries substantial risk of harm to the client if not performed accurately. The communication of a diagnosis **involves identifying a disorder or dysfunction** for the client or his or her personal representative, as the **cause** of the individual's symptoms or difficulty. The diagnosis usually falls within a recognized classification system of disorders and dysfunctions such as ICD10 or DSM-IV. The diagnosis carries with it a high level of certainty based upon appropriate assessment techniques such as history taking, standardized testing and/or clinical interviews relevant to the symptoms presented by the client in a way that the exclusion of alternate diagnoses is also possible. The communication of the diagnosis is made to the client or his or her personal representative within the context of a professional relationship in which it is likely that the client will rely upon the information.

Information provided to an individual or his or her personal representative resulting from an evaluation may not always be considered communicating a diagnosis. Under the RHPA, it is explained that an individual is not considered to be performing the controlled act:

> with respect to a communication made in the course of counselling about emotional, social, educational or spiritual matters as long as it is not a communication that a health professsion Act authorizes members to make [Subsection 29(2)].

Learning Disability As Psychological Diagnosis

The finding of a *learning disability* is a psychological diagnosis when this term is used to identify the cause of a set of symptoms exhibited by an individual. As with other diagnoses, the determination of a *learning disability* involves quantitative and qualitative information gathering through which the individual's presenting symptoms are categorized within a diagnostic classification system such as DSM-IV, ICD10 or other generally accepted definition or categorization system. The diagnostic use of the term *learning disability* is in contrast to the same or similar terms commonly used to describe an individual's educational or academic performance without suggesting a diagnostic classification as the cause of the difficulty. When the result of the evaluation concludes that the cause of an individual's difficulty is a *learning disability*, communication of this diagnosis is a controlled act under the RHPA and may be performed only by those authorized to do so under the law.

Criteria for Providing Feedback from an Assessment

Non-diagnostic feedback is a process of providing information on assessment results and outcomes, gathered from a variety of sources. These sources may include testing, interviews with client or other informants, and professional judgment. Feedback may include a description of the procedures used in carrying out an assessment, identification of personnel who were involved, such as psychometrists or other unregulated providers, and a description of their roles. A feedback session usually includes a general description of the test performance and/or the information that was gained in the clinical or counselling interviews or through behavioural observation. It may include recommendations for interventions to alter behaviour or to reduce the presenting problems, or a referral for further assessment. If the feedback is to include reporting of test results, one must be cautious not to inadvertently communicate a diagnosis. For example, to tell a client that he or she performed in the high range on a variety of tests measuring depression or attention deficit, or in the intellectually deficient range on a measure of intelligence could readily be construed by the client as providing a diagnosis. Similarly, to inform a client that his or her assessment performance is *consistent with* or *suggestive of* depression or attention deficit for example, can readily be interpreted by the client as diagnostic statements which identify the disease or disorder as the cause of his or her symptoms.

In providing feedback, the problem may be described, but no diagnosis of a disease or disorder is identified as the cause of the symptoms.

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No classification, formulation or causal statement is provided.

Examples of feedback may include:

- describing a child's academic achievement or problems (e.g., present vs. expected reading level) or a client's cognitive, linguistic, social, emotional or other behaviour functioning (strengths and weaknesses);
- discussing or recommending classroom or program modifications, academic interventions, behavioural strategies or teaching styles;
- reiterating a diagnosis already communicated to the client or his or her personal representative by an authorized health professional. Confirming or restating a diagnosis, based on one's own evaluation, would be construed as communicating a diagnosis.
- communicating opinions to other colleagues in team meetings, IPRC meetings, etc., where the client, or his or her personal representative, is not present. It should be noted that unless the team/IPRC member is authorized under the law to perform the controlled act, he or she cannot convey the diagnosis discussed at the team/IPRC meeting to the client, or his or her personal representative, unless this has already been done by a legally authorized health care professional.

PENALTIES FOR PERFORMING A CONTROLLED ACT WITHOUT AUTHORIZATION

Under the RHPA:

> Every person who contravenes subsection 27(1) . . . is guilty of an offence and on conviction is liable to a fine of not more than $25,000 or to imprisonment for a term of not more than six months, or to both. [Subsection 40(1)]
>
> Every person who procures employment for an individual and who knows that the individual cannot perform the duties of the position without contravening subsection 27(1) is guilty of an offence and on conviction is liable to a fine of not more than $25,000. [Section 41]
>
> The employer of a person who contravenes subsection 27(1) while acting within the scope of his or her employment is guilty of an offence and on conviction is liable to a fine of not more than $25,000. [Subsection 42(1)]

SPECIAL APPLICATION: Education

This section presents information related to the controlled act primarily of interest to those whose practice includes educational, learning or school psychology.

The Controlled Act of Communicating a Diagnosis under the Psychology Act and the Identification of Exceptional Pupils by the Identification Placement Review Committee (IPRC) under the Education Act.

The Education Act, R.S.O. 1990, defines an Exceptional Pupil as:

> a pupil whose behaviourial, communicational, intellectual, physical or multiple exceptionalities are such that he or she is considered to need placement in a special education program by a committee of the board,

For the purpose of identification under the Education Act, the exceptionalities of pupils are set out by exceptionality groupings, specific exceptionality identifications, and specific exceptionality definition.

These Exceptionality Groupings and Exceptionality Identifications are used by an IPRC for the purpose of identifying those pupils who require special education placements. Under the Education Act, the IPRC may identify pupils under these Exceptionality Groupings and Exceptionality Identifications and communicate this information to the Exceptional Pupils or their parents, guardians or personal representatives, in circumstances where it is reasonably foreseeable that the pupils, parents, guardians or personal representatives will rely upon the identification. By doing so, members of the IPRC are not performing the controlled act of communicating diagnoses which falls within the Psychology Act but rather providing an identification solely for educational placement purposes.

By informing the parents or student that the student has been identified as Exceptional, the IPRC is not communicating a diagnosis but rather only indicating an educational placement category. Parents and students should be made aware of this. If a diagnosis is required or desired, the individual should be referred to a member of the College authorized to communicate a diagnosis.

To come to the conclusion that a pupil may be categorized under an Exceptionality Grouping or Exceptionality Identification, the IPRC relies on a wide variety of information provided by the pupil's parents, teachers and other professionals

who have assessed the pupil. Where a psychological assessment is provided, the IPRC may rely upon a description of the pupil's characteristics or a psychological diagnosis provided in the psychological report in determining a pupil's Exceptionality Identification. The IPRC may also rely on descriptions of the pupil's characteristics and disorders provided by other professionals such as physicians, speech-language pathologists, physiotherapists, etc.

Normally, the outcomes of psychological assessments, including any psychological diagnoses, have been communicated to the pupil or his or her parents, guardians or personal representative prior to the IPRC meeting because of the implications of potential harm and the right of the client to have direct access to the regulated professional who is accountable to the public. Unless a member of the IPRC team is authorized under the law to perform the controlled act, a diagnosis should not be conveyed to the client or his or her personal representative at, or following the meeting, unless this has already been done by a legally authorized health care professional.

Several Exceptionality Groupings describe conditions which fall within the meaning of the controlled act as defined in the Psychology Act. These difficulties identify a neuropsychological disorder, or a psychologically-based psychotic, neurotic or personality disorder as the cause of the pupil's symptoms. Such groupings include, but are not limited to:

Communication

Autism
Language impairment
Learning disability

Intellectual

Educable retardation
Trainable retardation

Behaviour

Emotional disturbance and/or social maladjustment
Attention Deficit (ADD), or Attention Deficit Hyperactive (ADHD) Disorders

If a pupil is included in one of these categories due to a determination of the **cause** of the disorder, this would require a psychological diagnosis. This is in contrast with the use of similar terminology by the IPRC to refer to the nature of services provided by the educational system. Care must be taken in making this distinction clear to the client so as to avoid the unauthorized communication of a diagnosis.

Diagnosis under the Psychology Act: Learning and Behaviour Disorders

In the course of providing assessment and consultation services, a diagnosis is formulated in circumstances where the assessment or consultation:

- identifies a significant delay in development or a serious impairment of skill or a distortion of development which is linked to a neuropsychological disorder or a psychologically-based psychotic, neurotic or personality disorder;
- classifies the person's intellectual capacity and adaptive functioning as falling within a category of mental retardation;
- determines that a person has a learning disability in that his or her skill level in an area of academic functioning is markedly below the level expected on the basis of the person's intellectual capacity, where the discrepancy is not due to deficient educational opportunities, cultural or linguistic difference, hearing or vision impairment, physical disability, or primary emotional disturbance;
- compares a person's language, speech or motor skill development to an expected developmental level and identifies a disorder which is not due to demonstrable physical disorders, mental retardation, a pervasive developmental disorder or deficient educational opportunities;
- provides an explanation for poor academic performance through a classification, formulation or causal statement linking it to a neuropsychological disorder or a psychologically-based psychotic, neurotic or personality disorder.

Various classification systems, such as DSM-IV, include such categories of learning and behaviour disorders as are described above.

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Learning and Behaviourial Characteristics that are not Diagnoses under the Psychology Act

Academic deficits which are described in terms of academic skills are not diagnoses under the Psychology Act. For example, reading specialists, teaching staff and unregulated staff in psychology departments may describe and communicate to others the specific subskills of reading that a student has not yet mastered, without performing the controlled act. These may include awareness of sound-symbol relationships, phonics knowledge, word decoding and reading comprehension. Similarly, unregulated providers may describe and communicate the subskills related to mathematical computation or arithmetic problem-solving which the student has yet to master.

Academic deficits which are attributed to cultural or linguistic differences or lack of exposure to education are not diagnoses under the Psychology Act.

Educators such as English as a Second Language teachers may describe and communicate the areas of a specific curriculum which a student has not mastered without performing the controlled act.

Identification of exceptionally high intellectual or cognitive functioning does not constitute a diagnosis of a learning disorder. Practitioners who assess these students and IPRC's may, for example, communicate the conclusion that the student is "gifted" without performing psychology's controlled act.

Restrictions imposed on the performance of controlled acts are not uniquely the policy of the College of Psychologists of Ontario. They are legislated under the RHPA and apply to all regulated health professionals, unregulated service providers, and the public generally. §

GOVERNMENT CONSULTATION BEGINS ON DRAFT LAW TO PROTECT PERSONAL HEALTH INFORMATION WHICH WILL IMPACT ON EVERY PSYCHOLOGICAL SERVICE PROVIDED

On November 21, 1997, the Ministry of Health released the draft Personal Health Information Protection Act, 1997. The government news release stated that, *"the Ontario government is proposing tough new measures to protect the confidentiality, privacy and security of Ontarians' personal health information. The protections in the draft Personal Health Information Protection Act, 1997 are some of the toughest that Ontario has ever seen. The draft Act would, for the first time ever in Ontario, establish consistent and comprehensive rules, safeguards and legal protection governing the collection, use and sharing of health information to improve patient care and to better manage the complex health care system. . .*

The draft Act outlines strict rules and limits on the gathering and sharing of personal health information. These include:

- *holders of personal health information would be held responsible and accountable for maintaining confidentiality and security of personal health information*
- *wherever possible, health information would be collected and used in a way that does not identify the patient*
- *individuals would have the statutory right to look at their own health records and request a correction*
- *a new "lock box" provision would be put in place to give individuals the right to stop certain information from being shared with another health care provider*
- *strict new rules and safeguards would ensure that personal health information be shared only for legitimate, lawful purposes and on a need-to-know basis*

The draft Act also sets up a special independent Health Information Privacy Commissioner who would be responsible for policing information practices, reviewing complaints and ensuring compliance with the Act. Tough penalties are proposed for violation of the Act, with potential fines of $25,000 for individuals and $100,000 for corporations."

The Ministry is inviting written submissions in response to the draft Act to complement the meetings they will be holding across the province in the new year. The College will be preparing a submission and would be pleased to hear your views. Should you choose to provide comments directly to the Ministry, the College would appreciate receiving a copy. Submissions to the Ministry are due by February 28, 1998 and should be forwarded to:

Draft Personal Health Information Act, 1997, Consultation Response, Health Policy Branch, Ministry of Health
80 Grosvenor Street, 8th floor, Hepburn Block, Toronto, ON M7A 1R3 Fax: (416) 327-8458

Copies of the draft legislation are available on the government Website at http://www.gov.on.ca/health/ or by calling the government Infoline at 1-800-268-1153.

TRICKY ISSUES FEATURE: STOLEN CLIENT FILES

The Issue:

The College recently has been asked for advice and direction from members who have had client files or information stolen from them. These incidents occurred in a number of different circumstances including the loss of client material on a member's computer stolen from his or her office, and theft of files in a member's briefcase stolen from the trunk of his or her car.

The College's Advice:

The security of client information is of significant importance to all members of the College, be it the steps taken to safeguard confidentiality and unauthorized release of information or the physical protection of the actual record. Assurances of privacy and confidentiality, with the limited exceptions discussed with the client, is a highly held value among members of the profession. When this security is breached through theft, it is a very troubling and stressful experience for the member.

In speaking with members who had this unfortunate experience, the College offered the following advice.

1. As with any nonprofessional occurrence of this type, the theft should be reported to the police.

2. The member should make every effort to contact the clients whose information was stolen and apprise them of the situation. In doing so, it would be helpful for the member to inform the client of the nature of the missing material, the steps taken, e.g., reported to police, and the steps the member has taken in an effort to ensure it doesn't happen again. This last action may seem like 'closing the barn door after the horse has escaped' but it may provide some reassurance to the client regarding ongoing therapeutic involvement.

3. Report the theft to the College. It is helpful for the College to know of such occurrences should a client call regarding the matter. As well, should a member of the public find the stolen material, they may contact the College to ask for direction. A call to the College can also allow the member to receive general advice as provided in this article, or other information specific to the situation.

The theft may not be directed at the client information but rather, the loss of the information may be an unfortunate byproduct.

With respect to computerized records, this is a very difficult problem and one which will become of growing concern as the use of computers in professional practice steadily increases. Some members have begun to use numbers rather than names to identify clients, keeping a master list in a separate location. It is recognized this remedy may work for clinical data however it may have limitations with respect to word processing reports. Other members use various password protections to make it more difficult for unauthorized access.

Members are advised to discuss security with their computer supplier to understand both the limitations and what methods of protection are available. It is interesting to note that in the case of the computer theft, the police told the member that generally, the target of the theft is the computer, not the information. In these cases the hard drive is immediately either erased or destroyed before the computer is disposed of, making it much more difficult to trace its origin.

Members are urged to use caution in leaving clinical material in their cars, even in the trunk. Cars are very vulnerable to theft or being broken into and client information may be stolen along with the car or briefcase left inside.

As an interesting final note, in each of the cases reported to the College, members found their clients to be quite understanding. While certainly concerned about the loss of their private information, the clients appreciated being informed personally and immediately by the member.§

CONFLICT OF INTEREST

In October 1996, a Draft Conflict of Interest Regulation was published in the Bulletin for member consideration and comment. Further targeted consultation was conducted with members employed by the school boards. The consultation process raised many interesting questions and elicited many valuable suggestions resulting in the following revised version being approved by Council for submission to the Ministry. The Council wishes to thank those members who took the time to respond to the request for input. In addition to specific comments regarding the wording of the Regulation, the consultation raised a number of specific questions or scenarios pertaining to Conflict of Interest which can be addressed in future Tricky Issues columns of the Bulletin.

Proposed Regulation Submitted to Ministry of Health, December 1997

1 Introduction [1]

1.1 This Regulation is made under the authority of the Psychology Act, 1991, and the Regulated Health Professions Act (Code), 1991, 95.(1) 21.

1.2 The purpose of this regulation is to identify what constitutes a conflict of interest in the practice of the profession, and to regulate and/or prohibit the practice of the profession in cases where there is a conflict of in terest. In addition, this regulation defines conflict of interest for the purpose of Ontario Regulation 801/93 (Professional Misconduct).

Note 1. The Regulated Health Professions Act and the associated Code require that each of the regulatory Colleges of the health professions establish Conflict of Interest Regulations. Guidelines from the Ministry of Health establish the general categories of content required in the Regulation, and provide for some specific content. Each College's Conflict of Interest Regulation is somewhat different from the others, because the individual circumstances of the Colleges vary to a significant degree.

In general, the purpose of a Conflict of Interest Regulation as defined in the legislation and the regulatory guidelines is to ensure that Members are not unduly influenced by their own personal interests in the practise of the profession. The underlying assumption is that one must respond to the particular interests of the patient or client, without allowing personal interests to shape that response.

2 Definitions

2.1 *Conflict of Interest.* In the context of a professional relationship in which psychological services are being provided, conflict of interest refers to a situation in which a Member's material, personal or moral interest influences, or might reasonably be perceived to influence, the exercise of the Member's professional duty with respect to the Member's client(s).

Note 2.1. It is important that members avoid being influenced by conflicts of interest; it is also important that Members understand that clients or others may believe there is a conflict of interest, even though the Member may not believe that he or she is being influenced by the perceived conflict. Members are expected to take steps to avoid a situation where they might be perceived to be in a conflict of interest situation, even when they believe they are not being influenced in a way detrimental to the patient's interests.

2.2 *Material interest.* Financial or other material circumstances favourable to a Member.

Note 2.2 "Material interests" are actual financial or other concrete benefits that a Member might receive as a consequence of, for instance, influencing a client to take a particular action. These are the interests that are most often understood as giving rise to conflicts.

2.3 *Personal interest.* Personal circumstances of a Member, including but not limited to, family and personal relationships.

Note 2.3. "Personal interests" refer generally to interests associated with the personal and family relationships of a member, but also apply to other similar situations. For instance, it would not be appropriate under most circumstances for a Member to undertake marital therapy with a couple when one spouse is a sibling of the Member. The issues are similar to those that arise with "material interests", but are extended to realms where the potential benefits a member might receive by influencing a client to take a particular action are "personal" rather than "material".

[1] *Shaded areas are provided as explanatory notes and are not part of the formal Regulation.*

2.4 *Moral interest.* A Member's personal values, religious beliefs or other personal convictions.

Note 2.4. "Moral interests" refer to the convictions a Member holds that may prescribe or prohibit particular actions. Religious convictions fall within this category, as do strongly held personal values of other sorts.

2.5 *Relative.* A family member by virtue of blood relationship, adoption, marriage, common law or life partner relationship.

2.6 *Self referral.* When a Member refers a client to himself/herself or to a relative, or to an organization or agency in which the Member or a relative has a material interest, for treatment, services or acquisition of materials.

Note 2.6. "Self Referral" is one of the primary sources of material conflicts of interest. It arises, for instance, when a Member refers a client for assessment to a facility in which the Member has a financial interest, or in which the Member's family has a financial interest. The concern is that the material benefit to the Member of such a referral will influence the Member to make the referral, when it might not be clinically indicated, or when other facilities might provide equivalent or better service.

3 Professional Misconduct

3.1 It is professional misconduct for a Member to prac tise the profession while in a conflict of interest, ex cept as otherwise provided for in this regulation.

Note 3.1. The Professional Misconduct Regulation (Section 10) provides that it is misconduct for a Member to practise the profession while in a conflict of interest. This Conflict of Interest Regulation defines the terms under which such misconduct can be said to occur. In effect, this Regulation provides the extended definition of conflict of interest for the purposes of the Professional Misconduct Regulation.

4 Material Conflicts of Interest

Notes 4 - 6. Clauses 4, 5 and 6 all provide specific definitions of conflict of interest situations. However, each also provides that the definitions do not limit the general applicability of the concept of conflict of interest, as practising while in a conflict of interest is professional misconduct.

4.1 Without limiting the generality of paragraph 2.1, a material conflict of interest occurs in the following circumstances:

4.1.1 a Member refers a client to himself or herself, or to a relative;

4.1.2 a Member or a relative receives or provides a material benefit in exchange for a referral to or from the Member, or in exchange for a promise to refer;

4.1.3 a Member advises a client on a course of action that will likely result in a material benefit for the Member or a relative except when the advice relates directly to the course of treatment, assessment or other professional intervention appropriate to the client needs;

Note 4.1.3. It is considered a conflict of interest if a Member advises a client on a course of action that will result in a material benefit for the Member. Examples might be the purchase of a particular stock or a real estate property, or acquisition of a product in which the Member has an interest. It does not apply, however, when the advice is with respect to the course of treatment being offered. It is not, therefore, a conflict of interest for a Member to advise a client to continue in therapy for another series of appointments, or to acquire other appropriate treatment. It should be borne in mind though, that retaining a client in treatment beyond the point where the client is obtaining benefit from the treatment is professional misconduct of a different sort.

4.1.4 a Member engages in any other form of self referral.

5 Personal Conflicts of Interest

5.1 Without limiting the generality of paragraph 2.1, a personal conflict of interest occurs when a Member has a family, personal, business or other non client relationship which reduces the capacity of the Member to act in the best interests of his or her client.

Note 5.1. "Dual Relationships" occur when a Member has a professional relationship with an individual, and also has an additional relationship with the person (either directly or through others). In many cases, these situations will reduce the capacity of the Member to provide appropriate treatment to the individual. One example would be if the client is related to the Member through marriage -- it will be difficult to provide unbiased assessment and treatment services if the Member knows that the client is married to a sibling. Another example might be when a Member has a business partnership with a client, or is in a position of authority with respect to a client.

6 Moral Conflicts of Interest

6.1 Without limiting the generality of paragraph 2.1, a moral conflict of interest occurs in the following circumstances:

6.1.1 a Member has a religious or personal conviction that prescribes a course of action with respect to client circumstances, or that otherwise limits the advice or treatment provided to a client, and

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Note 6.1.1. "Moral Conflicts of Interest" present a particularly difficult category to define and explain. The essential principle is that strongly held personal beliefs can, under some circumstances, inappropriately limit the treatment options that a Member offers to a client. For instance, if a Member has strong religious convictions, of any sort, it may be difficult for the Member to work with a client who is struggling with his or her spiritual identity, without the Member's convictions colouring the treatment being provided. Similarly, a Member with strong anti-abortion convictions would find it difficult to work with a client considering abortion, without having his or her convictions influence the interventions. This clause does not prohibit a Member from having strong convictions of a religious or moral nature — it simply requires that these convictions be recognized as having an impact on the Member's practice under some circumstances, therefore requiring appropriate action on the part of the Member.

6.1.2 the prescription or limitation goes beyond those provided in law.

*Note 6.1.2. It would be difficult to justify a prohibition on **any** moral conviction influencing the course of treatment, so it is acknowledged that there are certain moral standards that are generally accepted and codified in the law. For instance, it is permissible to have a personal conviction, strongly held, that murder is wrong, and to allow that conviction to influence the course of treatment with a client considering murdering someone. There are gray areas that should be considered carefully by practitioners. It is not against the law to receive payment for sexual services. Having a moral objection to prostitution might therefore make it difficult to treat an unrepentant prostitute. It is probably good practice to ensure such convictions are clearly explained to the client, in order to obtain the client's consent to continue with treatment (see Clause 7).*

7 A material, personal or moral conflict of interest is permissible, and will not be considered Professional Misconduct, under the following circumstances:

***Note 7.** In general, conflicts of interest are to be avoided. However, there are circumstances where conflicts can be allowed. The key is fully informed consent of the client. A conflict must be clearly explained and alternative treatment options identified when these are available. If the client chooses to continue with treatment despite the conflict of interest, then the conflict becomes permissible and will not be grounds for a professional misconduct charge.*

7.1 the conflict of interest is accurately and clearly explained to the client, and the client demonstrates an understanding of the issues; and,

7.2 alternative courses of action for the client are identified, including referral to another practitioner when practical, and the Member undertakes to facilitate implementation of these options if they are chosen by the client; and,

7.3 the client chooses to continue with the course of action giving rise to the conflict of interest; and,

7.4 the client's interests are not compromised as a consequence of the client's trust relationship with the Member.

Note 7.4. It is recognized that a Member may have considerable influence over the decision of a client to continue or to seek alternative assistance, in the face of an apparent conflict of interest. If that influence is exercised, in order to persuade the client to continue, then it cannot be said that truly informed consent has been obtained, and continuing while in conflict of interest might not be appropriate.

8 Section 7 does not apply when the informed consent of the client cannot be obtained. In particular, it does not apply when:

8.1 the Member is in an authority relationship with respect to the client;

Note 8.1a. There are circumstances when informed consent cannot be obtained. One of these is when a Member is in an authority relationship with a client or potential client. It is never permissible for a Member to take on as a client an individual who is an employee, or a subordinate in an organization. This is because it might well be impossible for the employee to say "No" to the establishment of the treatment or assessment relationship, or to freely make the choices that are normally required within a treatment process.

Note 8.1b. Similarly, it will usually be inappropriate for a Member to take on as a client a person who is in a position of authority over the Member. When a Member is treating an individual who has authority over him or her, it may be difficult for the Member to exercise properly independent judgement with respect to the client.

8.2 the client is incapable of appreciating the significance of the conflict of interest; or,

Note 8.2. It is also possible that an individual might be incapable of appreciating the implications of the conflict of interest. This might be true for children (although children may be capable of giving informed consent), for the intellectually disabled, or for individuals who are sufficiently psychologically disturbed to have their judgement impaired. In all such cases, a conflict of interest cannot be allowed on the basis of the consent of the client.

8.3 continuing to provide a service to the client would violate other applicable Regulations or Standards of practice of the profession or any Statute relevant to the practice of the profession.

9 It is not a conflict of interest for a Member to engage in appropriate association, partnership or employment with other regulated health professionals or organizations, provided that the Member's material or personal interests do not influence the quality of care provided to the Members' clients.

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Note 9. In general, the mere fact of a business relationship (partnership or otherwise) with another practitioner to whom one refers appropriately does not constitute a conflict of interest. Although it might be perceived that some benefit might flow to a Member if he or she referred a client to a professional partner for assessment, Clause 9 specifically provides that this does not in itself constitute a conflict of interest. However, if a portion of the fee for the assessment was provided directly to the referrer, a conflict of interest will clearly be present, and there will also probably have been a breach of other aspects of the professional misconduct regulation. In general, Clause 9 does not waive any of the other provisions of this Regulation, it simply clarifies that the fact of a business relationship does not, in itself, represent a conflict of interest. §

COLLEGE NOTICES

THE COLLEGE OF PSYCHOLOGISTS OF ONTARIO

Deceased

The College has learned with regret of the death of the following members, and extends its condolences to their families, friends and professional colleagues.

Pierre Baron
Sidney Folb
Gerald Gladkowski
Nalini Mhatre
Douglas Quirk
Clare Stoddart

Retired

The following persons have advised us of their retirement, and we would like to wish them well.

Janet Alderman
Facharuddin Bachteram
Raymond Berry
Vivian Darroch-Lozowski
Betty Flint
Maurice Fryatt
Laurent Isabelle
Beverly-Mae Knight
Umesh Kothare
Jacqueline Marshall
Malcolm Marshall
Nancy Montgomery
Warren Robinson
Guy Thibaudeau
Hugh Vincent
Robert Weir

Suspended

Certificates of registration for the following persons have been suspended due to unpaid fees.

Richard Alapack
Neil Applebaum
Arthur Blank
Diane Claude
William Dick
Marie-France Dionne
Marshall Dorosh
Myron Eisenberg
Pamela Foreht
Bruce Fournier
Louise Fryer
Norman Greenberg
Kathryn Hall
Judith Hashmall
Gerald Kroetsch
Hans Albert Kuechler
John Lawrence
Tony Le Page
Marc Lewis
Kenneth Livingston
Ian Martyn
James Mosley
Richard Neufeld
Anne Nicholls
Jack Parlow
Izabela Schultz
Lauren Shewfelt
Ronald Trites
Aaron Wolfgang

COLLEGE NOTICES
THE COLLEGE OF PSYCHOLOGISTS OF ONTARIO

Regulations, Standards of Professional Conduct and Guidelines of the College of Psychologists of Ontario: Amendments and Changes

At its meeting in September 1997, the Council approved two motions to amend *The Regulations, Standards of Professional Conduct and Guidelines of the College of Psychologists of Ontario* of December 1995.

Quality Assurance:

The Legal Services Branch of the Ministry of Health has indicated that the College needed a section in the Quality Assurance Regulation which would require members to participate in the Quality Assurance Program and prescribed that failure to do so would be act of Professional Misconduct. Following discussion at Council, it was decided that it would be better to develop a Standard of Professional Conduct to address this issue since failure "to maintain the standards of the profession" is already an act of Professional Misconduct [Ont. Reg. 801/93 (2)]. To this end, the Council moved that Principle 1 of the Standards of Professional Conduct be amended to include the following addition:

1.6 A member shall participate fully in all mandatory aspects of the Quality Assurance Program of the College.

Custody and Access Guidelines:

The *Guidelines for Custody and Access Assessments*, published by the Ontario Psychological Foundation (1988) had been formally adopted, as of December 1995, as applicable to all members. In response to concern expressed by members regarding the continued applicability and currency of these guidelines, the Council voted to withdraw the endorsement previously given to them. The College will no longer be relying on these guidelines.

The Council received a document entitled *Ethical Guidelines for Psychological Practice Related to Child Custody and Access* developed by the Ethics and Policy Committee of the Ontario Psychological Association. Council did not wish to formally adopt these as a replacement for the other guidelines it had withdrawn. Council did however, vote to advise members of the guidelines as useful information for those working in this area and expressed their thanks to the Ontario Psychological Association for preparing the new guidelines.

Members are advised that the *Guidelines for Custody and Access Assessments*, published by the Ontario Psychological Foundation (1988) are no longer endorsed by the College. Members may wish to review the *Ethical Guidelines for Psychological Practice Related to Child Custody and Access* developed by the Ontario Psychological Association and the *Guidelines for Child Custody Evaluation in Divorce Proceedings* (1994) of the American Psychological Association, [American Psychologist, 49(7)677-680], for guidance in this area of practice. §

Use of Information from the Public Register by the Complaints Committee

Effective as of the date of publishing this policy in the Bulletin:

Any information that is noted on the public register of the College, with respect to a member against whom there is a complaint, will be brought to the attention of the Complaints Committee at the time the complaint is considered. This information will be brought to the Committee's attention after the Committee has reached conclusions on all of the issues raised in the current complaint but before the Committee has decided on the appropriate disposition of the matter.

Background

The Health Professions Board, which has the authority to review decisions of the College Complaints Committee, has expressed the view that it is impossible for the College to regulate the profession adequately if it does not: 1) maintain records of and respond to the existence of recurring complaints of a strikingly similar nature against the same member of the profession; and, 2) monitor patterns of conduct by its members. For these reasons, other regulatory Colleges such as the College of Physicians and Surgeons and the College of Nurses have adopted policies of this nature.

Procedure

Prior to bringing the information from the public register to the attention of the Complaints Committee, the member in question will be provided with a copy of the previous Decision(s) and Reasons, arising from the case(s) noted on the public register. The member will be asked to make a submission in writing as to the degree of relevance and weight the Committee should place on this information in determining the appropriate disposition of the current matter. This submission will be provided to the Committee at the same time that the information from the public register is provided to the Committee.

Only matters that were placed on the public register within six years from the date of receipt of the current complaint will be brought to the attention of the Committee except in the case of information pertaining to sexual abuse. With the exception of information pertaining to sexual abuse, information that predates the six year period will not be brought to the Committee's attention even if it remains on the public register.

Section 23 of the Health Professions Procedural Code authorizes the public register and sets out the information it shall contain. Information on the public register with respect to Discipline includes:

- terms, conditions and limitations imposed on each certificate of registration;
- a notation of every revocation and every suspension of a certificate of registration that is in effect;
- the results of every disciplinary and incapacity proceeding completed within six years before the last time that the Register was prepared or last updated:
  - i) in which a member's certificate of registration was revoked or suspended or had terms, conditions or limitations imposed on it, or;
  - ii) in which a member was required to pay a fine or attend to be reprimanded or in which an order was suspended if the results of the proceeding were directed to be included in the Register by a panel of the Discipline or Fitness to Practise Committee;
- information related to appeals of findings of the Discipline Committee;
- the results of every disciplinary proceeding, completed at any time before the register was prepared or last updated, in which the member was found to have committed sexual abuse;
- other information designated as public in the regulations.

Summary

This policy sets out that information on the public register, which is not similar fact to the complaint under current consideration, **only can be used in determining the appropriate disposition** of the current complaint. This information **cannot be used to determine whether the current complaint is substantiated**. It also provides the opportunity for the member in question to make a written submission to the Committee on the degree of relevance and weight this information should have with respect to the disposition of the current matter. Both the public register information and the member's submission would be considered together.

This policy should be read in conjunction with the *Policy re: Use of Similar Fact Evidence by Complaints Committees* (Bulletin, vol. 22(2) Sept.1995), which describes how information on the public register, which is "similar fact" to a current complaint, can be used by the Complaints Committee in reaching a decision regarding a current complaint.§

Invitation to Participate on the Communications Committee

The Communications Committee of the College is looking for two or three members who would be interested in joining this Committee.

The College established the Communications Committee to develop and coordinate communication between the College and the members. The mandate includes overseeing the publication of the Bulletin, development of the College website and general responsibility for communication with the members. The Committee is interested in making the current communication vehicles as useful and effective as possible and in looking at ways to expand and enhance communication between members and the College.

If you are interested in volunteering on this Committee, please let us know by writing to Dr. Rick Morris, Director of Professional Affairs at the College. It would be helpful for us to know what your interests are and how you see them furthering the work of the Committee.

In addition to members who are interested in participating on the Committee, we would like to hear from members who may wish to contribute articles to the Bulletin. As a profession we have a very diverse range of knowledge, skills, abilities and areas of practice, and we encounter a very broad spectrum of practice issues. The Bulletin can be a valuable, educational forum for sharing this information and expertise with colleagues. If you would be interested in submitting an article for the Bulletin or collaborating with others on a particular topic or area of practice, please contact Dr. Rick Morris.§

Council Meeting Dates,1998

Dates currently scheduled for Council meetings are as follows:

√ **March 27 and 28, 1998**

√ **May 29 and 30, 1998**

Erratum

In the previous issue of the Bulletin, there was a College Notice regarding the individuals elected and appointed to Statutory Committees for the year 1997/1998. In announcing the names of the Executive Committee, the name of Judith Van Evra, Ph.D., C.Psych. was inadvertently omitted. As well, in providing the brief biographies of the College Council members for 1997/1998, Ron Myhr, Ph.D., C.Psych. should have been listed as representing District 6 - Metropolitan Toronto.

We apologise for these inaccuracies, and regret any inconvenience they may have caused Dr. Van Evra and Dr. Myhr. §

THE COLLEGE OF PSYCHOLOGISTS OF ONTARIO
NOTICE OF ELECTION TO COUNCIL, 1998

Information for Members

Nominations

Date: A date of **March 31, 1998** has been set for election to Council.

Elections will be held for electoral districts 1, 3, and 4

District 1 - North This district is composed of the districts of Kenora, Rainy River, Thunder Bay, Cochrane, Algoma, Manitoulin, Nipissing, Sudbury, Timiskaming and Parry Sound, The District Municipality of Muskoka and The Regional Municipality of Sudbury.

District 3 - Central West This district is composed of the counties of Brant and Dufferin and the regional municipalities of Haldimand-Norfolk, Halton, Hamilton-Wentworth, Niagara and Waterloo.

District 4 - East This district is composed of the counties of Frontenac, Hastings, Lanark, Prince Edward and Renfrew, the united counties of Leeds and Grenville, Lennox and Addington, Prescott and Russell, Stormont, Dundas and Glengarry and The Regional Municipality of Ottawa-Carleton.

Eligibility: To be eligible, a psychologist or psychological associate must be engaged in the practice of psychology or residing in the electoral district (if not practising); must not be in default of payment of any fees; the certificate of registration must not have been revoked or suspended in the six years preceding date of election or subject to a term or limitation within two years leading up to election.

Nominations: A nomination form is enclosed. A psychologist or psychological associate may be a candidate for election in only one electoral district in which he or she is an eligible voter. A nomination must be signed by at least five members (psychologists or psychological associates) who support the nomination and are eligible to vote in that electoral district.

What's Up...

Election to Council has been set for March 31, 1998

Elections are being held in:
District 1 - North
District 3 - Central West
District 4 - East

Nominations are due by February 13, 1998

Deadline for nominations: Nominations are due by 5 p.m., February 13, 1998. Further nominations will be received until 15 days before the election; Tuesday, March 17, 1998 is the last day for receiving nominations for the election. Those needing nomination forms may contact the College office.

Withdrawal of nomination: A candidate may withdraw his or her nomination by giving notice to the Registrar in writing, not less than 15 days before the election; the last day for withdrawal is Tuesday, March 17, 1998.

Mailing lists: On written request to the College, a candidate may obtain a mailing list (or address labels), at cost, of members in the electoral district, for use in the electoral process.

Procedures

Distribution of ballots: No later than 10 days before the election, a final list of candidates in the electoral district, a ballot, the candidates' biographies and statements and an explanation of the voting procedures will be sent out.

Scrutineers: The College will engage a private firm to distribute the ballots to members in each electoral district, to receive the completed ballots, to confirm the voters against the voters' list, to count and record the votes, and to report the results of the election to the Registrar. The voting will be confidential and only the final tally will be provided to the Registrar.

Voting procedures: Each member eligible to vote in a given district will receive a pre-addressed envelope in which to seal the completed ballot. **The name and address of the voting member must be recorded in the appropriate space on the outside of the envelope** so that the scrutineers may verify the voter's name and address against the voters' list. The envelope containing the ballot with your vote must be postmarked no later than March 31, 1998.

Members in the electoral districts will receive candidate statements and biographies with their ballots.

Ballots are mailed to voters no later than 10 days before the election.

Other Information

Council Composition: The Council is composed of seven professional members elected by geographical area; two academic members; and five public members appointed by the Ministry of Health. In addition, there is a psychological associate member elected to a three-year ex-officio position. Each eligible member of the College may vote for one representative to the Council.

New Council members will be appointed to one of seven statutory committees (executive, registration, complaints, discipline, fitness to practise, quality assurance, and client relations) and can expect to serve on at least two such committees.

New Council members could become members of other standing committees, as well as various ad hoc committees established.

Term of Office: The term of office for elected members is three years. During that time a member may be appointed to chair one or more committees.

Time Commitment: Council meetings will be held at least quarterly and normally last for two full days (usually a Friday and Saturday). Committees may meet the day before the Council meeting or between Council meetings. Committees are likely to meet twice as often as the Council for at least one full day.

The Council meetings for 1998 have been scheduled as follows: March 27 & 28, May 29 & 30. Council will elect a new Executive Committee on May 29. At the end of the first day on May 27, the Executive will meet to appoint new Council members to Committees.

Per diems and Expenses: Current Council policy provides for a per diem of $267 for Council and Committee meetings. Half day meetings are pro-rated.

Expenses covered include necessary travel (economy fare or mileage); meals up to $46 plus G.S.T. per day; and necessary taxi fare or parking expenses. If a meal, such as lunch, is provided during a full day meeting, then the amount allocated for lunch is deducted from available expense coverage.

Note: You may refer to *The Regulations, Standards of Professional Conductt and Guidelines of the College of Psychologists of Ontario*, December 1995, for the complete elections regulation.

Please ensure that you have printed your name on the ballot envelope to ensure that your vote can be counted.

Ballots need to be postmarked by March 31, 1998, to be counted.

THE COLLEGE OF PSYCHOLOGISTS OF ONTARIO

~ presents ~

THE SEVENTH ANNUAL

Barbara Wand Symposium on Professional Practice

A full-day seminar:

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An interesting and informative day of discussion, exchange, and participatory activities focusing on challenges facing the profession of Psychology as we move towards the new millennium.

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525 Bay Street
Toronto

Please see flyer insert for program details.

The Bulletin is a publication of the College of Psychologists of Ontario

The Bulletin is published quarterly. Subscriptions for members of the College are included in their registration fee. Others may subscribe at $10.00 per year, or $2.50 per single issue. We will also attempt to satisfy requests for back issues of the Bulletin at the same price.

Please address all correspondence to:

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web site: www.cpo.on.ca

Les articles dan ce numéro de The Bulletin sont disponibles en français.

THE COLLEGE OF PSYCHOLOGISTS OF ONTARIO
L'ORDRE DES PSYCHOLOGUES DE L'ONTARIO

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1998 ELECTION NOMINATION FORM

Please type or print clearly, using black ink.

We, the undersigned members of the College of Psychologists of Ontario practising or residing in Electoral District _____
nominate _____
in Electoral District _____
as a candidate for election to the Council of the College on March 31, 1998 as a registered psychologist or psychological associate representative of the said Electoral District.

Nominee's Registration Number: _____

Telephone Number: _____

Address: _____

_____

I, _____, am willing to stand for election, and if elected, to assume all duties of the member of Council for Electoral District _____

Signature: _____

NOMINATOR'S NAME	DISTRICT	REGIST. #	SIGNATURE

PLEASE RETURN THIS FORM BY 5:00 p.m. FEBRUARY 13, 1998, to:
The College of Psychologists of Ontario, 1246 Yonge St., Suite 201, Toronto, Ontario M4T 1W5
Telephone: (416) 961-8817 **Fax:** (416) 961-2635