

STANDARDS OF PRACTICE



FOR MEMBERS OF

**THE ONTARIO ASSOCIATION
OF
CONSULTANTS, COUNSELLORS,
PSYCHOMETRISTS AND PSYCHOTHERAPISTS**

2012

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1. Compliance with Statutes and Regulations

1.1 General Conduct

Members should ensure that their activities and/or those conducted under their direction comply with relevant statutes and regulations that apply to the provision of mental health services. Some or all of following are applicable to members practising in Ontario.

- Regulated Health Professions Act
- Personal Information Protection and Electronic Documents Act
- Personal Health Information Protection Act
- Child and Family Services Act
- Mental Health Act
- Health Care Consent Act
- Substitute Decisions Act
- Human Rights Code
- Occupational Health and Safety Act
- Accessibility for Ontarians with Disabilities Act
- Public Hospitals Act
- Health Protection and Promotion Act
- Municipal Freedom of Information and Protection of Privacy Act

Members of the Association who practise outside Ontario are advised to familiarize themselves with the relevant statutes and regulations of the province or territory.

1.2 Controlled Act of Psychotherapy (future)

A member will not perform the controlled act of psychotherapy as set out in the Regulated Health Professions Act (RHPA) 1991, unless it is accordance with the RHPA:

Controlled acts restricted

27. (1) No person shall perform a controlled act set out in subsection (2) 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 to the person by a member described in clause (a). 1991, c. 18, s. 27 (1); 1998, c. 18, Sched. G, s. 6.

Controlled acts

(2) A “controlled act” is any one of the following done with respect to an individual:

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (2) is amended by the Statutes of Ontario, 2007, chapter 10, Schedule R, subsection 19 (1) by adding the following paragraph:

14. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual’s serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual’s judgement, insight, behaviour, communication or social functioning.

Note: On a day to be named by proclamation of the Lieutenant Governor, section 27 is amended by the Statutes of Ontario, 2007, chapter 10, Schedule R, subsection 19 (2) by adding the following subsection:

(4) Despite subsection (1), a member of the Ontario College of Social Workers and Social Service Workers is authorized to perform the controlled act set out in paragraph 14 of subsection (2), in compliance with the *Social Work and Social Service Work Act, 1998*, its regulations and by-laws. 2007, c. 10, Sched. R, s. 19 (2).

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1.3 Controlled Act of Communicating a Diagnosis

A member will not perform the controlled act of communicating a diagnosis as set out in the Regulated Health Professions Act (RHPA) 1991, unless it is accordance with the RHPA:

Controlled acts restricted

27. (1) No person shall perform a controlled act set out in subsection (2) 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 to the person by a member described in clause (a). 1991, c. 18, s. 27 (1); 1998, c. 18, Sched. G, s. 6.

Controlled acts

(2) A “controlled act” is any one of the following done with respect to an individual:

- 1. 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. 1991, c. 18, s. 27 (2); 2007, c. 10, Sched. L, s. 32

Exemption

- (3) An act by a person is not a contravention of subsection (1) if the person is exempted by the regulations under this Act or if the act is done in the course of an activity exempted by the regulations under this Act. 1991, c. 18, s. 27 (3).

Delegations

- 28. (1) The delegation of a controlled act by a member must be in accordance with any applicable regulations under the health profession.
- (2) The delegation of a controlled act to a member must be in accordance with any applicable regulations under the health profession Act governing the member’s profession. 1991, c. 18, s. 28.

Exception for Counselling

- 29. (2) Subsection 27 (1) does not apply 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 profession Act authorizes members to make. 1991, c. 18, s. 29.

With respect to Section 29 (2) of the RHPA, the diagnoses that psychologists or psychological associates are authorized to communicate are set out in the Psychology Act:

- 4. 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 perform the following:
 - (1) To communicate a diagnosis identifying, as the cause of a person’s symptoms, a neuropsychological disorder or psychologically based psychotic, neurotic, or personality disorder. 2007, c. 10, Sched. R, s. 18

1.4 Restricted Titles

Members must abstain from holding themselves out as someone qualified to practise as a psychologist, psychological associate, or in a speciality of psychology and abstain from using legally protected terms, such as "psychology" or "psychological" or their variations or abbreviations or an equivalent in another language to define or promote their services. Use of these terms is restricted as set out in Section 8 of the Psychology Act, 1991, S.O. 1991 c

- s.8 (1) No person other than a member shall use the title “psychologist” or “psychological associate”, a variation or abbreviation or an equivalent in another language.
- (2) No person other than a member shall hold himself or herself out as a person who is qualified to practice in Ontario as a psychologist or psychological associate or in a specialty of psychology.

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- (3) A person who is not a member contravenes subsection (2) if he or she uses the word “psychology” or “psychological”, an abbreviation or an equivalent in another language in any title or designation or in any description of services offered or provided.
- (4) Subsections (1) and (3) do not apply to a person in the course of his or her employment by a university.
- (5) In this section, “abbreviation” includes an abbreviation of a variation.

Members are advised that the College of Psychologists of Ontario feels it is inappropriate to use a reference to “psychology” in any manner that could be perceived as a violation of Section 8 of the Psychology Act. This includes prohibiting use of the word “psychology” when providing university degree credentials in promotional materials (e.g., website, business cards). In other words, members must refrain from identifying that they received their degrees in the discipline of psychology.

Members must comply with the restrictions with respect to use of the title doctor which are set out in Section 33 of the Regulated Health Professions Act (RHPA), 1991, S.O. 1991 c.18

- (1) Except as allowed in the regulations under this Act, no person shall use the title doctor, a variation or abbreviation or an equivalent in another language in the course of providing or offering to provide, in Ontario, health care to individuals.
- (2) Subsection (1) does not apply to a person who is a member of:

- The College of Chiropractors of Ontario
- The College of Physicians and Surgeons of Ontario
- The College of Psychologists of Ontario
- The Royal College of Dental Surgeons of Ontario

In other words, only members of the regulated health professions identified above may use the title doctor, “Dr.”, or the equivalent in Ontario in the course of providing health services.

1.5 Duty to Report a Child in Need of Protection

The Child and Family Services Act (R.S.O. 1990, Chapter C.11) outlines the circumstances in which professionals have a duty to report child in need of protection.

- 72.1 Despite the provisions of any other Act, if a person, including a person who performs professional or official duties with respect to children, has reasonable grounds to suspect one of the following, the person shall forthwith report the suspicion and the information on which it is based to a society:
- 1. The child has suffered physical harm, inflicted by the person having charge of the child or caused by or resulting from that person's,
 - i. failure to adequately care for, provide for, supervise or protect the child, or
 - ii. pattern of neglect in caring for, providing for, supervising or protecting the child.
 - 2. There is a risk that the child is likely to suffer physical harm inflicted by the person having charge of the child or caused by or resulting from that person's,
 - i. failure to adequately care for, provide for, supervise or protect the child, or
 - ii. pattern of neglect in caring for, providing for, supervising or protecting the child.
 - 3. The child has been sexually molested or sexually exploited, by the person having charge of the child or by another person where the person having charge of the child knows or should know of the possibility of sexual molestation or sexual exploitation and fails to protect the child.
- Note:** On a day to be named by proclamation of the Lieutenant Governor, paragraph 3 is repealed by the Statutes of Ontario, 2008, chapter 21, subsection 3 (1) and the following substituted:
- 3. The child has been sexually molested or sexually exploited, including by child pornography, by the person having charge of the child or by another person where the person having charge of the child knows or should know of the possibility of sexual molestation or sexual exploitation and fails to protect the child.
 - 4. There is a risk that the child is likely to be sexually molested or sexually exploited as described in paragraph 3.

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5. The child requires medical treatment to cure, prevent or alleviate physical harm or suffering and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, the treatment.
6. The child has suffered emotional harm, demonstrated by serious,
 - i. anxiety,
 - ii. depression,
 - iii. withdrawal,
 - iv. self-destructive or aggressive behaviour, or
 - v. delayed development,and there are reasonable grounds to believe that the emotional harm suffered by the child results from the actions, failure to act, or pattern of neglect on the part of the child's parent or the person having charge of the child.
7. The child has suffered emotional harm of the kind described in subparagraph i, ii, iii, iv or v of paragraph 6 and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, services or treatment to remedy or alleviate the harm.
8. There is a risk that the child is likely to suffer emotional harm of the kind described in subparagraph i, ii, iii, iv or v of paragraph 6 resulting from the actions, failure to act or pattern of neglect on the part of the child's parent or the person having charge of the child.
9. There is a risk that the child is likely to suffer emotional harm of the kind described in subparagraph i, ii, iii, iv or v of paragraph 6 and that the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, services or treatment to prevent the harm.
10. The child suffers from a mental, emotional or developmental condition that, if not remedied, could seriously impair the child's development and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, treatment to remedy or alleviate the condition.
11. The child has been abandoned, the child's parent has died or is unavailable to exercise his or her custodial rights over the child and has not made adequate provision for the child's care and custody, or the child is in a residential placement and the parent refuses or is unable or unwilling to resume the child's care and custody.
12. The child is less than 12 years old and has killed or seriously injured another person or caused serious damage to another person's property, services or treatment are necessary to prevent a recurrence and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, those services or treatment.
13. The child is less than 12 years old and has on more than one occasion injured another person or caused loss or damage to another person's property, with the encouragement of the person having charge of the child or because of that person's failure or inability to supervise the child adequately. 1999, c. 2, s. 22 (1).

1.6 Personal Information Protection and Electronic Documents Act (PIPEDA)

Excerpts from the act are not included here; rather, a general guideline outlining the responsibilities of members is provided. Personal information is identifying information about an individual, which includes information that relates to his or her personal characteristics (e.g., gender, age, income, home address and telephone number, ethnic background, family status), health (e.g., health history, health conditions, health services received by the individual), or activities and views (e.g., religion, politics, opinions). Personal information is to be contrasted with business information (e.g., business address and telephone number), which is not protected by privacy legislation.

In accordance with the Personal Information Protection and Electronic Documents Act (PIPEDA) a copy of the member's privacy policy should be given to the client and reviewed with him or her. The privacy policy should clearly state how the member handles personal information, addressing each of the following ten principles:

1. Accountability

Your responsibilities:

- a) Comply with all 10 of the principles of Schedule 1 of PIPEDA.
- b) Appoint an individual (or individuals) to be responsible for your organization's compliance.
- c) Protect all personal information held by your organization or transferred to a third party for processing.
- d) Develop and implement personal information policies and practices.

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2. Identifying Purposes

Your responsibilities:

- a) Before or when any personal information is collected, identify why it is needed and how it will be used.
- b) Document why the information is collected.
- c) Inform the individual from whom the information is collected why it is needed.
- d) Identify any new purpose for the information and obtain the individual's consent before using it.

3. Consent

Your responsibilities:

- a) Inform the individual in a meaningful way of the purposes for the collection, use, or disclosure of personal data.
- b) Obtain the individual's consent before or at the time of collection, as well as when a new use is identified.

4. Limiting Collection

Your responsibilities:

- a) Do not collect personal information indiscriminately.
- b) Do not deceive or mislead individuals about the reasons for collecting personal information.

5. Limiting Use, Disclosure, and Retention

Your responsibilities:

- a) Use or disclose personal information only for the purpose for which it was collected, unless the individual consents, or the use or disclosure is authorized by the Act.
- b) Keep personal information only as long as necessary to satisfy the purposes.
- c) Put guidelines and procedures in place for retaining and destroying personal information.
- d) Keep personal information used to make a decision about a person for a reasonable time period. This should allow the person to obtain the information after the decision and pursue redress.
- e) Destroy, erase, or render anonymous information that is no longer required for an identified purpose or a legal requirement.

6. Accuracy

Your responsibilities:

- a) Minimize the possibility of using incorrect information when making a decision about the individual or when disclosing information to third parties.

7. Safeguards

Your responsibilities:

- a) Protect personal information against loss or theft.
- b) Safeguard the information from unauthorized access, disclosure, copying, use, or modification.
- c) Protect personal information regardless of the format in which it is held.

8. Openness

Your responsibilities:

- a) Inform clients that you have policies and practices for the management of personal information.
- b) Make these policies and practices understandable and easily available.

9. Individual Access

Your responsibilities:

- a) When requested, inform individuals if you have any personal information about them.
- b) Explain how it is or has been used and provide a list of any organizations to which it has been disclosed.
- c) Give individuals access to their information.
- d) Correct or amend any personal information if its accuracy and completeness is challenged and found to be deficient.
- e) An organization should note any disagreement on the file and advise third parties where appropriate.

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10. Challenging Compliance

Your responsibilities:

- a) Develop simple and easily accessible complaint procedures.
- b) Inform complainants of their avenues of recourse. These include your organization's own complaint procedures, those of industry associations, regulatory bodies, and the Office of the Privacy Commissioner of Canada.
- c) Investigate all complaints received.
- d) Take appropriate measures to correct information handling practices and policies.

2. Confidentiality

2.1 Maintaining Confidentiality

The legal obligation of confidentiality is the obligation not to *willingly* disclose information obtained in confidence from a person, without that person's consent. Members must respect the privacy of clients by holding in strict confidence all information about them, according to applicable privacy and other legislation.

2.2 Multiple Clients

When individuals meet for couple therapy, family therapy, or group therapy, there is implicit consent to share personal information with the other members present. However, they must be informed of the possibility of some aspect of the private life of one of the members or a third party being revealed. They must secure a commitment from the members of the group to preserve the confidentiality of information on the private life of the members or third party.

2.3 Clarification of Confidentiality to Clients and Third-Party Payers

In situations where more than one party has an appropriate interest in the mental health services provided by members to a client or clients, members should clarify as much as possible to all parties prior to providing the service, the dimensions of confidentiality and professional responsibility that should pertain in providing services.

2.4 Limits of Confidentiality

At the onset of the provision of mental health services, or at the earliest reasonable opportunity, members are responsible for informing clients of the limits of confidentiality maintained by them and anyone they may supervise.

In certain limited situations (i.e., search warrants, subpoenas, and mandatory reporting obligations), members may be required by law to release what would otherwise be confidential information without consent. Such disclosures do not constitute breaches of confidentiality because the disclosure is not made willingly.

2.5 Reporting Obligations

There are reporting obligations under a number of federal and provincial laws so members are advised to ensure that they comply with any legislation applicable to them (e.g., Regulated Health Professions Act, Occupational Health and Safety Act, Health Protection and Promotion Act). In particular, members should familiarize themselves with the Child and Family Services Act regarding the duty to report a child under the age of 16 in need of protection as outlined in the first section of the Standards of Practice.

2.6 Duty to Warn

Three factors should be taken into consideration in determining whether a duty to warn exists:

- a) Is there is a clear risk to an identifiable person or group of persons?
- b) Is there a risk of serious bodily harm or death?
- c) Is the danger imminent?

Although members have an ethical responsibility to breach confidentiality if these criteria are met, it is important to note they are *not required* by Canadian law to do so. It is in the best interest of members to advise each client at the time of obtaining informed consent that confidential information will be disclosed if it is believed that the client poses a danger to him/herself or others.

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3. Consent

3.1 Informed Consent

Although not all members of OACCPP are regulated health professionals, the Health Care Consent Act provides the essential elements required for consent to treatment:

- a) The consent must relate to the mental health service;
- b) The consent must be informed;
- c) The consent must be given voluntarily; and
- d) The consent must not be obtained through misrepresentation or fraud.

Consent to mental health services is informed if, before giving it, the individual received the information (as set out below) that a reasonable person in the same circumstances would require in order to make a decision about the service; and the individual received responses to his or her requests for additional information about those matters. The information must include:

- a) The nature of the treatment/service (purposes, goals, techniques, procedures, modalities, orientation);
- b) The expected benefits, outcomes, potential risks, and limitations of the service and alternative courses of action.

3.2 Minimum Age of Consent

In Ontario, legislation regarding the minimum age at which children are deemed capable of consenting to treatment is found in the Child and Family Services Act.

Child and Family Services Act (R.S.O., 1990, c. C.11, s. 28)

Counselling service: child twelve or older

28. A service provider may provide a counselling service to a child who is twelve years of age or older with the child's consent, and no other person's consent is required, but if the child is less than sixteen years of age the service provider shall discuss with the child at the earliest appropriate opportunity the desirability of involving the child's parent.

The Health Care Consent Act (R.S.O. 1996, c. C.2, s. 10,11) of Ontario does not specify a minimum age of consent. Following the principle of common law, it is reasoned that if a person has the capacity to understand the proposed treatment, including its risks/benefits, then the individual can provide consent. Therefore, the onus is on the member to use professional judgment in determining whether a child is capable of consenting to treatment.

3.3 Disclosure by Member Prior to Consent

Members should provide a complete disclosure of information and not withhold any information from the clients that may affect their ability to be an informed client.

The following matters should be discussed prior to obtaining consent:

- a) The member's credentials, training, and relevant experience;
- b) Expectations regarding client involvement (participation in the development of a treatment plan);
- c) Intended use of tests, assessments, and reports;
- d) Policies and procedures concerning access to service (frequency and length of service, availability between sessions, provisions for crises/emergencies, contingencies in the event of a disruption, plan for termination of service);
- e) Fee policies and procedures (billing arrangements, cancellations and missed appointments);
- f) Confidentiality and limits of confidentiality, including statutory exceptions, involvement of supervisors or other team members, peer consultation, and risks of electronic communications;
- g) Disclosure regarding the nature of any affiliation relationships (third party payers, insurance companies);
- h) Information regarding storage of files (retention, retrieval, preservation, and disposal);
- i) The process for disputes or complaints.

3.4 Consent for Special Purposes

Members must obtain written client consent to record any session, identifying the purpose and use of the recording. They should also specify the length of retention and disposal of the recording. Note that an audio or video recording need not be retained with the file if it is not considered part of the file. For example, a psychotherapy session might be recorded for

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clinical supervision purposes with the intention that it be destroyed immediately after viewing. Alternatively, a client may agree to permit a recording to be retained for training purposes.

Members must obtain written client consent to be viewed with a one-way mirror for training or research purposes.

Members must inform all research subjects of the purpose of their research. In addition, subjects must be made aware of any experimental procedures, possible risks, disclosures, and limitations on confidentiality. Subjects should be informed that they are free to ask questions and discontinue at any time.

4. Competence

4.1 Practicing Within Boundaries of Competence

Members are responsible for practising within the parameters of their competence, based on their education, training, supervised experience, professional experience, and credentials.

Members should practice in specialty areas new to them only after obtaining appropriate education, training, and supervised experience. While developing skills in new areas, members take steps to ensure the competence of their work and to protect others from harm. Members wishing to provide services outside their areas of competence and scope of practice should do so only under supervision.

Members should not delegate activities to persons not competent to carry them out.

Members should take immediate steps to obtain consultation or to refer a client to a colleague or other appropriate professional, whichever is more likely to result in providing the client with competent service, if it becomes apparent that a client's problems are beyond their training and competence.

4.2 Cultural Competence

Cultural, or multicultural, competence is the ability to work effectively with individuals whose background (i.e., colour, culture, ethnicity, age, disability, gender, religion, sexual orientation, socio-economic status, and marital status) is different from one's own. Members are responsible for being knowledgeable and sensitive to cultural and ethnic diversity and to forms of social injustice such as poverty, discrimination, and imbalances of power that exist in the culture and that affect clients.

Members should take steps to increase their knowledge, personal awareness, sensitivity, and skills when working with a diverse client population.

4.3 Maintaining Competence

Members are expected to maintain current knowledge of theoretical, clinical, and professional developments relative to their areas of professional practice, fields of specialization, or directly related to the services they provide. Professional development includes: reading relevant literature and research findings, attending workshops, lectures, seminars, and study groups; participating in clinical supervision and peer consultation.

Members should continually monitor their effectiveness as professionals and take steps to improve when necessary.

4.4 Compromised Competence

Members should not undertake or continue to provide mental health services when they are, or could reasonably be expected to be, impaired due to mental, emotional, physiological, pharmacological or substance abuse conditions. If such a condition develops after mental health services have been initiated, members should discontinue the mental health services in an appropriate manner. Members should make reasonable efforts to ensure that clients are notified and assisted in obtaining replacement services to ensure continuity of care.

Members assume responsibility for their own emotional, mental, and physical health. When personal matters arise that could compromise their work, they take whatever steps are necessary, including obtaining individual therapy and/or supervision.

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5. Professional Boundaries

5.1 Conflict of Interest

Conflict of interest may be defined as a situation in which members have an actual or potential personal, legal, financial, or other professional interests or obligations that may influence or appear to influence them in the performance of their professional responsibilities. It is important to note that actual influence is not required in order for a conflict of interest situation to exist. It is sufficient if there is reasonable concern that there might be such influence.

Since conflict of interest has the potential to betray trust and compromise integrity, members should not accept as clients, or continue to provide services to current clients, when personal, legal, financial, or other professional interests or obligations could reasonably be expected to impair their objectivity, competence, or effectiveness in delivering mental health services, or expose the client to harm or exploitation.

5.2 Dual or Multiple Relationships

A dual relationship is defined as a situation in which members have one or more other relationships with the client in addition to their professional relationship, regardless of whether this occurs prior to, during, or following the provision of professional services.

A dual relationship does not necessarily constitute a conflict of interest; however, where dual relationships exist, there is a strong potential for conflict of interest and there may be an actual or perceived conflict of interest. Relationships beyond the professional one include, but are not limited to, those in which members receive a service from the client, members have a personal, familial, or business relationship with the client, or members provide services to students, employees, or supervisees.

Members should not accept as clients persons with whom they are having, or have had, a personal, professional, or financial relationship and are advised not to enter into other professional or financial relationships with their clients.

In cases where dual relationships are unavoidable, members should evaluate whether a dual relationship might impair their professional judgment or increase the risk of exploitation or harm to clients. In rural settings where therapists are scarce, dual relationships may be unavoidable. If members provide mental health services to individuals with whom there is a social or business relationship, special attention must be paid to preserving the therapeutic relationship and preventing boundary violation. Contact between the member and the client outside the therapeutic hour should be avoided as much as possible.

5.3 Avoidance of Exploitation

Members should not exploit persons over whom they have supervisory, evaluative, or other authority such as clients, students, supervisees, or employees.

Members should not use information obtained during the provision of mental health services to directly or indirectly acquire advantage over or exploit the client or to improperly acquire a benefit.

5.4 Bartering

Due to the power differential inherent in therapeutic relationships, some consider anything other than regular fee payment to be a boundary issue since there is substantial risk for exploitation. It is crucial to consider the influence of transference, the kind of dual relationship that will result between the member and the client, the economic context (what the arrangement will cost both the member and the client), the other power differences that might exist between the member and the client, and how the services will be evaluated. In some cases, community norms must be considered. In other words, members must take into account the role of cultural beliefs and practices for small communities, particularly those with few resources.

Members who consider engaging in bartering should employ the following safeguards: analysis of the possible implications and therapeutic issues, establishment of a clear contract/unambiguous guidelines with the client, discussion about potential difficulties and methods of resolution, and ongoing consultation with their supervisor and/or colleagues.

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5.5 Gifts

Members should not accept gifts of more than token value.

Members should not persuade or influence a client to make gifts or contributions of any kind or request favours or services for themselves.

5.6 Sexual Relations with Clients

Members bear the burden of responsibility to uphold ethical standards and to act in the best interest of the client, not to further their own interest. Clients are vulnerable, therefore, members have a moral responsibility to maintain professional standards and to model ethical behaviour.

Members should avoid any type of sexual intimacies with clients and not counsel persons with whom they have had a sexual relationship. Members should not engage in sexual intimacies with former clients within a minimum of two years after terminating the therapeutic relationship. This prohibition is not limited to the two-year period but extends indefinitely if the client is clearly vulnerable, by reason of emotional or cognitive disorder, to exploitative influence by the member. Members should be aware that the client's autonomy remains at risk even after the therapeutic relationship ends because of the power differential inherent in therapy. Members, in all such circumstances, clearly bear the burden to ensure that no such exploitative influence has occurred, and to seek consultative assistance.

5.7 Sexual Relationships with Others

Members should not engage in a sexual relationship with an individual with whom they have a current evaluative relationship or with whom they might reasonably expect to have a future evaluative relationship.

5.8 Sexual Harassment

Members should not engage in sexual harassment in any professional context. Sexual harassment includes, but is not limited to, any or all of the following:

- a) The use of power or authority in an attempt to coerce another person to engage in or tolerate sexual activity. Such uses include explicit or implicit threats of reprisal for noncompliance or promises of reward for compliance.
- b) Engaging in deliberate and/or repeated unsolicited sexually oriented comments, anecdotes, gestures, or touching, where the member knows or ought to know that such behaviours are offensive and unwelcome, or creating an offensive, hostile, or intimidating professional environment.
- c) Engaging in physical or verbal conduct of a sexual nature when such conduct might reasonably be expected to cause harm, insecurity, discomfort, offence, or humiliation to another person or group.

5.9 Other Forms of Harassment

Members should not engage in any verbal or physical behaviour of a demeaning or harassing nature in any professional context, including workplace harassment.

Workplace harassment can include:

- a) Bullying (repeated and hostile or unwanted conduct - verbal comments, actions or gestures that may affect a reasonable individual employee's dignity or psychological or physical integrity and that result in a harmful work environment for the employee).
- b) Intimidating or offensive jokes, remarks, or innuendos (that demean, ridicule, embarrass, offend, or humiliate a worker or group of workers).
- c) Displaying or circulating offensive pictures or materials (in print or electronic form).
- d) Offensive and intimidating phone calls or emails.
- e) Behaviour that intimidates, isolates, or even discriminates against the targeted individual(s).
- f) Inappropriate sexual touching, advances, suggestions, or requests.

6. Representation of Services

6.1 Accuracy of Public Statements

Members should not knowingly make public statements that are false, misleading, or fraudulent, concerning their mental

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health services or professional activities, or those of persons or organizations with which they are affiliated.

Accordingly, members should not misrepresent directly or by implication their professional qualifications such as education, experience, or areas of competence.

Members should not misrepresent their qualifications by listing or displaying any affiliations with an organization that might be construed as implying the sponsorship or certification of that organization. Specifically, members should not include reference to OACCPP in any promotional material (e.g., website, business cards) unless they are certified members of the association.

Certified members should identify their designation publicly and in advertising only as follows: Certified Member, OACCPP or (C) OACCPP. They do not use the initials OACCPP as if it were an academic degree.

Members should ensure that their activities, functions, and likely or actual outcomes of their activities are not misrepresented by others, and act quickly to correct any such misrepresentation of which they become aware.

Members should take credit only for the work and ideas that they have actually generated, and give credit for work done or ideas contributed by others in proportion to their contribution.

6.2 Presentation of Qualifications

Members who are not members of a regulated profession must inform all clients as to their status as a non-regulated professional and to the scope of competencies that their credential and certification allows.

Members should accurately represent their own and associates/supervisees qualifications, education, experience, competence, and affiliations, in all spoken, written, or printed communications, being careful not to use descriptions or information, which could be misinterpreted.

Members should protect their own and associates/supervisees credentials from being misrepresented by others, and act quickly to correct any such misrepresentation.

Members should clearly delineate their client populations, and be prepared to provide the credentials and training certificates certifying competency in the areas in which they advertise services.

6.3 Promotion of Professional Practice

Members must accurately represent their activities, functions, and likely or actual outcomes of their work, in all spoken, written or printed communication. This includes, but is not limited to: advertisements of services, course and workshop descriptions, and reports.

Members must not make claims that guarantee cures or results.

When advertising or speaking about their services, members may not negatively compare their services with those of other OACCPP members or members of their profession.

Members must not use places of employment that are unaffiliated with their private practice in order to actively solicit for clients.

Members must not solicit prospective clients in ways that are misleading, that disadvantage fellow members or that discredit the profession(s) to which they belong.

Members must not include any endorsements or testimonials when advertising or speaking about their services. Members may, however, cite within their advertising, awards of excellence and other merits related to the practice of the profession.

6.4 Provision of Information to the Public

Members who provide information, advice, or comment to the public via any medium should take precautions to ensure that:

- a) The statements are accurate and supportable based on current professional literature or research;
 - b) The statements are consistent with the professional standards, policies and ethics currently adopted by OACCPP;
- and

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- c) It might reasonably be expected that the individual member of the public receiving this information understands that these statements are for information only, that a professional relationship has not been established and there is no intent to provide professional services to the individual.

Members should not compensate a representative of the media, in any way, in return for free publicity.

Members must not participate, as members of their professions(s), in advertising that recommends that the public buy or use a product or service that is unrelated to the field of their profession.

Members must only use their OACCPP designation in conjunction with their professional practices; members must not use this designation for unrelated business, recreational, or social activities.

Members must keep a copy of all advertisements for a period of three years following the date on which it was last broadcast or published. The copy must be presented, on request, to the Ethics Committee of the OACCPP.

6.5 Logo

Members cannot use the OACCPP logo on any personal professional material.

7. Records and Record Keeping

7.1 General Conditions

Members should make reasonable efforts to ensure that mental health records are complete and accessible.

Members should keep a record related to the mental health services provided by the member for each client who has engaged the member to provide mental health services, or for whom such services has been authorized.

7.2 Content of the Record

The record should be of sufficient detail and be organized so as to allow a third party to recreate what the member observed and thought, what he or she did, and why the approach was adopted. The record should also permit a colleague to assume responsibility for the client's care; in other words, provide continuity of care.

The record should include the following:

- a) The client's name, address, telephone number, as well as any other identifying information needed to distinguish the client from other clients;
- b) The client's date of birth;
- c) The date of every relevant contact between the member and the client;
- d) The date of every relevant consultation, either given or received by the member, regarding service to the client;
- e) A description of the presenting problem and of any history relevant to the problem;
- f) Relevant information about every service activity related to the client that is carried out by the member or under the responsibility of the member, including, but not limited to: assessment procedures, assessment findings, goals or plans of service developed, reviews of the progress on the goals and/or of the continued relevance of the plan of service, activities related to crises or critical incidents, interventions carried out or advice given;
- g) Relevant information about every service activity that was commenced but not complete, included reasons for non-completion;
- h) All reports of correspondence about the client received by the member, which are relevant to the member's service to the client;
- i) A copy of every written consent and/or documentation of the process of obtaining verbal consent related to the member's service to the client;
- j) Relevant information about every referral of the client by the member to another professional.

7.3 Guidelines for Creating Records

The following guidelines are recommended when creating records:

- a) Information should be recorded when the intervention or event occurs, or as soon as possible thereafter.
- b) Entries should be made in chronological order.

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- c) Subsequent alterations or additions should be made openly, with the original entry left intact and legible.
- d) Any corrections should be initialled, signed, and dated.
- e) Except in the case of a sole practitioner, the identity of the person who made the entry should be identifiable and the person should sign the record and indicate his or her position.
- f) If a third party makes an entry, the person who performed the service should verify it.
- g) If handwritten, the record should be made in dark ink and be legible.
- h) The level of detail should reflect the assessment of the client. For example, the record entry regarding a stable, long-standing client need not be as extensive as that of a new client or one with significant presenting problems. The amount of information recorded would likely be greatest at the outset of the relationship and would decrease once a treatment plan had been decided upon and initiated.
- i) The more sensitive the information, the more important it is to ensure that it is relevant to the client's goals or plan of service. Even if sensitive information is to be recorded, it may be appropriate to report the information in general terms.
- j) All statements should be written in an objective, professional tone, particularly those relating to substance use/abuse, sexual activities, mental health, or other sensitive matters. The member should refrain from pejorative or judgmental language, or terms that suggest ill will, malice, or sarcasm.
- k) Items that are relevant should not be omitted simply because they are embarrassing or uncomplimentary.
- l) There is no legal prohibition from recording the names of individuals reported by the client if the information is relevant to the client's care.

7.4 Access by the Client to the Record

Members should provide access by the client or his or her authorized representative to the client's information contained in record in accordance with any applicable privacy and other legislation unless prohibited by law or they are otherwise permitted to refuse access.

7.5 Couple, Family, or Group Therapy Records

When treating individuals together, either in couple, family, or group therapy, the personal information of the individuals is shared and communicated in a group setting; therefore, the records must reflect information about each individual and also about the relationship. Since these individuals choose to share their personal information in the context of couple, family, or group therapy members do not have to make efforts to protect the privacy of these individuals in relation to the personal information that they share.

Where the individuals receive a combination of individual and group therapy, members must protect personal information that is disclosed during individual therapy, as this information is most likely disclosed only for the purpose of individual treatment. In these situations, it is advised that the member keep separate records for individual therapy and for group therapy.

7.6 Access by an Individual to Couple, Family, or Group Therapy Records

An individual has the right to access *any* record that pertains to him/her. When individuals meet for couple therapy, family therapy, or group therapy, there is implicit consent to share personal information with the other members present. Consequently, each individual has right of access to the record without the consent of the other(s). Members are advised to state this *explicitly* at the start of therapy and to include this information on the consent form. An alternative would be for the member to keep separate records for each client from the outset and inform the participants that each would only have access to their individual record.

Please note that for regulated health professionals, according to PHIPA, information provided by an individual during marital or family therapy is accessible by that individual only, unless that individual consents to its release to others participating in the therapy. Therefore, regulated members should ensure that the method used to record information does not prevent them from severing that information from other parts of the record.

7.7 Disclosure of Information from the Record to Third Parties

Members must inform clients early in their relationship of any limits of client confidentiality including with respect to the client record. Members can disclose information from the record to third parties with the written consent of clients or their authorized representatives. The consent must specify:

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- a) The information that is to be disclosed, for example a partial record, the entire record, or a summary of the member's contact with the client;
- b) The party or parties to whom the information is to be disclosed;
- c) The term of validity of the consent.

If, in the member's professional judgment, disclosure of information from the record to a third party could result in harm to the client, members make a reasonable effort to inform the client of the possible consequences and seek to clarify the client's consent to such disclosure. Members may disclose information from the record to third parties without the client's consent only if disclosure is required or allowed by law.

When members receive a request from a third party (e.g., mediators, lawyers, or courts) to disclose information from a record that pertains to more than one client, for example a couple, family, or group, members obtain consent to the disclosure of information from all of the clients before information from such record is disclosed to the third party. In addition, the consent needs to be specific to the material chosen or the reports given.

Members who are served with a formal notice or subpoena to produce client records before a court and who are of the opinion that disclosure would be detrimental to the client, should themselves, or through legal counsel, advocate for non-disclosure to the court.

7.8 Providing Reports

Members must provide a requested report to the client, or client's authorized representative (which may be any duly authorized representative such as a lawyer or insurance company) within a reasonable time period (usually no more than 30 days). The member should have an effective system within his or her office to track such requests to ensure that the reports, etc., are provided in a timely manner.

7.9 Retention of Records

Unless otherwise required by law:

- a) Records should be kept for a period of ten years* following the client's last contact; or
- b) If the client was less than eighteen years of age at the time of his/her last contact, ten years* following the day the client became or would have become eighteen.
- c) In cases of reported sexual abuse, it might be prudent to keep records for a much longer period.

* Note that although some regulatory Colleges suggest shorter retention periods, the Association recommends a minimum of ten years.

In private practice, the member owns, and is responsible for, the record.

If the member works in an agency/institution, the agency/institution owns, and is responsible for, the record.

7.10 Billing Records

A record of fees charged and received from clients should contain the following information:

- a) the payer;
- b) the recipient of mental health services;
- c) the service provider(s);
- d) the date of service;
- e) the nature of the service;
- f) the fee for the service;
- g) the payment received;
- h) the date of payment.

Such records should be retained for five years from the date of the last interaction with the client or the client's eighteenth birthday, whichever is later.

7.11 Appointment and Attendance Records

Record keeping includes creating and maintaining an appointment and attendance record for five years.

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7.12 Security of Client Records

Members should make reasonable efforts to properly store client records, ensuring that they are secure and protected from loss, tampering, or unauthorized use or access.

Members should exercise appropriate care when placing information in a common record in an effort to ensure that their reports and recommendations are not misunderstood or misused by others who may have access to the file.

Members should make reasonable efforts to ensure that the disclosure and transmission (including electronic) of information protects the privacy of the client record.

7.13 Client Records of Members Who Cease to Provide Mental Health Services

Members who plan to or cease to provide mental health services should:

- a) Take ongoing responsibility for the maintenance and security of client records or make arrangements, preferably with another member, for the security and maintenance of client records;
- b) Ensure that former clients have access to the client record for the prescribed retention period; and,
- c) If members of a regulated profession, inform their respective College of these arrangements prior to ceasing to provide mental health services or at the earliest reasonable opportunity.

Members in private practice should make arrangements, preferably with another member, for the security and maintenance of private practice client records in the event of their incapacity or death. Members of a regulated profession should inform their respective College of these arrangements.

8. Fees

8.1 Fees and Billing Arrangements

Members should reach an agreement with an individual, group, or organization, concerning the mental health services to be provided, the fees to be charged, and the billing arrangements prior to providing services. Members should provide clients with a clear written outline detailing these fees and payment procedures, along with any reasonable penalties for cancelled or missed appointments. If third party payment is involved, a written explanation should be provided to the client as to how these transactions will be handled. If additional services that fall outside of the initial agreement are requested by the client, a member must outline the charges for these additional services in order that the client may decide whether or not to contract for these services.

Any fees charged for missed or cancelled sessions must not exceed the originally agreed upon session or appointment fee.

Any changes in the services to be provided should be agreed to by the client before service is delivered or fees are changed. Fees should be based on the amount of time spent and complexity of the services rendered.

Fees should be reasonably based on the costs, expertise, time spent, and complexity of the services rendered. When assessing fees it is also reasonable to take into account any requests for exceptional celerity in the provision of a service. Members should not charge a fee that would be regarded by members as excessive in relation to the service provided. This includes charging more than one's usual fee for a service where a third party is paying it.

Fees should not be set on the basis of advantage or material benefits accruing to the individual receiving services, however members may defer the collection of fees, reduce or waive fees when clients are experiencing financial hardship. While it is acknowledged that bartering may be an accepted practice within some cultures and communities, extreme caution should be used when considering barter payments as these may create a conflict of interest along with tax ramifications; members should not enter into these agreements unless there is no conflict of interest, no risk of client exploitation, and no other suitable alternatives. Any barter agreements must be carefully discussed with the client and documented in writing. If a client is unable to pay for a member's services, the member may also refer the client to other suitable and affordable services.

Members employed by an agency or institution must not charge or accept private fees from agency clients for services that the client would be entitled to receive from the members' institution or agency of employment. Members employed by

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an agency or institution should follow the policies set out by their employer regarding seeing clients and accepting fees from those clients within the members' private practice.

8.2 Interest Charges

A member may charge interest on an overdue account if the client is informed of this practice at the time of billing. Interest charges must be at a previously agreed upon rate and should not exceed what is reasonable to cover costs.

8.3 Collection of Unpaid Fees

If the client does not pay for mental health services as agreed, and if the member intends to use a collection agency or legal options to collect the fees, the member should first inform the client of this intention and provide a reasonable opportunity and options for payment to be made.

8.4 Retainers

A member should not ask a client to prepay for mental health services, except in the case of a block service such as group therapy or workshop series. Funds may be held in trust if agreed by the client and the member. These trust funds should only be applied to services rendered and any excess returned to the client following the termination or conclusion of services.

Members may, however, ask for advance partial payment to cover necessary expenses (e.g., travel costs) with performing the requested contract work or professional services.

8.5 Fee Splitting

A member should not enter into a contractual arrangement such as a lease for use of premises or equipment or administrative services that provides for fee or income splitting based on a percentage of fees invoiced or collected.

Any arrangement for payment for services should be based on a fixed rate of remuneration and not on a percentage of fees invoiced or collected.

Members should not accept fees, commissions, rebates, or anything of value for either accepting or making referrals.

Members may divide fees with other professionals who have participated in the provision of care or services in relation to the client. Such division should be in proportion to the level of responsibility and time contributed by the other professional.

9. Testing

9.1 Test User Qualifications

The phrase *test user qualifications* refers to the combination of knowledge, skills, abilities, training, experience, and credentials necessary for the responsible use of tests, including psychological tests. Members who use such tests should be aware of their level of competency in terms of appropriate selection of tests, test administration, and test interpretation. With respect to the use of psychological tests designated as 'C' level, members are obliged to acquire and administer such tests under the direct supervision of a registered psychologist or psychological associate.

9.2 Test Copyright and Security

Members should respect test copyright laws and not violate them by photocopying or reproducing test materials. Members should protect the security of tests, distinguishing between raw test data and test materials. When reasonable and appropriate, raw data from standardized tests should, upon request and with proper authorization, be released to clients and others. Test material, such as test questions and stimuli, manuals, and protocols should not be released.

9.3 Guidelines for Testing

Test Selection

1. Members should be familiar with the evidence for the relevance and utility of the interventions used and with the proper use and application of these interventions.

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2. Tests to be used should have evidence in the manual that it corresponds sufficiently to the construct being measured.
3. Tests selected for individual testing should be appropriate for the population of test taker. Whenever possible, tests that were standardized with Canadian norms should be used.
4. If tests are to be used in combination, there should be a rationale made evident by the test manual and other literature.
5. Members should confine their testing activities to their areas of competence as demonstrated through education, experience, and credentialing.
6. For cases of differential diagnosis, the test should distinguish between clinical groups instead of just distinguishing abnormal cases from the general population.
7. Tests selected to address a complex referral issue should be appropriate for the purposes of assessment, as determined by validity studies and professional judgment.
8. Members should be familiar with the standardization, norms, reliability, and validity of any tests and techniques used and with the proper use and application of these tests and techniques. They should be able to articulate a logical analysis that supports the use of any test.
9. Members should not use outdated or obsolete tests.
10. Tests used should have adequate reliability and validity indexes with supporting research.
11. Tests used should be theoretically diverse.

Test Administration

1. Prior to testing, the test taker ought to be provided with appropriate prefatory information about the test and circumstances for retesting.
2. Members should carefully follow the exact instructions for administration to facilitate optimal performance of test takers.
3. Members who supervise others in testing should ensure that these persons have received adequate training to properly administer the test.

Test Interpretation

1. Members should render only those professional opinions that are based on current, reliable, adequate, and appropriate information.
2. Members should not introduce biases that accommodate individuals or groups who have a vested interest in decisions influenced by test interpretation.
3. Use carefully defined diagnostic terms, categories, and methods when using test results as a comparison to check the validity of a diagnosis.
4. Members who supervise others in testing activities should ensure that these persons have received adequate training to interpret the test.
5. Interpretation of test results should take into account the many qualitative features of test-taking behaviour, such as fatigue, level of motivation, and other factors that may affect the results. Description and analysis of alternative explanations should be provided with the interpretation.
6. Imply that a relationship exists between test results, prescribed interventions, and desired outcomes only if empirical evidence for that relationship exists.
7. Tests that are used for recommendations or decisions should be based on multiple sources of convergent data and an understanding of the test's foundations and limits.
8. Members should not infer that interpretations of test data are based on empirical evidence of validity unless such evidence exists.
9. Multicultural factors must be considered in test interpretation, diagnostic decision, and prognostic formulations.
10. Members are responsible for evaluating the relevance and appropriateness of the norms upon which the interpretation is based.
11. Members should use information about norms to consider the possibility of bias.
12. Members are responsible for evaluating the quality of computer software interpretations of test data. Computer-generated assessments, reports, or statements should not be substituted for a member's professional opinion.

Reporting Test Results

1. Members should render only those professional opinions they qualified to make. Care must be taken to avoid performing the controlled act of communicating a diagnosis unless qualified to do so, or when working under the

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- direction and supervision of a registered psychologist.
2. The purpose of the test should be disclosed to the test taker.
 3. Members should provide test results in as positive and nonjudgmental a manner as possible.
 4. Members should make reasonable efforts to present information in a manner that is likely to be understood by the client and other recipients of their reports. For example, avoiding the use of jargon, acronyms, overly technical or complex language, and vague, unclear, or ambiguous statements.
 5. Members should share with the client, in a language that the client can understand, information about test results, interpretations, and the range of error for such interpretations.
 6. Members are responsible for ensuring the confidentiality of test results and testing materials according to prevailing privacy legislation.
 7. Members can only disclose test results to persons other than the test taker when the test taker has signed a release of information to those specific individuals.

10. Electronic Practice (E-Practice)

10.1 Definition of Electronic Practice

Electronic practice is defined as the provision of mental health services (assessment, treatment, or other intervention) via electronic means rather than standard in-person methods. Delivery may be synchronous or asynchronous and provided by: telephone; teleconferencing; e-mail; text messaging; Internet-based voice, video, instant messaging, or videoconferencing (including Voice Over Internet Protocol - VoIP); social media; or other media. These alternative forms may be utilized as the sole means of contact with clients or may be used as an adjunct to in-person mental health services. It is understood that regardless of the delivery method the same standards of practice and ethical guidelines should be observed as for in-person mental health services. It must also be acknowledged that there are some additional considerations connected with electronic practice. These additional considerations are outlined within this section.

10.2 Informed Consent and Contact Information

If members contemplate providing mental health services through electronic means to a client they have never met face-to-face, they should take all reasonable measures to ascertain that the person is representing him/herself with verisimilitude. Members are encouraged to have potential clients confirm that they have read and understood consent to mental health services, along with providing complete contact information. Members should attempt to verify that the client is old enough and has the capacity to consent to assessment or treatment; this may, for example, be done via questionnaire. Additionally, members should ask potential clients to agree to accurately portray themselves at all times unless they are specifically being asked by the member to engage in a role-play.

Members should ascertain which issues, conditions, or disorders they have the capacity to assess or treat via electronic practice. If issues are deemed to be inappropriate for mental health services delivered through electronic practice, members should inform the potential client of this and, whenever practical, suggest alternative appropriate services.

Members should be clear with potential clients that they are not providing crisis counselling. As crises may arise during the provision of mental health services, members should ensure that they have alternate means for contacting the client and that they have provided the client with clear directions as to how to connect with crisis services. If members are providing mental health services through electronic practice to someone outside their immediate geographical area, they should make themselves familiar with the mental health and crisis intervention services available in the client's area; members should be prepared to connect clients with services in the client's area.

10.3 Special Concerns Regarding Privacy

When providing mental health services through electronic means, members are responsible for ensuring that privacy is maintained for clients. Members should take all reasonable measures to ensure that electronic communications are accessible only to them and the client. For example, electronic messages and transmissions should ideally be encrypted and password protected to reduce the possibility that transmissions might be "hacked" or accessed by someone other than members and their clients. Members should outline to clients how to enact encryption and password protection.

If, for whatever reason, members operate their electronic practice without encryption or password protection, members must inform the client that these exchanges may not be secure.

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10.4 Jurisdictional Issues

Members must not provide services to clients living within jurisdictions that require a license to practice, unless the member has a license for the jurisdiction.

10.5 Response Time and Appointment Times

If providing asynchronous services through electronic means, members should clearly convey to clients the time frame within which a response may be expected.

Members should inform clients as to when they may be reached for synchronous exchanges and should attempt to set appointment times for these exchanges.

10.6 Payment

Members should ensure that clients have a secure and confidential means for making payments. Members should be clear as to what the client is paying for and should establish rates in advance of commencing services. For example, if a client is paying for telephone psychotherapy, fees should be established for a set time frame prior to the commencement of the telephone session. Similarly, if clients are receiving asynchronous e-mail responses, members should be clear as to how much time they will devote to responses and should establish a fee prior to delivering the service. Once established, fees should not be altered without prior consultation and agreement with the client.

10.7 Record Keeping

All record keeping standards that pertain to in-person mental health services should be adhered to in an electronic practice. For example, members should keep session notes along with billing records.

10.8 Training

As electronic practice can present special challenges not inherent in more traditional forms of mental health services, members are advised not to engage in electronic practice without adequate training such as that provided by a formalized training course.

10.9 Liability Insurance Issues

Members should discuss the policy regarding liability insurance for electronic practice with their insurance provider.

11. Supervision and Consultation

11.1 Ongoing Clinical Supervision for Regulated and Non-regulated Members

Members are expected to engage in ongoing clinical supervision. It is recommended that members ensure that supervision is conducted by a practitioner who has extensive clinical experience, preferably five years or more. Ideally, the supervisor is a member of a regulated profession or a certified member of OACCPP and has successfully completed courses in clinical supervision.

For members who have the type of practice where clients frequently require referral to a registered psychologist for a formal diagnosis, members are strongly advised to receive regular supervision from a registered psychologist.

In practices where supervision comprises a regular part of the member's provision of service, supervisors should co-sign progress notes; in particular, if one session is being used in case supervision, both the notes regarding the consultative process and the corresponding progress notes should be signed by the supervisor. Co-signing of progress notes is strongly advised if the member works in a clinic under direct supervision.

11.2 Peer Consultation

Members should seek consultation from colleagues and/or appropriate groups and committees, and give due regard to their advice in arriving at a responsible decision, if faced with difficult situations. Such consultation can add knowledge or objectivity to the decision-making process.

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Some members may wish to participate in a peer consultation group. These groups differ from group supervision in that there is no evaluative component and they typically function without a designated leader. Peer consultation groups generally consist of colleagues with similar levels of professional experience who may gather to discuss cases, provide referrals, suggest referral alternatives, or help manage caseloads during absence from practice. These groups can offer the opportunity for professional development, growth and enhancement of clinical skills, deepening of knowledge, and self-reflection. Peer consultation groups can serve as a source of both professional and personal emotional support.

11.3 Informed Consent from Clients

If identifying information about clients will be shared in supervision, clients must be informed and consent to participate in treatment with an understanding of this condition must be obtained. Even when identifying information is not used, clients should be informed that their cases might be shared in a consultation group. In either case, members should be judicious in their disclosure of client information, presenting only what is necessary. Efforts to disguise clients' identities should go beyond excluding a client's last name. Sometimes nonessential details (e.g., age, number of children, marital status, occupation) can be deliberately altered while still preserving the integrity of the case.

11.4 Responsibility of Clinical Supervisors

Members who are responsible for supervising employees, students, and trainees, including those registered with a College, should ensure that:

- a) They have the necessary knowledge, skills, and qualifications to supervise others;
- b) They provide supervision appropriate to the knowledge, skills, and competence of the individuals being supervised;
- c) They take responsibility for clarifying their respective roles and obligations;
- d) They take steps to safeguard the welfare of clients during the period of supervision and intervene when necessary to ensure this obligation is met;
- e) They co-sign all reports and formal correspondence related to services prepared by non-regulated providers;
- f) Billing for services is in the name of the supervising member, Professional Corporation, or employer.