College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

AGENDA ITEM 1.0

COUNCIL AGENDA

DATE: Tuesday, June 26, 2018 **FROM**: 9:00 a.m. – 3:30 p.m.

	Agenda Item	Objective	Attachment
1.0	**Call to Order**		
2.0	**Declaration of Conflict of Interest**		
3.0	**Approval of Agenda**	Decision	✓
4.0	**Draft Minutes**		
	4.1 *Draft* Council Minutes of March 29, 2018	Decision	✓
	4.2 *Draft* Council Officer Election Minutes of March 29, 2018	Decision	✓
5.0	**Registrar's Report**		
	5.1 Annual Registrar Evaluation Process – *in camera (confidential human resources matter)*	Information	
	5.2 Registrar's Written Report	Information	✓
	5.3 Presentation: *Operational Status Report for Q4 2017-2018* By: Elinor Larney, Registrar	Information	
	5.4 Priority Performance Report	Decision	✓
	5.5 Risk Management Program	Decision	✓
6.0	**Finance**		
	6.1 March 2018 Financial Report	Decision	✓
	6.2 Reserve Fund at Year-End	Information	✓
	6.3 Projected 2018 – 2019 Budget	Decision	✓
7.0	**Council Development (11:00 a.m.)**		
	Presentation: *Quality Assurance Program, Ontario College of Pharmacists* By**:** Shirin Jetha, Quality Assurance Lead, Registrant Competence, and Sandra Winkelbauer, Manager of Registrant Competence		
8.0	**Governance**		
	8.1 Bylaw Amendments	Decision	✓
	8.2 Reappointment of Non-Council Member – QA Committee	Decision	✓
9.0	**Business Arising**		
	9.1 Regulations – Controlled Act of Psychotherapy	Decision	✓
	9.2 Revised Standards for Psychotherapy	Decision	✓
	9.3 Standards for the Prevention of Sexual Abuse	Decision	✓
	9.4 Guide to Discretionary Reporting	Decision	✓

	Agenda Item	Objective	Attachment
10.0	**Roundtable**		
	10.1 Evaluation of Officer Nomination Process	Discussion	✓
11.0	**Environmental Scan**		
12.0	**Committee/Task Force Reports**		
	12.1 Executive	Information	✓
	12.1.1 Practice Issues Subcommittee	Information	✓
	12.2 Registration	Information	✓
	12.3 Inquiries, Complaints & Reports	Information	✓
	12.4 Discipline	Information	✓
	12.5 Fitness to Practice	Information	✓
	12.6 Quality Assurance	Information	✓
	12.7 Patient Relations	Information	✓
13.0	**Other Business**		
	13.1 Council Meeting Evaluation	Complete & Submit	✓
14.0	**Next Meetings**		
	- Council Education Session: Wednesday,October 24, 2018, 9:00 a.m. – 4:00 p.m. (Location TBA) - Council Meeting: Thursday, October 25, 2018, 9:00 a.m. -3:30 p.m., at the College - Council Meeting: Thursday, January 31, 2019, 9:00 a.m. – 3:30 p.m., at the College - Council Meeting: Thursday, March 28, 2019, 9:00 a.m. – 4:00 p.m., at the College - Council Meeting: Tuesday, June 25, 2019, 9:00 a.m. – 3:30 p.m., at the College		
15.0	**Adjournment**		

College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

AGENDA ITEM 4.1

DRAFT COUNCIL MINUTES

DATE: Thursday, March 29, 2018 FROM**:** 9:00 a.m. – 3:00 p.m.

PRESENT:
Jane Cox, *Chair*
Donna Barker
Julie Chiba Branson
Mary Egan
Julie Entwistle
Jeannine Girard-Pearlman
Shannon Gouchie
Jennifer Henderson
Patrick Hurteau
Winston Isaac
Kurisummoottil S. Joseph
Ernie Lauzon
Laurie Macdonald
Annette McKinnon
Serena Shastri-Estrada
Peter Shenfield
Paula Szeto
Abdul Wahid

OBSERVERS:
Heather McFarlane
Stephanie Schurr
Teri Shackleton

GUESTS:
Carolyn Everson, Consultant, The Everson Group

ALSO PRESENT:
Elinor Larney, Registrar
Kara Ronald, Deputy Registrar
Anne MacPhee, Interim Director of Finance & Corporate Services
Nancy Stevenson, Director of Communications
Sandra Carter, Practice Advisor*, (8.1-8.5)*
Aoife Coghlan, Manager, Investigations & Resolutions, *(7.3)*
Tim Mbugua, Policy Analyst *(8.1-8.5)*
Sonia Mistry, Practice Advisor, (*8.1-8.5)*
Brandi Park, Manager, Registration, *(1.0-7.0)*
Seema Sindwani, Manager, Quality Assurance, *(5.0-5.3, 7.3)*
Andjelina Stanier, Executive Assistant, *Scribe*

1.0 Call to Order

The Chair welcomed everyone and called the meeting to order at 9:02 a.m. She introduced new public member, Peter Shenfield, and welcomed as observers, newly elected members of Council: Teri Shackleton for District 3, Heather McFarlane for District 5, and Stephanie Schurr for District 6. The Chair introduced Anne MacPhee, Interim Director of Finance and Corporate Services. Council members introduced themselves and spoke about their professional experience and work on Council. She personally thanked outgoing members, Shannon Gouchie, Laurie Macdonald and Abdul Wahid for their hard work and commitment to the work of the College.

2.0 Declaration of Conflict of Interest

The Chair asked if members had a conflict of interest to declare. None was reported.

3.0 Approval of Agenda

The Chair asked if there were any additions or changes to the agenda. None were reported.

MOVED BY: Winston Isaac
SECONDED BY: Jennifer Henderson

THAT *the agenda be approved as presented.*

CARRIED

4.0 Approval of Minutes

4.1 Draft Council Minutes of January 25, 2018

The Chair asked if there were any edits to the draft Council minutes of January 25, 2018. None were reported.

MOVED BY: Laurie Macdonald
SECONDED BY: Kurisummoottil S. Joseph

THAT *the draft Council minutes of January 25, 2018 be approved as presented.*

CARRIED

5.0 Registrar's Report

5.1 Registrar's Report

Council reviewed the written report and the Registrar responded to questions. A discussion took place on the controlled act of Psychotherapy.

5.2 Registrar's Presentation

The Registrar reported on the outcomes of specific areas of focus related to the 2017-2018 Strategic Plan.

5.3 Priority Performance Report

A revised report was distributed. Council reviewed and discussed performance data for Q3 (December 1, 2017 – February 28, 2018) of the 2017-2018 fiscal year, related to the College's progress towards meeting objectives as outlined in the 2017-2020 Strategic Plan.

MOVED BY: Jeannine Girard-Pearlman
SECONDED BY: Patrick Hurteau

THAT *Council receives the Priority Performance Report for the third quarter as presented.*

CARRIED

6.0 Finance

6.1 January 2018 Financial Report

Council reviewed the report and held a discussion.

MOVED BY: Winston Isaac
SECONDED BY: Laurie Macdonald

THAT *Council receives the January 2018 financial report, statement of financial position, and statement of operations, as presented.*

CARRIED

6.2 Annual Investment Report

The Chair presented the Annual Investment Report and asked if there were any concerns. No concerns were reported.

7.0 Governance

7.1 2018 Elections – Districts 3, 5 & 6

Elinor presented the results of the 2018 Elections and reported that the process went smoothly with no concerns. She responded to questions from members related to processes with a goal of increasing voter turnout in the future.

7.2 Council Policy Review – Per Diems

Council reviewed three governance documents and provided additional recommendations which included minor changes to the Allowable Expenses and Honoraria for elected and non-elected Council member documents and removing entirely the document on College procedures related to honoraria for public members.

MOVED BY: Jeannine Girard-Pearlman
SECONDED BY: Serena Shastri-Estrada

***THAT** Council approves the revisions to the following Council documents, including today's changes:*

1. *Allowable Expenses – Guidelines for Elected Council and Non-Council Members,*
2. *Honoraria – Guidelines for Elected Council and Non-Council Members.*

And deletion in its entirety of the following Council document:

3. *College Procedures for Honoraria/Expenses by the Ministry of Health and Long-Term Care, for all Order in Council Appointments (Public Members)*

CARRIED

7.3 College Values Statements

Carolyn Everson, governance consultant, joined the meeting for this item. Jennifer Henderson, Chair of the College Values Working Group which was tasked with developing the final updated version of the College Values Statements, presented the final draft. Overall, the draft was very well received by Council; an additional recommendation was made. Jennifer thanked Carolyn and working group members for their participation.

MOVED BY: Jennifer Henderson
SECONDED BY: Jeannine Girard-Pearlman

***THAT** Council approves the revised College Values Statements including today's recommendation.*

CARRIED

8.0 New Business

8.1 Controlled Act Regulation

Council reviewed the controlled act regulation which requires re-circulation given the long time lapse between 2009, when the regulation was originally circulated and proclamation of the Controlled Act in December 2017.

MOVED BY: Shannon Gouchie
SECONDED BY: Kurisummoottil S. Joseph

THAT *Council approves the proposed Controlled Act of Psychotherapy regulation for circulation to registrants and other stakeholders.*

CARRIED

8.2 Protecting Patients Act, 2017: Proposed Regulations & Next Steps

Kara Ronald presented this item.

8.3 Standards for the Prevention of Sexual Abuse

Julie Chiba Branson, Chair of the Patient Relations Committee, brought forward this document for stakeholder consultation, and responded to questions and comments. Council made further recommendations.

MOVED BY: Julie Chiba Branson
SECONDED BY: Patrick Hurteau

THAT *Council approves the revised Standards for the Prevention of Sexual Abuse for stakeholder consultation.*

MOTION DEFEATED

MOVED BY: Shannon Gouchie
SECONDED BY: Ernie Lauzon

THAT *Council approves the revised Standards for the Prevention of Sexual Abuse for stakeholder consultation with suggested changes outlined today.*

CARRIED

8.4 Standards for the Supervision of Occupational Therapist Assistants

Shannon reported on the proposed revisions of this document following an internal review and stakeholder consultation. Council reviewed the draft document and provided further recommendations.

MOVED BY: Shannon Gouchie
SECONDED BY: Laurie Macdonald

THAT *Council approves the revised Standards for the Supervision of Occupational Therapist Assistants, including today's suggested changes.*

CARRIED

8.5 Guidelines for Working Within Managed Resources

Shannon reported on the proposed revisions which include a change of title. This document does not require stakeholder consultation. Council reviewed the draft document and provided further recommendations.

MOVED BY: Shannon Gouchie
SECONDED BY: Jennifer Henderson

***THAT** Council approves the revised Guidelines for Working Within Managed Resources, including today's suggested changes.*

CARRIED

9.0 Environmental Scan

Council members provided various updates on changes in systems and information of interest that impact the practice of occupational therapy.

10.0 Committee Reports

10.1 Executive – Report by Jane Cox, Chair

10.1.1 Practice Issues Subcommittee – Report by Shannon Gouchie, Chair

10.2 Registration – Report by Serena Shastri-Estrada, Chair

10.3 Inquiries, Complaints & Reports – Report by Julie Entwistle, Chair

10.4 Discipline – Report by Paula Szeto, Chair

10.5 Fitness to Practise – Report by Kurisummoottil S. Joseph, Chair

10.6 Quality Assurance – Report by Laurie Macdonald, Chair

10.7 Patient Relations – Report by Julie Chiba Branson, Chair

10.8 Nominations – Report by Mary Egan, Chair

11.0 Other Business

11.1 Council Meeting Evaluation

The Chair asked members to complete and submit their meeting evaluation forms and encouraged everyone to provide recommendations for future improvements.

12.0 Next Meeting

The next Council Meeting will be held Tuesday, June 26, 2018, 9:00 a.m. – 3:30 p.m., at the College. Meetings for October 2018 – June 2019 will be determined at the conclusion of the Council Elections meeting today.

13.0 Adjournment

There being no further business, the meeting was adjourned at 2:00 p.m.

MOVED BY: Jeannine Girard-Pearlman
SECONDED BY: Serena Shastri-Estrada

***THAT** the meeting be adjourned.*

CARRIED

College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

AGENDA ITEM 4.2

DRAFT MINUTES – ELECTION FOR COUNCIL OFFICERS

DATE: Thursday, March 29, 2018 **FROM:** 3:00 – 4:00 p.m.

PRESENT:
Elinor Larney, *Chair*
Donna Barker
Julie Chiba Branson
Mary Egan
Julie Entwistle
Jeannine Girard-Pearlman
Jennifer Henderson
Patrick Hurteau
Winston Isaac
Kurisummoottil S. Joseph
Ernie Lauzon
Heather McFarlane
Annette McKinnon
Stephanie Schurr
Teri Shackleton
Serena Shastri-Estrada
Peter Shenfield
Paula Szeto

REGRETS:
Abdul Wahid

SCRUTINEERS:
Jane Cox
Shannon Gouchie

ALSO PRESENT:
Kara Ronald, Deputy Registrar
Anne McPhee, Interim Director of Finance & Corporate Services
Nancy Stevenson, Director of Communications
Andjelina Stanier, *Scribe*

1.0 Call to Order

The Chair called the meeting to order at 3:00 p.m.

2.0 Appointment of Scrutineers

Jane Cox and Shannon Gouchie were appointed as scrutineers.

3.0 Approval of Agenda

The Chair asked if there were any changes to the agenda. None were reported.

MOVED BY: Ernie Lauzon
SECONDED BY: Annette McKinnon

***THAT** the agenda for the Election of Officers be approved as presented*.

CARRIED

4.0 Elections

4.1 Election of Officers

The Chair stated that according to the bylaws, the Executive Committee must be composed of two professional and two public members of Council. She said she would read the slate of nominees prior to the vote for each position and additional nominations would be accepted from

the floor. A call for nominations would be made three times before declaring the nominations closed for each position.

The Chair proceeded with the election as follows:

PRESIDENT

Julie Entwistle and Winston Isaac were nominated for the position of President. No further nominations were received for this position and nominations were declared closed. Julie Entwistle withdrew her nomination. Ballots were not completed.

Winston Isaac was declared elected by acclamation as President.

VICE-PRESIDENT

Julie Chiba Branson, Julie Entwistle, Jennifer Henderson and Winston Isaac were nominated for the position of Vice-President. Winston Isaac's name was removed from the slate. No further nominations were received for this position and nominations were declared closed. Ballots were completed.

Julie Entwistle was declared elected by majority of votes as Vice-President.

MEMBER-AT-LARGE, FINANCE

Jeannine Girard-Pearlman, Kurisummoottil S. Joseph and Winston Isaac were nominated for the position of Member-at-large, Finance. Winston Isaac's name was removed from the slate. No further nominations were received for this position and nominations were declared closed. Ballots were completed.

Jeannine Girard-Pearlman was declared elected by majority of votes as Member-at-Large, Finance.

MEMBER-AT-LARGE, EDUCATION

Jeannine Girard-Pearlman, Jennifer Henderson, Winston Isaac, Ernie Lauzon and Annette McKinnon were nominated for the position of Member-at-large, Education. The Chair reminded Council, according to the bylaws, that the Executive Committee must be composed of two professional and two public members of Council. Since the newly-elected President and Member-at- large, Finance were both public members, only professional members would be eligible for the remaining position. The following names were removed from the slate: Jeannine Girard-Pearlman, Winston Isaac, Ernie Lauzon, and Annette McKinnon. No further nominations were received for this position and nominations were declared closed. Ballots were not completed.

Jennifer Henderson was declared elected by acclamation as Member-at-large, Education.

4.2 Motion to Destroy Ballots

According to the bylaws, ballots from the election may only be destroyed with Council approval.

MOVED BY: Ernie Lauzon
SECONDED BY: Jeannine Girard-Pearlman

***THAT** the ballots for the 2018 Election of Officers be destroyed.*

CARRIED

Winston Isaac, newly elected President, assumed the Chair at this point of the meeting.

5.0 New Business.

5.1 Statutory Committee Form

The Chair asked Council members to complete the Statutory Committee Selection form and submit it to the Registrar.

5.2 Annual Signing

The Chair asked Council members to complete the Annual Confidentiality, Code of Conduct, and Conflict of Interest forms and submit them to the Registrar.

6.0 Next Meeting

Meeting Dates for October 2018 - June 2019 are as follows:

- Council Education Session: Wednesday October 24, 2018 (Full Day, Time TBA)
- Council Meeting: Thursday October 25, 2018, Time TBA
- Council Meeting: Thursday January 31, 2019, Time TBA
- Council Meeting: Thursday March 28, 2019, Time TBA
- Council Meeting: Tuesday, June 25, 2019, Time TBA

7.0 Adjournment

There being no further business, the meeting was adjourned at 3:30 p.m.

MOVED BY: Teri Shackleton
SECONDED BY: Serena Shastri-Estrada

***THAT** the meeting be adjourned.*

CARRIED

College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

AGENDA ITEM 5.2

REGISTRAR'S REPORT
Council Meeting of June 26, 2018

Governance Monitoring Report

As per Council Registrar Linkages Policy CRL5 - Monitoring Registrar Performance, this June report will include policies categorized as B or Registrar Limitations (RL).

Registrar Limitation Policies

I am pleased to inform Council that I am not in contravention of any of the Registrar Limitation policies.

Policies of this category that guided decisions during this period:

- The RL4 – Financial Planning and Budgeting and E1 – Ends Policies guided the development of the 2018-2019 Projected Budget.
- RL5 – Financial Condition and Activities – guided the allocation of funds to the Reserves.
- RL7 – Investments – The report is provided to Council along with the proposed budget.
- As per RL8 – External Audit, auditors of the office of Hilborn LLP will conduct an audit of the financial performance of the College for 2017-2018.
- RL10 – Compensation Administration guided the implementation of the salary adjustment for staff.
- RL11 – Communication and Support to Council – guided the compilation of feedback from the consultation related to the bylaws.
- RL12 – Risk Management – guided the information to be presented to Council on the Risk Management Program.

For Your Information:

Ends priority #1: Confidence in Occupational Therapy Regulation.

Registration

The registration program focuses on registration renewal in the 4th quarter of each year.

Some Stats:

Total number of Registrants at June 7, 2018

- 5965

RENEWAL

- 33 suspension notices went out (June 7, 2018). There were 37 last year. Registrants have until the end of the month to resolve their non-renewal or they will be suspended.

RESIGNATIONS

- 331 resignations between June 1, 2017 and May 31, 2018 (some may have rejoined already and therefore not included in count)
- 62 indicated retirement as reason
- 43 indicated leaving province
- 16 indicated leaving country
- 12 indicated changing profession
- 3 indicated returned to school

- 126 indicated leave of absence
- 61 indicated 'other' as reason
- 8 indicated 'resigned' as reason

IEOTs

- 5 IEOTs remain who applied prior to SEAS May 31, 2015 start. (extended for work eligibility or for additional training as per Registration Committee decision followed by 2 permitted exam attempts under their pre-SEAS application)
- 27 IEOTs have completed SEAS and applied to the College between June 1, 2017-May 31, 2018
- 16 of those IEOTs who completed SEAS and applied to the College between June 1, 2017-May 31, 2018 are now registered

Communications Program

- The Ontario Health Regulators marketing campaign continues. This campaign is a collaborative effort by the Federation of Health Regulatory Colleges of Ontario to assist with ensuring the public is aware of the regulatory system. The promotional video is now available with subtitles in multiple languages. A targeted promotion via Zoomer magazine and other channels continues. Visit ontariohealthregulators.ca to learn more.
- College website enhancements are in progress. Changes include plain language revision of key content areas, refinement of navigation elements and enhancements to the A-Z resources area to optimize usability.
- French voiceover has been recorded for College videos that explain the role of the College and the work we do to protect the public. Watch for a summer launch.

Ends Priority #2: Quality Practice by Occupational Therapists

Quality Assurance

- Successful first year of the College's new QA site – MyQA
  - Registrant compliance for 2017 annual QA requirements, approximately:
  - Self-Assessment (SA): 100%
  - Prescribed Regulatory Education Program (PREP): 99%
- Professional Development (PD) Plan: 83%
- Implemented: Compliance with Quality Assurance Program Requirements Policy; case files to be brought forward for QAC decision-making in summer, 2018
- Approved the 2018 PREP on Professional Boundaries and the Prevention of Sexual Abuse – to be launched with 2018 requirements in June 2018
- Completed Competency Review and Evaluation (CRE) process research study; QAC approved three decision-making points for the redevelopment of the CRE process, including:
  - Registrant Selection
  - Assessment Process
  - Peer Assessment Approach

Practice Resource Program

- The Practice Resource Service has had another successful year with a significant increase in the volume of OTs, students and public accessing the service (322 more queries over last year)
- To ensure professional standards reflect evolving practice the Practice issues subcommittee has been instrumental in providing guidance in the development and revision of the following standards:

Practice Advisory on the OTs role in Naloxone Administration, the Standards for the Supervision of Occupational Therapist Assistants and Guidelines for Working Within Managed Resources, Standards for Psychotherapy, Standards for Use of Title.

- The Practice team has been working closely with the Ministry of Transportation to understand how discretionary reporting of unsafe drivers will impact occupational therapy and has developed the Interim Guide for Discretionary Reporting to assist OTs in applying the legislation.
- The Fitness to Drive webinar set College participation records with 784 people registered and 508 attendees.
- To promote collaboration across regulatory Colleges, COTO hosted the Practice Advisors' group meeting in April. This is an opportunity for the College to work together with other regulatory stakeholders to support quality practice by occupational therapists.
- McMaster students, as part of their Evidence Based Project undertook a review of the Practice Resource Service. Their review included an environmental scan and literature review to identify knowledge translation and continuing professional development that are effective in changing knowledge and practice behaviour. Findings from their work will inform future directions for the practice education provided by the College.
- To assist OTs in understanding and applying professional standards and ethical reasoning, practice resource has launched the first 3 cases of the month and Q & As. To date, 98% of the readership have indicated that these case studies are useful.
- Over the past year the practice team has provided 16 presentations which include: OTs at their work sites, participated in panels, attended the 5 OT university programs. Presentation topics include: professional boundaries, professionalism, role of the College, scope of practice, conflict of interest, and working with support personnel/OTA.

Investigations and Resolutions Program

- For the first time this year, the College published a summary of ICRC issued Specified Continuing Education and Remedial Programs, (SCERPS) Cautions and Undertakings on the public register. So far, information of this nature is published in 5 OTs' profiles – 1 caution summary, 4 SCERPs, no undertakings as of yet.
- The Investigations and Resolutions program continues to work through the increased volume of case files opened during the 2016/2017 fiscal year. In November 2017, a second full-time Investigations and Resolutions Associate was hired to help work through the backlog and ensure timely processing of case files going forward. While the number of complaints received during the 2017/2018 fiscal year returned to levels seen prior to the 2016/2017 fiscal year, the number of Registrar's Inquiries and Reports opened remained high.
- New Conduct Declaration Process:
- The amount of information occupational therapists must self-report to the College has increased. During the 2018 annual renewal period, the College received 8 self-reports from OTs respecting the various conduct questions posed. Only 1 of these reports required continued attention and forms the basis of one of the Registrar's Inquiries reported in the below stats. 1 declaration is still under investigation to determine if regulatory action is required and whether it should form the basis of a Registrar's Investigation.

I&R Statistics:

COMPLAINTS	
FISCAL YEAR	**# COMPLAINTS**
2013/2014	24
2014/2015	19
2015/2016	24
2016/2017	33
2017/2018	25

REGISTRAR'S INQUIRIES & INVESTIGATIONS	
FISCAL YEAR	**# REPORTS**
2013/2014	17
2014/2015	15
2015/2016	16
2016/2017	53
2017/2018	59

INSURANCE REFERRALS FROM REGISTRATION	
FISCAL YEAR	**# REPORTS**
2015/2016	9
2016/2017	289
2017/2018	237

UNAUTHORIZED PRACTISE CONCERNS	
FISCAL YEAR	**# of concerns**
2015/2016	1
2016/2017	3
2017/2018	3

Ends Priority #3: System Impact Through Collaboration

Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO)

- After writing this report I will be in Victoria, chairing the ACOTRO board meeting. At this meeting we hope to approve their new strategic plan, and the cross-jurisdictional Memorandum of Understanding (MOU). This MOU will facilitate a process whereby OTs registered in one province can more easily provide short-term, appropriate follow up services to clients in another province. COTO will be developing a policy, to be approved by the Registration Committee to operationalize this.
- The ACOTRO AGM was held by teleconference on May 9, 2018.
- CORECOM - ACOTRO has engaged with the Canadian Association of Occupational Therapists (CAOT) and the Association of Canadian Occupational Therapy University Programs (ACOTUP) to work together towards developing one set of competencies for the profession. As chair of this group, I have been actively liaising with Federal Government representatives to secure funding for this project.
- ACOTRO, through its MOU with CAOT related to the National Certification Exam for OT, now participates in an Exam Oversight Committee with CAOT to provide the necessary oversight for this exam that contributes to registration decisions across the country.

Federation of Health Regulatory Colleges of Ontario

- I continue in my second year into my term on the Executive. This has helped me and the College to stay abreast of the issues affecting regulation.

- As previously mentioned, the Federation has been focused on implementation of provisions in Bill 87 – Protecting Patients Act. Our College has collaborated with the Federation Working Group to develop consistent practices.

Ministry of Health and Long-Term Care

- As there has been a provincial election and the government in power has changed, we are monitoring to see what the new priorities of the government will be related to regulation. It is expected that the new government will announce a new cabinet, including who will be the new Minister of Health, by June 29. We also expect that the employees of the government in the regulatory program have continued to work on regulations that were initiated through the Protecting Patients Act 2017. So, we still expect these regulations to appear sometime in the fall.
- We were informed, in May 2018, that the Ministry of Health and Long-Term Care would be re-enacting the process of sending a representative to each College's meeting. I expect that we will have our first visit from such a representative at this meeting. I have been able to connect with her and give her a brief orientation to our processes. For your information, her name is Sarah Kibaalya. I'm sure we will give her our warm COTO welcome.
- Public Member appointments – We have three public members whose current appointments to Council expire in this calendar year. Due to the timing of the election, these members could either not be reappointed this spring, or just received limited time appointments. The Council can continue to operate with just five members. We will be at three public members by January 2019 if there is no action on appointments.
- Psychotherapy – The College is proceeding with the Regulation for OTs related to the controlled act of psychotherapy. The College of Psychotherapists has submitted for consultation, the regulation about what constitutes the controlled act of psychotherapy for their members. This is a result of the Minister of Health requirements. In addition, they have developed several other documents geared to assisting their members, as well as non-regulated individuals to determine if they are practicing psychotherapy, and if so, do their activities fall within the controlled act. This is an incredibly challenging topic due to nature of psychotherapy practice. See the draft regulation in your FYI package.

Ends Priority #4: Effective financial, Organizational and Governance Practices

<u>2017/18 Operational Planning</u>

- The fourth quarter of the year has passed, and an update will be presented at Council on the status of initiatives.
- This is the time of year where Council and Executive review the performance of the organization and the Registrar. The information presented today during the Registrar's report will assist Council to reflect on the outcomes for the organization in the previous year and communicate to the Registrar their level of satisfaction.

<u>2018/19 Operational Planning</u>

- A new fiscal year has started and the operational initiatives for implementation within the final year of the strategic plan will be presented at the meeting.

<u>Staffing Update</u>

- Kara Ronald, Deputy Registrar, has resigned and will move to a position within the Health Care System in July.
- Karen Giallelis, associate in the Quality Assurance Program resigned her position at the beginning of May.
    - The College is recruiting a Junior Associate for Corporate Services, an Associate for Quality Assurance and, of course, a New Deputy Registrar.

See you at the meeting! Elinor

College of Occupational Therapists of Ontario
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AGENDA ITEM 5.4

COUNCIL BRIEFING NOTE

Date: June 26, 2018
To: Council
From: Kara Ronald, Deputy Registrar
Subject: Priority Performance Report – Q4 (March 1, 2018 – May 31, 2018)

Recommendation

THAT *Council receives the Priority Performance Report for the fourth quarter of 2017-2018.*

Background

Council is presented with quarterly data in alignment with the 2017-2020 strategic directions outlined in the Ends policies. The report reflects performance for the fourth quarter as well as the first full year of Council's current strategic plan.

Of note, this year saw significant increases in volumes of inquiries to the Practice Resource Service and the General Information line with 27% and 37% more calls year-over-year respectively. Consistent with previous years, query volumes peak in Q2 and Q4 in alignment with Quality Assurance due dates, liability reporting requirements and annual renewal.

As part of the education and outreach sessions offered, the webinar on the Interim Guide to Discretionary Reporting saw record number of registrations (784) and attendees (508).

Response rates to College consultations this year dropped from 9.1% to just over 3%. In part this was anticipated as some specific consultations such as the Bylaws were not expected to generate a high volume of responses and other consultations such as those associated with psychotherapy did not apply to the practice of all OTs. However, despite the lower response rates, there was meaningful feedback provided that resulted in substantive revisions to the affected documents.

With the addition of program resources and significant efforts of Investigations and Resolutions staff, all Q4 ICRC notifications were sent within required timelines.

In this quarter, the practice standards that are current and comply with the review timeline outlined in the Framework for College Publications dropped below 70%. This is the result of a conscious decision to focus on the development of new and the review of current resources impacted by legislative changes and practice trends. Priority was given to the development of a Naloxone Practice Advisory, the development of the Interim Guide to Discretionary Reporting, revisions to the Guidelines for Medical Assistance in Dying, the Standards for Psychotherapy and the Standards for the Prevention of Sexual Abuse, and the reissuing of the Standards for Use of Title Psychotherapist.

The College also saw a 10% increase in the open rate of College eblasts, an important indicator of OT engagement as eblasts and email are the primary vehicles of communication with OTs.

Discussion

Council is invited to ask questions and provide comment on the Priority Performance Report.

Attachment

Priority Performance Report – Q4 (March 1, 2018 – May 31, 2018)

College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

Strategic Framework 2020

Strategic Priorities

- Confidence in OT Regulation
- Quality Practice by Occupational Therapists
- System Impact Through Collaboration
- Effective Financial, Organizational and Governance Practices

Core Programs

- Registration
- Quality Assurance
- Practice
- Investigations & Resolutions

Mission

The College of Occupational Therapists of Ontario is the regulatory body that protects the public and instils confidence and trust by ensuring that occupational therapists are competent, ethical and accountable.

Vision

Leaders in collaborative quality regulation.

College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

Priority Performance Report 2017-2018

Q4 March 1, 2018 - May 31, 2018

Strategic Priority	Objective	Indicators	Targets	Outcomes					Comments
				Q1	Q2	Q3	Q4	YTD	
Registrant Demographics	Registrant Demographics	Total number of active registrants	N/A	5769	5962	6108	5977		At May 31, 2018
		% of registrants in clinical practice	N/A	73%	73%	72%	75.27		At May 31, 2018
		% of registrants in mixed practice	N/A	13%	13%	13%	13.70%		At May 31, 2018
		% of registrants in non-clinical practice	N/A	8%	8%	8%	8.14%		At May 31, 2018
		% self-employed registrants	N/A	26%	25%	24%	25%		1522 registrants indicated self-employed in one or more employment settings
Confidence in OT Regulation	The Public trusts occupational therapy regulation.	Total # of general information queries	N/A	292	592	350	852	2086	245 calls, 105 emails. This represents a 37% annual increase over 2016-2017 volumes.
		% general information queries from members of the public	N/A	60%	39%	41%	21%	40%	178/852 queries were received from non-registrants, applicants and individuals who did not verify their status.
		Total # of Practice Resource Service queries	N/A	322	449	313	421	1505	This represents a 27% annual increase over 2016-17 volumes.
		% queries to the Practice Resource Service from members of the public	N/A	23%	17%	19%	9%	17%	39/421 queries from non-registrants
		Total # of visits to the public register/month	N/A	7547	8105	6373	8155	7545	
		Average # of unique visits to the public register/month	N/A	3906	4487	1919	3563	3469	
		Total # of coto.org website visits	N/A	21,768	51,246	25,953	50,105	149,072	Defined as total number of website sessions.
		Average # of website users/month	N/A	4652	9301	5452	9793	7300	Defined as unique visits to the website.
	The College's input to government priorities and legislative initiatives is valued.	Total # of Consultation Submissions	N/A	1	3	2	2	8	The College made two submissions in Q4: 1) Ministry of Government and Consumer Services (Service Ontario) on Accessible Parking Permits; 2) Ontario Palliative Care Network on the Palliative Care Competencies validation process
	Stakeholders understand the role of the College and its value.	# Education/Outreach Sessions Offered	N/A	2	5	0	9	16	Education and outreach sessions were provided to academic programs and healthcare organizations. 2 COTO webinars (QA & Discretionary Reporting) with record attendance (508)

Strategic Priority	Objective	Indicators	Targets	Outcomes					Comments
				Q1	Q2	Q3	Q4	YTD	
Confidence in OT Regulation	College decision-making processes are open, transparent, and accountable.	# of Registration Committee decisions appealed to HPARB	N/A	0	0	0	1	1	This is the College's first Registration HPARB appeal in approximately 5 years and relates to refusal of registration based on the exam requirement.
		% of Registration Committee decisions upheld by HPARB	100%	N/A	N/A	N/A	N/A	N/A	No decisions issued by HPARB in Q4
		# of applications reviewed by Registration Committee	N/A	5	2	0	5	12	Cases related to conduct, currency and exam requirements.
		Registration Statutory timelines are met	100%	100%	100%	N/A	100%	100%	One case reviewed in Q4
		# of ICRC Decisions appealed to HPARB	N/A	2	1	3	1	7	
		% of ICRC Decisions upheld by HPARB	100%	100%	N/A	100%	100%	100%	
		# of complaints received	N/A	4	4	6	9	23	
		# of mandatory reports received	N/A	2	2	3	5	12	
		# of Registrar's inquiries initiated	N/A	1	5	4	31	41	Excludes mandatory reports captured above.
		ICRC 14 day acknowledgement notification timeline met	100%	100%	100%	100%	100%	100%	8/8 notifications sent on time.
		ICRC 150 day delay notifications sent to registrants and complainants by required date.	100% 90-99% <90%	17%	29%	60%	100%	52%	4/4 sent on time
		QA statutory timelines are met	100%	100%	100%	N/A	100%	100%	2 decisions issued by QAC in Q4.

Strategic Priority	Objective	Indicators	Targets	Outcomes					Comments
				Q1	Q2	Q3	Q4	YTD	
Quality Practice by Occupational Therapists	Occupational Therapists are accountable for quality, safety, and ethics in practice – ***OTs are competent.***	Registrant compliance with completion of mandatory QA requirements (Self-Assessment, PD Plan, PREP)	100% 90-99% <90%	N/A	95%	99%	93%	96%	Self-Assessment -100%; PREP - 96%; PD Plan - 83% QA requirement deadlines are Oct 31, 2017 and May 31, 2017.
		% registrant compliance with updating liability insurance information within 30 days of the scheduled expiry date.	100% 90-99% <90	100%	96.50%	97%	97%		The majority of OTs have insurance plans that expire within Q2. Staff have followed-up with all OTs who failed to update their expiry date.
		# of OTs issued education and/or remediation by the ICRC with required follow-up (SCERP, caution, undertaking).	N/A	3	0	4	2	9	1 remedial agreement, 1 undertaking. Excludes OTs provided advice and guidance.
		# of Step 2 OTs issued a SCERP by QAC	N/A	2	0	0	N/A	2	The CRE process is currently under review.
	Occupational Therapists are accountable for quality, safety and ethics in practice – ***OTs understand and apply professional standards and ethical reasoning*** .	% of queries to the Practice Resource Service from OTs	N/A	77%	83%	81%	91%	83%	382/421 queries received from OTs
		% of general information queries from OTs	N/A	40%	63%	51%	79%	58%	
		Total # of Unique Website Page Views (Standards and Guidelines; A-Z Resources)	N/A	2202	3638	3820	3422	13082	
		# of new and returning applicant "Practising Without Authority" cases (per quarter)	0 0-1 2 >3	1	1	0	0	2	
	The College engages OTs to advance quality, ethical practice.	% Practice Resources circulated for stakeholder feedback (standards, guidelines)	100%	100%	N/A	100%	66%	89%	2/3 resources circulated for consultation (Standards for Psychotherapy and Standards for the Prevention of Sexual Abuse); Guideline for Working within Managed Resources not circulated)
		Response Rates to College Consultations	N/A	5%	N/A	4%	1%	3%	2016/2017 average response rate 9.1%. There were 4 consultations in Q4: 1) Controlled Act Regulation (134); 2) Bylaws (5); 3) Standards for Psychotherapy (98); 4) Standards for the Prevention of Sexual Abuse (63). Depsite the low volume of responses, comments from feedback resulted in substantive changes to the standards.
		Open Rate on College eBlasts	70% >55% 40-54% <40	63%	70%	59%	69%	65%	5 eblasts sent to all registrants. 2016/17 average was 59%.
	The College engages OTs to advance quality, ethical practice.	Click through rate on College eBlasts	TBD	20.5%	25%	25%	20%	23%	2016/17 average click through rates 14%. In Q4, average click through rates on eNewsletters was 29%.

Strategic Priority	Objective	Indicators	Targets	Outcomes					Comments
				Q1	Q2	Q3	Q4	YTD	
		# of Views of relevant YouTube Videos	N/A	475	775	751	1459	3460	Total views of all College YouTube videos.
	Professional standards reflect evolving practice.	% of practice standards that are current and comply with the Framework for College Publications.	90-100% 70-89% <69%	71%	75%	71%	69%	72%	9/26 practices standards and guidelines exceed the 5 year review period. 2 resources coming to Council in June, additional 2 planned for October.
System Impact Through Collaboration	The College is recognized as a regulatory leader.	# of Presentations delivered to external stakeholders	N/A	0	1	0	1	2	Presentation provided to FHRCO on Executive Committee Nominations Process
	The public contributes to College decision-making.	# of key issues brought to the attention of the public and feedback sought – public input to key decisions.	N/A	0	2	0	0	2	No targeted feedback sought from the public. Consultations on regulations, bylaw and standards open to the public.
	Collaboration with stakeholders supports the College's effectiveness and influence as a regulator.	% of College management team actively collaborating with external stakeholders on shared initiatives.	90-100% 70-89% <70%	100%	100%	100%	100%	100%	
		# of formal interactions with system partners	N/A	2	1	2	2	5	MOHLTC - Protecting Patients Act Consultation Teleconference; MTO & OSOT - Discretionary Reporting
	Collaboration promotes systems alignment to support quality practice by occupational therapists.	# of queries received from employers (general information and practice)	N/A	20* only Practice data included	26	24	15	85	
		# of mandatory reports received from employers (competence, capacity)	N/A	2	2	3	4	11	
		# of mandatory privacy breach reports received from health information custodians (HICs)	N/A	0	0	0	1	1	One privacy specific reports has been made by an employer.

College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

AGENDA ITEM 5.5

COUNCIL BRIEFING NOTE

Date: June 26, 2018
To: Council
From: Executive Committee
Subject: Risk Management Program

Recommendation

THAT *the review of the risk management program be delegated to Executive, with quarterly reports presented to Council.*

Issue

On the list of projects for this fiscal year was the development of a comprehensive Risk Management Program. The discussion today aims to review the Risk Management Report and confirm the processes of Executive and Council review going forward.

Background

During strategic planning, confidence in occupational therapy regulation was determined to be one of the strategic priorities. To that end, an operational objective was developed around creating a risk management program. Ergo, if the College is managing its risks well, then those looking in will have confidence in the regulatory processes.

In January 2018, Council approved a new policy related specifically to risk management. However, it should be noted that the entire Council Policy manual is based on a risk management approach. That is, the policies were developed by Council imagining, from their perspective, all the things that could go wrong from their governance standpoint and creating policies to mitigate those risks. However, what was deemed missing was a comprehensive process to manage the entire College, including operations.

A 'risk' is the chance of something happening that will have an impact on objectives. It is measured in terms of consequences and likelihood. Council has an oversight role of risk management systems and processes.

Therefore, to assure Council that risks are being appropriately identified and managed, a project to develop a risk management framework and a risk register was started. A risk register is a method to collate, categorize and weigh the risks facing an organization. That is, to determine the consequences of the risk occurring, and the likelihood that the risk event will occur.

The College's risk management program includes the following elements:

1. Foundational – The Registrar Limitations Policy sets out Council's expectation to receive complete and appropriate risk management information to aid the Council in discharging its risk management oversight role.

2. Organization Arrangement – Set out a risk management context, systems, procedures and processes that can:
    a. Identify adverse events or circumstances relevant to College objectives;
    b. Assess the likelihood and magnitude of impact of these adverse events;

c. Determine an appropriate response or mitigation strategy;
d. Monitor progress to risk management.

3. Culture and Capacity – Sets out approaches that can enable the College to develop and sustain organization core competencies in risk management.

4. Governance Oversight - Defines reporting format and content to promote risk management accountability.

Risks for the College have been categorized into five dimensions:

1. Strategic risks: Threats that can materially affect the ability of the College to remain strong and relevant. This includes our ability to deliver on our core mandate. A strong strategic planning process is one method to mitigate this risk.

2. Operational risks: These risks result from inadequate or failed internal policies, processes, people and systems. Operational risks can lead to poor service delivery, day-to-day crisis, and misuse or neglect of human capital and other resources.

3. Compliance risks: These are risks of legal sanctions, material financial or reputational loss as a result of failure to comply with provincial legislation, internal policies, ministerial direction.

4. Stakeholder risks: These risks could lead to a negative impact with the College's relationship with its various stakeholders – the public, government, registrants, other regulatory bodies, educational institutions etc.

5. Quality risks: These risks occur when OTs are not appropriately monitored against expected performance standards to ensure they have relevant and appropriate competencies to provide safe, effective and ethical care.

While there are risks that may affect more than one dimension, staff who have developed the risk register have determined the most appropriate category to prevent duplication.

Risk Register Process

Risk Identification - The risk register has been developed based on comprehensive discussions with staff, a review of the current environment facing the College and with regard to the information from the strategic planning process conducted in 2016/17.

Following this, a *risk assessment* was conducted to determine the likelihood that the event will occur and the level of impact on the College should it occur. The next step is to determine any control procedures that are in place to manage the risk or to prevent it from occurring.

After this step the *residual risk* is determined. This process outlines what risk is left after mitigation strategies and controls have been implemented.

Monitoring Process – This process outlines how the residual risk will be monitored. Responsibility is assigned, and any actions are outlined.

Risk Register Discussion Outcomes

Staff, when determining the risks and their current level of threat, given the controls in place, identified the following types of risks:

1. Strategic Risks

   These were related to big picture risks that included regulatory modernization, knowledge of Council members, the relationship between staff and Council, the performance of the registrar, and not operating within our mandate. Except for the risk related to regulatory modernization, all strategic risks were deemed to have sufficient controls to mitigate risks to a residual level of moderate or low.

2. Operational Risks

   These risks related to human resources, information technology, premises, and finances. Risks within these areas pertained to compliance with legislation and/or failure of systems. Risks identified in this category included: compliance with human rights as an employer; compliance with financial systems like income tax; disaster planning; future space needs; privacy and security breaches.

3. Compliance Risks

   Identified in this area were risks related to compliance with the Regulated Health Professions Act (RHPA), the Human Rights Code, Fairness Commissioner directives, risk of litigation associated with statutory decision making.

4. Stakeholder Risks

   Risks identified in this area include oversight of third party service providers and associated processes such as the national exam, the SEAS process, accreditation of OT academic programs as well as lack of understanding of the college's role and mandate by stakeholders.

5. Quality Risks

   Risks identified in this area include: compliance and effectiveness of the Quality Assurance Program and the Investigations and Resolutions Program; ensuring expectations are well defined and communicated to OTs; And, quality and effectiveness of regulations.

Discussion

The risk register in its entirety was presented to Executive for review. It is a comprehensive list of all the specific risks identified by staff. Staff have gone through the entire risk management process with each risk to determine what residual risk remains. Based on the college's risk management model, only high or critical risks will be presented to Council on an ongoing basis. This is in line with the College's governance model, whereby operational issues are dealt with by staff and governance issues by Council. Based on Executive's review of the risk register, Executive is satisfied that the process was robust, and that a fair representation of the serious risks to the College, that merit reporting to Council, have been identified.

At this time, it is recommended that Council delegate the review of the risk management program to Executive with any area of concern being brought to Council quarterly.

Attachment:
Risk Management Report to Council

College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

COUNCIL BRIEFING NOTE

Date: June 26, 2018
To: Council
From: Executive Committee
Subject: Risk Management Report to Council

Recommendation

THAT *Council reviews the risk management report.*

Issue

Council in its policy RL12, requires that information on risks, to aid Council in discharging its risk management oversight role, shall not be incomplete or inappropriate. The following are the high or critical risks that have been identified by staff. Executive has reviewed the exhaustive list of risks, and have determined that any risks, with a residual level of risk of moderate or less once control procedures have been put in place, shall be managed by staff. These risks tend to be operational in nature and are therefore most appropriate for staff to manage. Operational risks may be presented to Council if their mitigation might result in significant expenditures by the College.

Discussion

Each risk is listed along with the control procedures and action plan developed to mitigate each risk. Some risks can only be monitored as they are out of the College's control, however, they are important enough to be listed so the College can move into action quickly, once more is known.

Risk Category	Risk	Control Procedure	Action Plan/Monitoring Process
Strategic	Regulatory Modernization - unknown significant changes to college operations and mandate.	1. Membership with FHRCO 2. Strategic plan 3. Government consultation in strategic planning process 4. Government priorities presented to Council 5. Capitalizing on consultation opportunities 6. Establishing and sustaining positive government relationships	**Monitor through:** 1. FHRCO meetings and working group participation 2. Ministry updates 3. College networking updates

Risk Category	Risk	Control Procedure	Action Plan/Monitoring Process
Stakeholders	Lack of awareness, understanding or trust of the regulation of health professionals	1. Identified as a strategic priority 2. Active involvement in FHRCO 3. Promotion of Ontario Health Regulators website 4. FHRCO public awareness campaign 5. Plain language content regarding how the College protects the public	**Monitor through:** 1. Effectiveness of OHR public awareness campaign 2. Metrics and media scanning 3. Monitoring of political messages 4. Environmental scanning **Action Plan:** 1. Partnership with and use of Citizens Advisory Group 2. Development and promotion of College videos 3. Website refinement 4. COTO public engagement campaign – social media, videos 5. Promotions such as Google ads, Zoomer show and Zoomer materials
Quality	OTs with significant competency deficits may be continuing to practice, unchecked by the College.	1. Monitoring of compliance metrics (MyQA) 2. Competency enhancement in place for all OTs, (PREP, Self assessment and professional development plan) 3. Peer assessment process in place for deferred and follow-up cases 4. Liability insurance 5. Police checks for new registrants 6. Complaints mechanisms	**Monitor Through:** 1. Bi-monthly review of program redesign progress and approval by QAC 2. Quarterly registrar report 3. Priority Reporting **Action Plan**: 1. Workplan outlining steps required to redesign QA program 2. Research to support rationale for redesign 3. Collaboration with key stakeholders on relevant current QA programming initiatives
Operational	Organizational design not current to meet growing IT needs.	1. Day to day IT work shifted to staff from outsourced vendor. 2. Expectations and accountabilities reviewed with third party vendors.	**Action Plan:** 1. IT Strategic Plan underway to identify solutions and prioritize workplan 2. Resources allocated in budget to implement IT strategic directions

Risk Category	Risk	Control Procedure	Action Plan/Monitoring Process
Strategic	Council will be unable to discharge its decision-making duties due to lack of public appointees.		**Action Plan:** 1. Liaise with public appointment's office to facilitate the appointments process as appropriate. 2. Determine processes to be put into place if Council finds itself un-constituted.

College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

AGENDA ITEM 6.1

COUNCIL BRIEFING NOTE

Date: June 26, 2018
To: Council
From: Anne MacPhee, Director of Finance & Corporate Services
Subject: March 2018 (10 months) Financial Report

Recommendation

THAT *Council receives the March 2018 Financial Report, Statement of Financial Position, and Statement of Operations, as presented.*

This Financial Report contains three sections:

1. Financial Statement Highlights
2. Summary of statutory remittances and filings;
3. Financial Statements:
   - **Statement of Financial Position** as at March 31, 2018;
   - **Statement of Operations** for the period June 1, 2017 to March 31, 2018;
   - **Statement of Reserves** for the period June 1, 2017 to March 31, 2018.

HIGHLIGHTS OF STATEMENT OF FINANCIAL POSITION

(Please refer to the attached Statement of Financial Position as at March 31, 2018*)*

The Short-term marketable securities balance of $2,776,909 reflects the investment portfolio balance as of the May 31, 2017 audited financial statements. For interim financial reports prepared throughout the year, this balance will not align with the monthly BMO Investment Reports. Standard audit adjustments (i.e. to recognize accrued interest and to reclassify certain items between cash and investments) are recorded at fiscal year-end only.

Deferred Revenue includes Registration income that cannot be recognized as income until later in the fiscal year. The current balance in deferred revenue of $644,727 consists of approximately $315,131 to be recognized in April and May 2018.

HIGHLIGHTS OF STATEMENT OF OPERATIONS

(Please refer to the attached Statement of Operations for March 31, 2018*)*

The net surplus of revenues over expenses for the 10 months ended March 31, 2018 was $603,104.

The 10 months' revenues compared to the full year budget is 85 percent, consistent with the recognition of Deferred Revenue.

Most expenses are tracking better than budget, due to the timing of expenses. Capital Equipment expenditures are over the full year budget; however, it is a small overall amount so the percentage over budget appears to be quite excessive. Expenses were related to computers, furniture and a voice mail

system upgrade. IT expenses seem low relative to the budget, however a number of expenses were recorded in April and the actual year-to-date expenses are within 6% of the year-to-date budget.

HIGHLIGHTS OF STATEMENT OF RESERVES
(Please refer to the attached Statement of Reserves as January 31, 2018*)*

In addition to expenses incurred in the regular course of operations, certain expenditures are made against the designated reserves funds in accordance with approved Council Guidelines for Establishing and Maintaining Reserve Funds.

Year to date expenditures are costs for disciplinary hearings drawn from the Hearings Fund.

STATUTORY REMITTANCES AND FILINGS
The College is required to remit various taxes and filings to the government.

Description	Frequency/Timing	Status
Remittance of payroll withholding taxes (CPP, EI, Income Tax)	Bi-weekly	Up to date
Remittance of CPP on Council per diems	Monthly	Up to date
Remittance of Employer Health Tax	Remittance for fiscal year is a set 1.95 % of calendar year payroll over $450,000.	Up to date
Filing of Harmonized Sales Tax return(Quarterly)	Quarterly	Up to date, HST return filed up to February 28, 2018. Next filing due June 2018 for the period March 01 2018 to May 31, 2018.
Filing of T4, T4A returns	Annually based on calendar year. Due last day of February.	Up to date. Next filing, February 2019 for the calendar year ending December 31, 2018.
Filing of Corporate Income Tax Return (T2)	Annually based on fiscal year. Due November 30, 2017	Up to date, filed September 21, 2017 for the fiscal year ended May 31, 2017.
Filing of Non-Profit (NPO) Information Return (T1044)	Annually based on fiscal year. Due November 30, 2017.	Up to date, filed September 21, 2017 for the fiscal year ended May 31, 2017.

College of Occupational Therapists of Ontario

STATEMENT OF FINANCIAL POSITION
As at March 31, 2018

	31-Mar-18	31-Mar-17
ASSETS		
Current Assets		
Cash	1,531,439	1,130,900
Short-term marketable securities	2,776,909	2,730,703
Accounts receivable and prepaid expenses	36,496	35,862
Total Current Assets	4,344,844	3,897,465
Property and equipment, net of accumulated depreciation	221,879	206,415
TOTAL ASSETS	4,566,722	4,103,880
LIABILITIES		
Current Liabilities		
Accounts payable and accrued liabilities	**275,033**	203,026
HST payable	**(13,883)**	(38,648)
Deferred revenue	**644,728**	604,747
Total Current Liabilities	**905,878**	769,125
Deferred lease inducement	**19,503**	22,583
Total Liabilities	**925,381**	791,708
NET ASSETS		
Reserve Funds	**2,237,613**	1,856,436
Invested in Fixed Assets	**221,879**	206,415
Unrestricted	**578,745**	713,842
Net income for the period	**603,104**	535,478
Total Net Assets	**3,641,341**	3,312,171
TOTAL LIABILITIES AND NET ASSETS	**$ 4,566,722**	$ 4,103,879

College of Occupational Therapists of Ontario
STATEMENT OF OPERATIONS
March 31, 2018

	Actual YTD for 10 months ended March 2018	12 month Budget 2017-18	Actual YTD as % of 2017-18 Budget
REVENUES			
Registration Fees	$ 3,347,983	$ 3,936,744	85.0%
Application Fees	74,400	82,400	90.3%
Professional Corporation Fees	14,500	13,132	110.4%
Interest Income	20,974	10,000	209.7%
Other Income	18,239	25,000	73.0%
TOTAL REVENUES	3,476,096	4,067,276	85.5%
EXPENSES			
Salaries and Benefits	1,821,885	2,353,600	77.4%
Programs	155,556	335,000	46.4%
Communications	65,808	130,000	50.6%
Council	115,242	203,700	56.6%
Rent	239,252	301,000	79.5%
Information Technology	70,037	147,656	47.4%
Other Office Operations	205,502	291,000	70.6%
Operational Initiatives	105,192	173,000	60.8%
Professional Fees	62,544	104,000	60.1%
Capital Equipment	31,975	28,320	112.9%
TOTAL EXPENSES	2,872,993	4,067,276	70.6%
SURPLUS (DEFICIT)	$ 603,103	$ -	

* Target for ytd March is 83% representing 10/12 of total budget for the year

STATEMENT OF RESERVE FUNDS

	Opening Balance June 1, 2017 (Budgeted)	Spent to Date	Closing Balance March 31, 2018
Hearings Fund	$ 350,000	$ (20,387)	329,613
Sexual Abuse Therapy Fund	18,000	-	18,000
Contingency Fund	1,390,000	-	1,390,000
Premises Fund	500,000	-	500,000
Invested in Fixed Assets	221,879		221,879
Unrestricted	578,745	-	578,745
Surplus (Deficit) for the Period	-	563,357	603,104
TOTAL RESERVES	$ 3,058,624	$ 542,970	$ 3,641,341

College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

AGENDA ITEM 6.2

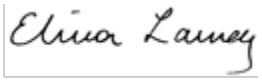
MEMO

Date: June 6, 2018
To: Anne MacPhee, Director of Finance & Corporate Services
From: Elinor Larney, Registrar
Subject: Direction to Allocate Funds to the Reserve Funds

Reserve funds have been established in policy. As of this date, the amounts in the designated reserve funds need to be reflected as presented in the chart below.

Allocated Reserve Fund	Reserve Fund Recommended Levels by Policy	Allocations at Year End 2017 2017 - 2018
Hearings	$350,000	$350,000
Sexual Abuse Therapy & Counseling	$18,000	$18,000
Contingency	3 to 6 months' expenses: $1,063,500 – 2,127,000	$1,590,000 (4.5 months)
Premises	Minimum goal $200,000	$500,000

The remainder of the funds after the above amounts have been identified in the allocated reserve funds will remain as unrestricted. Where expenditures have occurred in these designated funds during the 2017/18 fiscal year, please ensure that the funds are topped up to these levels.



Elinor Larney, MHSc., OT Reg. (Ont.)
Registrar

College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

AGENDA ITEM 6.3

COUNCIL BRIEFING NOTE

Date: June 26, 2018
To: Council
From: Elinor Larney, Registrar
Subject: Projected 2018-2019 Budget

Recommendation/Action Required

THAT *Council reviews the Projected 2018-2019 Budget as presented.*

Background

The governance policies direct the budget planning for each year. The Registrar Limitations Policy RL4 – Financial Planning and Budgeting includes such limitations as not failing to provide cash flow to support operations throughout the year, not failing to provide sufficient resources to support Council's ability to provide its leadership role and not creating a budget where expenditures exceed the projected revenue. The Registrar Limitations Policy RL5 – Financial Condition and Activities provides debt guidelines that allow a deficit budget of up to 3%.

Discussion

The number of occupational therapists in Ontario continues to grow by 3% annually. The College has continued to meet the increased demands of a growing registrant base and has generated surpluses that has increased the restricted and unrestricted reserves. The Projected 2018-2019 Budget is a deficit budget of $70,000. This is within the Registrar Limitations and should be reviewed with the following considerations:

- Three new full-time positions are proposed – Manager IT, Registration Associate and HR Coordinator. The increased revenue projected in this year's budget will not absorb the full cost of these positions, but with no further staff additions and continued growth in the number of registrants the 2019-20 budget will.
- The reserves continue to grow and should be utilized to support this one-time investment in new staff resources.
- The budget does not include a vacancy factor. Turnover naturally occurs and could offset the proposed deficit.
- The timing of the hires has been assumed to be June 1, 2018 to show the full impact of the salary additions and to allow some flexibility for negotiation of the actual salaries and benefits.
- Lower than expected expenditures, due to potential timing differences, for projects and program expenses could offset the deficit.

The budget includes a projected net increase of $90,000 in the revenue and expense from the 2017-2018 Budget. Projected year-over-year growth of $100,000 in registration fees reflects an estimated net increase in the number of registrants of 150 over the course of the year. Renewal fee rates continue to be held to current levels. The increase in Other Income is due to the Gift in Kind to ACOTRO and is offset by the exact amount increase in Other OFFICE OPERATIONS. (The Gift in Kind to ACOTRO is the space to accommodate ACOTRO staff who operate the Substantial Equivalency Assessment System (SEAS)).

The growth in expenses is primarily due to increased salary costs including the three new positions. Projected salary expenses include a 2% cost of living increase.

Most program expenses are status quo; however, office expenses are increasing modestly while Council expenses are projected to be slightly lower. Rent cost is expected to increase by 5%.

The investment portfolio is managed by BMO Nesbitt Burns. There are two categories of investments:

- Short-term investments (which includes cash) and
- Longer term discounted notes (also referred to as “ladder” investments) which were purchased at a discount and will be held for up to ten years in accordance with Governance Policy RL7.

The investment plan for 2018 – 2019 is continue with this strategy.

Attachments:

Projected Budget Summary 2018-2019

College of Occupational Therapists of Ontario
Budget 2018-2019

	17/18 Budget	18/19 Budget	%change
Income			
REGISTRATION INCOME	3,936,744.00	4,035,294.00	3%
APPLICATION FEES	82,400.00	84,872.00	3%
PROFESSIONAL CORPORATIONS FEES	13,132.00	13,525.96	3%
Interest Income	10,000.00	20,000.00	100%
Other Income	25,000.00	20,000.00	-20%
Total Income	**4,067,276.00**	**4,173,691.96**	**3%**
Expenses			
SALARIES AND BENEFITS	2,353,600.00	2,546,342.19	8%
CAPITAL EQUIPMENT	28,320.00	41,000.00	45%
RENT	301,000.00	316,050.00	5%
INFORMATION TECHNOLOGY	147,656.00	155,000.00	5%
OTHER OFFICE OPERATIONS	291,000.00	283,000.00	-3%
OPERATIONAL INITIATIVES	173,000.00	173,000.00	0%
COUNCIL/PROF MBRS	203,700.00	153,200.00	-25%
PROFESSIONAL FEES	104,000.00	111,000.00	7%
COMMUNICATIONS	130,000.00	130,000.00	0%
PROGRAMS	335,000.00	335,000.00	0%
Total Expenses	**4,067,276.00**	**4,243,592.19**	**4%**
Net Income	**-**	**- 69,900.23**	**0%**

College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

AGENDA ITEM 8.1

COUNCIL BRIEFING NOTE

Date: June 26, 2018
To: Council
From: Executive Committee
Subject: Draft Bylaw Amendments

Recommendation

THAT *Council approves the proposed amendments to parts 16, 17 and 20 of the bylaws, which were circulated for consultation as required.*

Purpose

The proposed bylaw amendments are presented for consideration to ensure College bylaws are consistent with changing laws.

Background

On May 30, 2017, the *Protecting Patients Act, 2017* (the "PPA"), was passed resulting in significant changes to the *Regulated Health Professions Act*, *1993* (RHPA). Among the numerous amendments introduced, was the requirement for health regulatory Colleges to further expand on what information is available on their respective public registers, as well as new provisions to address the sexual abuse of patients/clients by regulated health professionals.

In June 2017, Council passed numerous bylaw amendments many of which were for the purposes of keeping the College bylaws consistent with changes introduced under the PPA. Despite these efforts, College staff discovered that minor language changes and further amendments are required to ensure consistency with the legislative changes.

On January 25, 2018, following a recommendation from the Executive Committee, Council approved for circulation the proposed amendments.

Discussion

The consultation on the proposed changes was conducted between March 12 and May 11, 2018. The College received feedback from 2 OTs and 1 person who identified as being a professional working in regulation. Both Executive Committee and Council requested that the consultation circulated for feedback clearly communicate that while it might seem futile to carry out the consultation in circumstances where some of the proposed changes are already in effect due to amendments to the RHPA, and the remaining proposed changes are merely editorial and will not alter how the College operates, the College is legally required to circulate the consultation. The low response rate is attributed to the success of this messaging.

The proposed bylaw amendments can be summarized as follows:

i. Editorial changes to ensure appropriate use of language

ii. Altering paragraphs t, u and v of Part 17 - Public Register, which deal with the publishing of specified continuing education or remedial programs (SCERPs) and cautions issued by the investigations, complaints and reports committee, (ICRC), so that the College bylaws are consistent with changes made to the RHPA which are already in effect. The proposed amendments make it clear that where the ICRC issues a SCERP or caution on or after May 30, 2017, regardless of when the complaint or report was received, information about the outcome will be posted on Find an Occupational Therapist.

iii. Deleting paragraph l of Part 17 - Public Register, which deals with the publishing of information relating to referrals made by the ICRC to the Discipline Committee. This deletion is proposed because due to legislative changes paragraph l is now a duplication of what is already contained in the RHPA.

iv. Deleting Part 20 - Therapy and Counselling for Sexual Abuse. This deletion is proposed because the provision is redundant where the existing provisions in the RHPA and the College's general regulation (Ontario Regulation 226/96) enable the College to fulfil its duty to provide funding for therapy and counselling to persons alleging sexual abuse by an OT.

Overall the feedback received was positive and supports the proposed amendments. At appendix 1 you will find a chart noting the proposed amendments and quoting all feedback received save as to one comment from an OT thanking the College for a "[n]icely done [and] well explained" consultation survey.

As you will see on pages 3 and 4 of appendix 1, a person identifying as a professional working in regulation did query why the College is proposing to change the word "remediation" to "remedial" in the phrase "specified continuing education and remediation program". This amendment is proposed because subsection 23(2)7 of the Code provides that the College must publish on its public register a notation of any "any specified continuing education or remedial programs" issued by the ICRC. While it is true that elsewhere in the RHPA the phrase "specified continuing education or remediation program" is used, it is done so in reference to decisions issued by the QAC and not the ICRC. Thus, the Code appears to delineate a distinction between the term used for SCERPs issued by the ICRC vs. those issued by the QAC. Where the change in word to "remedial" is proposed in the bylaws, it relates to SCERPs issued by the ICRC and not the QAC.

Attachments

Appendix 1: Feedback Received re Proposed Bylaw Amendments

Appendix 1- Feedback Received re Proposed Bylaw Amendments

Proposed Bylaw All changes marked in red	Feedback Received	Comments re Feedback Received
Part 16: Information to Be Provided by Registrants **16.01 Information to Be Provided by Registrants** 16.01.1 When requested, a Registrant shall promptly provide the College with the information required to be kept on the register pursuant to section 23 of the Health Professions Procedural Code and pursuant to section 17.01.1 of these ~~is~~ bylaws and the following information in the manner determined by the Registrar:	From an OT: If the edit proposed is this: "...pursuant to section 17.01.1 of these bylaw and the following information..." it appears to be grammatically incorrect - should it be 'bylaws'? Is the strikethrough 's' an error, given the information you provide on this webpage https://www.coto.org/news/open-consultation-on-proposed-changes-to-college-bylaws states this is "an editorial change revising the phrase "of this bylaw" to "of these bylaws" The change seems wise when grammatically corrected. From an OT: agree with edits From a Professional working in Regulation: agree	The proposed editorial change does recommend that the sentence be changed to "of these bylaws" as the feedback suggests it should be. It appears the respondent misread the suggested amendment.
Part 17: Public Register **17.01 Public Register** **17.01.1** in addition to the information set out in section 23 of the *Code*, the following information about each Registrant shall be included in the public register: ~~l. details of allegations of professional misconduct or incompetence that have been referred to the Discipline Committee and not~~	From an OT: Removing duplication is wise From an OT: agree with change From a Professional working in Regulation: agree	All feedback received agrees with the proposed deletion of this provision on the basis that it is now a duplication of what is already contained in the RHPA due to amendments introduced under the *Protecting Patients Act* (the PPA).

Appendix 1- Feedback Received re Proposed Bylaw Amendments

Proposed Bylaw All changes marked in red	Feedback Received	Comments re Feedback Received
~~yet decided, including dates, times and locations of hearings;~~		
t. Where, for a complaint filed on or after January 1, 2017 or for a report received on or after January 1, 2017 for which an investigator is appointed under 75(1)(a) or 75(1)(b) of the Code, or for any decision made by the Inquiries, Complaints and Reports Committee on or after May 30, 2017, in respect of a complaint filed or report received, a panel of the Inquiries, Complaints and Reports Committee requires a Registrant to appear before a panel of the Committee to be cautioned in person, as authorized by paragraph 26(1)3 of the Code, i. a notation of the fact, ii a summary of the caution-in-person, iii. the date of the panel's decision, iv. the date upon which the caution-in-person was administered by the Committee panel, and v. if applicable, a notation that the panel's decision is subject to review and therefore is not yet final, which notation shall be removed once the review and any reconsideration by the Committee is finally disposed of.	From an OT: Consistency with the RHPA is essential From an OT: agree with change From a Professional working in Regulation: agree	All feedback received agrees with the proposed amendment to this provision to ensure the bylaws are compliant with existing provisions in the RHPA due to amendments introduced under the PPA.

Appendix 1- Feedback Received re Proposed Bylaw Amendments

Proposed Bylaw All changes marked in red	Feedback Received	Comments re Feedback Received
u. Where, for a complaint filed on or after January 1, 2017 or for a report received on or after January 1, 2017 for which an investigator is appointed under 75(1)(a) or 75(1)(b) of the Code, or for any decision made by the Inquiries, Complaints and Reports Committee on or after May 30, 2017, in respect of a complaint filed or report received, a panel of the Inquiries, Complaints and Reports Committee requires a registrant to complete a specified continuing education or ~~remediation~~ remedial program, as authorised by paragraph 26(1)4 ~~and subsection 26(3)~~ of the Code, i. a notation of that fact, ii. a summary of the specified continuing education or ~~remediation~~ remedial program, iii. the date of the panel's decision, iv. the date that the specified continuing education or ~~remediation~~ remedial program is successfully completed, and iv. if applicable, a notation that the panel's decision is subject to review and therefore is not yet final, which notation shall be removed once the review and any reconsideration by the Committee is finally disposed of.	From an OT: The proposed consistency and alignment is essential From an OT: agree with change From a Professional working in Regulation: RHPA uses "remediation" as the word defined in "SCERP" - why would the language differ in these bylaws?	This amendment is proposed to ensure the bylaws are compliant with existing provisions in the RHPA due to amendments introduced under the PPA. The feedback received is generally in favour of the proposed changes. The reason for the proposed change from the word "remediation" to "remedial" is because subsection 23(2)7 of the *Health Professions Procedural Code*, which is schedule 2 to the RHPA (the Code), provides that the College must publish on its public register a notation of "any specified continuing education or remedial programs" issued by the Inquiries, Complaints and Reports Committee (ICRC). While it is true that elsewhere in the RHPA the phrase "specified continuing education or remediation program" is used, it is done so in reference to decisions issued by the Quality Assurance Committee and not the ICRC. Accordingly, to ensure alignment with the language used in the Code, which appears to delineate a slight distinction between the term

Appendix 1- Feedback Received re Proposed Bylaw Amendments

Proposed Bylaw All changes marked in red	Feedback Received	Comments re Feedback Received
		used for SCERPs issued by the ICRC vs. the QAC, and as this bylaw relates to those issued by the ICRC, "remedial" is being proposed This amendment is proposed to provide clarity on how the College treats information respecting the review of a decision and reasons of the ICRC, where it issues an undertaking involving allegations of professional misconduct or incompetence.
v. Notwithstanding paragraphs (t) and (u) above, and subsection 23(2)(11) of the Code, where after a review by the Health Professions Appeal and Review Board or a judicial review by an appellate court of the decision and reasons of the ICRC, the ICRC has been required to remove or vary a caution-in-person, ~~or~~ a specified continuing education or ~~remediation~~ remedial program, or an acknowledgment and undertaking in relation to matters involving allegations of professional misconduct or incompetence, the notation and summary may be removed once the ~~Committee~~ ICRC makes a new decision. Where the original requirement to appear for a caution-in-person, ~~or~~ to	From an OT: This clarity and alignment is essential From an OT: agree with change From a Professional working in Regulation: RHPA uses "remediation" as the word defined in "SCERP" - why would the language differ in these bylaws?	Again, the reason for the proposed change from the word "remediation" to "remedial" is because subsection 23(2)7 of the Code provides that the College must publish on its public register a notation of "any specified continuing education or remedial programs" issued by the ICRC. While it is true that elsewhere in the RHPA the phrase "specified continuing education or remediation program" is used, it is done so in reference to decisions issued by the Quality Assurance Committee and not the ICRC. Accordingly, to ensure alignment with the language used in the Code, which appears to delineate

Appendix 1- Feedback Received re Proposed Bylaw Amendments

Proposed Bylaw All changes marked in red	Feedback Received	Comments re Feedback Received
complete a specified continuing education or ~~remediation~~ remedial program, or an acknowledgment and undertaking has been varied, the Registrar may enter on the public register a summary of the process leading up to and the results of the variation.		a slight distinction between the term used for SCERPs issued by the ICRC vs. the QAC, and as this bylaw relates to those issued by the ICRC, "remedial" is being proposed
~~**Part 20: Therapy and Counselling for Sexual Abuse**~~ ~~**20.01 Therapy and Counselling for Sexual Abuse**~~ ~~**20.01.1** A person receiving funding for sexual abuse counselling or therapy from a therapist or counsellor who is a member of a regulated profession must sign a document, acceptable to the Registrar:~~ ~~a. indicating that she/he is aware of the therapist's or counsellor's training and experience;~~ ~~b. confirming that the therapy or counselling is being provided~~ ~~c. confirming that the funds received are being used for therapy or counselling.~~ ~~**20.01.2** A person receiving funding for sexual abuse counselling or therapy from a therapist or counsellor who is not a member of a regulated profession must sign a document, acceptable to the Registrar:~~	From an OT: Removing such redundancy is prudent From an OT: agree with change From a Professional working in Regulation: agree	All feedback received agrees with the proposed deletion of this provision on the basis that it is expected that the MOHLTC will introduce regulations expanding the types of expenses for which funding must be provided under the College's funding for sexual abuse program and as Part 20 is not required to enable the College to fulfill its legislative duty of maintaining its established program to provide such funding, its removal is proposed to avoid having to make further future bylaw amendments once the anticipated regulations are introduced.

Appendix 1- Feedback Received re Proposed Bylaw Amendments

Proposed Bylaw All changes marked in red	Feedback Received	Comments re Feedback Received
~~a. indicating that she/he understands that the therapist or counsellor is not subject to professional discipline;~~ ~~b. indicating that she/he is aware of the therapist's or counsellor's training and experience;~~ ~~c. confirming that therapy or counselling is being provided; and~~ ~~d. confirming that the funds received are being used only for therapy or counselling~~ ~~**20.01.3** The therapist or counsellor providing therapy to an individual who is eligible for funding must sign a document, acceptable to the Registrar:~~ ~~a. indicating that she/he has not at any tine or in any jurisdiction been found guilty of professional misconduct of a sexual nature or been found civilly or criminally liable for an act of a similar nature;~~ ~~b. detailing his or her training and experience;~~ ~~c. confirming that the therapy or counselling is being provided; and~~ ~~d. confirming that the funds received are being used only for therapy or counselling~~		

College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

AGENDA ITEM 8.2

COUNCIL BRIEFING NOTE

Date: June 26, 2018
To: Council
From: Quality Assurance Committee
Subject: Reappointment of Non-Council Member – QA Committee

Recommendation

THAT *Council approves the reappointment of Jun Maranan as a Professional non-Council member of the Quality Assurance Committee for a second 3-year term, commencing on June 18, 2018.*

Background

Jun Maranan was appointed to the Quality Assurance Committee as a non-Council professional member for a 3-year term, in June 2015. Quality Assurance Committee is recommending that Jun be reappointed to the committee for a second 3-year term commencing on June 18, 2018. At present, the Quality Assurance Committee is comprised of six members:

- One academic Council member
- Two public Council members
- One professional Council member
- Two professional non-Council members (including Jun)

This committee composition is consistent with the QAC Terms of Reference.

Discussion

During his first term on the committee, Jun has provided valuable insights into case decisions and key committee initiatives such as the launch of MyQA, review of the Competency Review and Evaluation process research findings, oversight of the development of the annual Prescribed Regulatory Education Program (PREP) and future directions for the CRE program redesign. Jun brings practice experience and perspective from his clinical and non-clinical roles in mental health as well as his commitment to teaching future members of the profession. Reappointing Jun will enable continuity with the current work of the committee and would support the ongoing effectiveness of the committee as they focus on priorities for ensuring competent practice by occupational therapists.

College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

AGENDA ITEM 9.1

COUNCIL BRIEFING NOTE

Date: June 26, 2018
To: Council
From: Executive Committee
Subject: Controlled Act Regulation

Recommendation

THAT *Council approves the proposed Controlled Act of Psychotherapy Regulation, which was circulated to registrants and other stakeholders as required, for submission to Government.*

Background

In 2007, the Government passed the *Health System Improvement Act* (Bill 171) that amended the *Regulated Health Professions Act, 1991* (RHPA) and introduced the 14th controlled act of Psychotherapy. Controlled acts set out restrictions, sanctions, or limit actions considered harmful or protected. These high-risk activities are only to be practised by health professions that have legislative access to them.

The controlled act of psychotherapy was not proclaimed into law until December 30, 2017.

The controlled act to which the occupational therapists have access to is; *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*.

The College submitted a regulation to the Ministry of Health and Long-Term Care in 2009 after the controlled act was proposed in legislation. However, due to the time lag, the Ministry asked the College to re-circulate this regulation which should be in force before occupational therapists can access the controlled act of psychotherapy. In the meantime, occupational therapists can continue to provide psychotherapy services as usual including any service that falls under the controlled act until the end of the two-year transition period that was given to allow unregulated providers to become regulated if they want to practice the controlled act.

Discussion

During the Council meeting in March, members approved the draft controlled act regulation for circulation to registrants and other stakeholders. The College conducted a feedback survey between April 3 and June 3, 2018 to comply with the stipulated requirement that respondents must be given a 60 days consultation period.

The College received 134 responses from registrants, other regulated health professionals, members of the public, professionals working in regulation and other stakeholders.

The highlights of the regulation that respondents were asked to comment on included:

- that occupational therapists will provide the controlled act within the occupational therapy scope of practice

- that an occupational therapist will not delegate the performance of the controlled act.

These and other provisions under this regulation are outlined in Appendix A.

Some of the Supportive Comments Received

- *This is very clear and comprehensive and a practical approach to regulating OT's in Ontario who will be engaging in psychotherapy.*
- *Occupational Therapists are trained to have high degree of skills that are transferrable across continuums of care. We are the ideal profession to assist with health care burdens by utilizing our skills and work in advanced practice roles.*
- *I appreciate the attention that the College has taken to support OT's continued work in the field of mental health. I have been practicing in this field for almost two decades and the advocacy on the part of the College is commendable.*
- *Clear, understandable and appropriate.*
- *I find the regulation and requirements clear. I like the statement about accountability and responsibility (section E) I agree that the performance of this controlled act should not be delegated to others (section F).*
- *This appears to be clear in outlining what expectations are for an OT performing this act. It addresses the most pertinent areas that OT's should be considering when performing any interventions but particularly when the intervention is a controlled act*
- *Looks good! Makes a lot of sense, very straight forward.*
- *It reads clearly. I like the rationale portion of the chart, although in one place (1 A) the rationale did not provide any further insight. The regulation, as it is worded above makes sense and seems very reasonable and is easy to understand.*
- *I definitely agree in the proposed regulation as far I know, Occupational Therapist can truly provide excellent psychotherapy especially with clients with Brain Injury as O.T's are providing cognitive stimulation program and understand well the "Brain "function and manifestation of behaviour of each part of the brain injury. I highly recommend that Occupational Therapists can perform psychotherapy treatments.*

Summary of Some of the Issues Raised

Main Theme	Individual Comments	College Response
Counselling and Psychotherapy	• *…… At times it is confusing to understand what counselling vs psychotherapy is - though COTO has put out documents on this. Also there is literature on providing brief psychotherapy which is effective. I think what I have read from COTO is that it tends to happen over a period of many sessions, but it is possible to provide (in my understanding) psychotherapy over just a few sessions…..* • *makes sense to me. I'm hoping somewhere there's a definition to identify when counselling crosses the line to psychotherapy.*	*The College recognizes this issue and has developed documents to address it. The revised Standards for Psychotherapy explains when an OT should know they are practising psychotherapy or counselling including an outline of general characteristics of psychotherapy and counselling.*

Main Theme	Individual Comments	College Response
Training and Experience	• *…..Psychotherapy presents many risks, to both the recipient and to the therapist. It would be helpful for the regulation to be more specific in the experience/educational requirements required to provide psychotherapy. Further, as mentoring or experience are indicated as potential requirements, the accountability associated with therapists who are in this training period should be more specifically outlined - who can mentor, in what context and setting is experience sufficient, who is accountable for the treatment plan and its implementation during the experiential period* • *…... This idea is consistent with work in any area of practice. I am always required to work in the capacity that my knowledge, skill and judgement allow, but with this regulation, I feel more compelled to be able to prove this with extra external certification etc. (though I realize this is not explicitly stated). It is hard for me to know when I've completed 'enough' training or had 'enough' supervision to meet this regulation's expectations. Some of the certification processes require quite intensive and expensive types of supervision and I am not sure whether I should be engaging in this kind of supervision to be considered competent and safe in my practice of psychotherapy. …..* • *My concern is that the proposed regulation isn't sufficiently strict in terms of necessitating the OT to be able to provide evidence of appropriate training. Far too many OTs practice psychotherapy in the context of little or no training, and to be frank do so much harm. They trivialize their potential to harm the client through their lack of insight and or training. In my opinion the standards of training need to be elevated and there to be stricter controls on which OTs are to be allowed to practice psychotherapy. In my experience as an OT and manager of OT's very few of my colleagues and supervisees have the capacity to conduct (the controlled act of psychotherapy) safely and/or effectively.* • *It lacks any specific criteria with respect to training required. I'm not aware of the current OT curriculum providing thorough training - academic and experiential - in psychotherapy. I don't believe that a newly qualified OT or one who doesn't have additional specified training and mentorship has the required skills to practice competently.*	*Any registered OT who has obtained further training in psychotherapy, professional development programs, mentoring or experience, can perform the controlled act of psychotherapy. All the finer details of the type, duration of training or experience cannot be accommodated in a regulation. Other College documents like the standards of psychotherapy, boundaries, sexual abuse, guidelines and code of ethics address some of these concerns.* *The regulation states that an OT should know the limits of their competence and must be able to demonstrate that they are competent in providing the controlled act of psychotherapy. They are also encouraged to refer clients to other qualified colleagues or professionals when they have limited knowledge, skills or judgement to perform the controlled act competently.* *As it has been stated in the regulation, there is no one specific training requirement. Competency can result from post-graduate training, mentoring, experience, professional development and the College's Standards for Psychotherapy outline more specific expectations for attaining and maintaining competence.*

Main Theme	Individual Comments	College Response
Scope of Practice	• *The proposed regulation content makes sense. Examples for 1 A) to clarify what would it would look like to provide psychotherapy for purposes "outside the scope of occupational therapy", would be helpful.* • *I don't fully understand the rationale for the proposed Act Regulation. The College already has a Standard for Psychotherapy, and most of the items in this regulation are included in the Standard. Can you give an example of when an OT provides psychotherapy outside the scope of OT? I don't fully understand bullet A* • *I think 1A needs to be more specific. How does one determine what is outside the scope? For example, if I am trained as a psychotherapist and am also an OT and people come to me for the reasons of counselling/psychotherapy is that not within the scope of OT? It seems a bit too vague.* • *Clarification is required regarding the definition of the practice of psychotherapy outside the scope of occupational therapy. ……*	*This is no different from any other intervention that OTs perform. OTs should always perform the controlled act of psychotherapy within the scope of practice of occupational therapy. If a client requires additional treatment or further treatment beyond the scope of practice or the limits of the OTs knowledge and skill, the OT should refer them to other qualified providers.*

Please see Appendix B for more details of specific feedback

Conclusion

In general, the College received significant support to the proposed regulation with about 82 per cent of the respondents supporting the proposed regulation. Only 5 per cent of the respondents were opposed to the proposed regulation, while about 13 per cent of the respondents did not know whether to support it or not. A total of 84 respondents answered the question, “Do you support the proposed regulation?”

About 43 per cent of all those who responded made comments. Most of those who commented made positive remarks about the regulation while the rest were asking for further clarification as outlined in the previous summary.

It is clear the majority of those who responded to this survey are supportive of this regulation. In addition, there was no feedback that would prompt a change to any of the provisions. Therefore, it is recommended that the College proceed with the submission to the Government.

Attachments

Appendix A: Draft Controlled Act Regulation and Rationale
Appendix B: Feedback on Proposed Controlled Act Regulation

College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

Appendix A: Draft Controlled Act Regulation & Rationale

Proposed Regulation	Rationale
1. An occupational therapist may perform the controlled act authorized by subsection 3.1(1) of the Act in accordance with the following requirements:	Subsection 3.1(2) of the *Occupational Therapy Act, 1991* permits occupational therapists to perform the new controlled act of psychotherapy so long as they do so in accordance with the provisions of this proposed regulation. This proposed regulation sets out the professional expectations for any occupational therapist who performs the controlled act. Failure to comply with the regulation constitutes professional misconduct under subsection 3.1(3) of the *Occupational Therapy Act, 1991*.
A. The occupational therapist provides the controlled act within the occupational therapy scope of practice.	Occupational therapists cannot provide psychotherapy for purposes outside of the practice of occupational therapy.
B. The occupational therapist has the knowledge, skill and judgment to perform the controlled act safely, effectively and ethically.	Part of being a professional is knowing the limits of one's personal competence. Occupational therapists providing psychotherapy must be able to demonstrate they are competent to do so. Competence can be demonstrated by professional training, post-graduate training, mentoring or experience, or a combination thereof. This provision provides an objective test. If a complaint is made or a quality assurance assessment is conducted, the relevant Committee can evaluate whether the occupational therapist was, in all of the circumstances, competent to provide the service.
C. The occupational therapist has the knowledge, skill and judgement to determine whether the individual's condition warrants performance of the controlled act.	A precondition to providing psychotherapy is the ability to assess the client's condition to determine its nature and whether the client will benefit from the treatment.

Proposed Regulation	Rationale
D. The occupational therapist determines that the individual's condition warrants performance of the controlled act, having considered, i. the known risks and benefits to the individual of performing the controlled act, ii. the predictability of the outcome of performing the controlled act, iii. the safeguards and resources available in the circumstances to safely manage the outcome of performing the controlled act, and iv. other relevant factors specific to the situation.	This provision provides examples of considerations when making judgements about performing the controlled act. These considerations are also relevant to the informed consent process.
E. The occupational therapist accepts accountability for determining that the individual's condition warrants performance of the controlled act.	It is acceptable for occupational therapists to consider information provided by others on the client's health care team about the client's condition. However, where an occupational therapist chooses to provide psychotherapy services, he or she has to assume professional responsibility for its performance. It is unacceptable for the occupational therapist to rely solely on the views of others for initiating this controlled act.
F. An occupational therapist shall not delegate the performance of the controlled act authorized by subsection 3.1(1) of the Act.	Psychotherapy, by its nature, requires the ongoing exercise of professional judgement. It is not suitable for an occupational therapist to delegate the performance of this controlled act to others.

	A	B	C	D	E	F	G	H	I	J
1	**Appendix B: Feedback on Controlled Act Regulation April 3-June 3 2018**									
2	**Date**	**Description**	**Other Description**	**Years of Practice**	**Nature of Practice:**	**Practice Setting:**	**Other Practice Setting**	**Currently Performing Psychotherapy?**	**Comments about the Regulation**	**Do you support the proposed regulation?**
3	05/30/2018	OT		20+ years	clinical	private practice		not applicable		
4	05/29/2018	OT		20+ years	clinical	hospital		both	it would be important also to clarify for OTs practicing psychotherapy about the issue whether sometimes we are providing service in just psychotherapy or sometimes practicing the controlled act; as in real practice situations, those two services can be present within the course of treatment when working with an individual;	Yes
5	05/28/2018	OT		11 - 20 years	clinical	hospital		both	For item D, I find the statement iii confusing (the safeguards and resources available in the circumstances to safely manage the outcome of performing the controlled act). Does this statement mean, for example, that if someone is suicidal that I know where to access services for this person? I don't know what statement iii means and I would want to know that. The statement is not clear to me. If this statement is made clearer, and I know what it means, I would then likely support the proposed regulation.	I don't know.
6	05/28/2018	OT		11 - 20 years	clinical	hospital		not applicable		Yes
7	05/25/2018	OT		11 - 20 years	mixed	hospital		both	Clear and easy to read and understand. Aligned with other expectations and standards of practice that OTs follow.	Yes
8	05/25/2018	OT		0 - 5 years	clinical	private practice		psychotherapy	Looks good	Yes
9	05/24/2018	OT		20+ years	non-clinical	other (please specify)	insurance	not applicable	I would be able to support the proposed regulation with a clear understanding of what constitutes psychotherapy within the scope of practice - it appears when speaking with colleagues and other professionals that this is very unclear. As I am in a non-clinical role, I need to clearly articulate to administration when OTs are performing the controlled act of psychotherapy - and what is within the OTs scope. Decisions are being made regarding which health care provider will be able to or not be able to provide certain specific services or interventions and this is dependent on clarity regarding these issues. Further discussion and a position needs to be taken by the College in conjunction with members as there needs to be a consensus and articulation supporting a position. At this time, occupational therapists may lose the ability to provide service within certain third party payers and institutions due to the lack of clarity.	I don't know.
10	05/24/2018	OT		0 - 5 years	clinical	community		psychotherapy		Yes
11	05/24/2018	OT		6 - 10 years	clinical	private practice		not applicable		
12	05/24/2018	OT		20+ years	non-clinical	other (please specify)	Academic Setting	not applicable	I think the proposed legislation is appropriate. I did wonder if the OT should be able to demonstrate knowledge (have taken training in CBT, for example).	Yes

	A	B	C	D	E	F	G	H	I	J
2	**Date**	**Description**	**Other Description**	**Years of Practice**	**Nature of Practice:**	**Practice Setting:**	**Other Practice Setting**	**Currently Performing Psychotherapy?**	**Comments about the Regulation**	**Do you support the proposed regulation?**
13	05/24/2018	OT		11 - 20 years	clinical	clinic/ treatment centre		not applicable		
14	05/24/2018	OT								
15	05/24/2018	OT		11 - 20 years	mixed	other (please specify)	hospital and corrections	both	The proposed regulations make sense and are appropriate in my opinion.	Yes
16	05/24/2018	OT								
17	05/24/2018	OT		20+ years	clinical	community		psychotherapy		I don't know.
18	05/17/2018	OT		0 - 5 years	clinical	hospital		not applicable		Yes
19	05/16/2018	professional working in regulation								
20	05/15/2018	other (please specify)	OT regulatory college in another province						This is very clear and comprehensive and a practical approach to regulating OT's in Ontario who will be engaging in psychotherapy.	Yes
21	05/15/2018	OT		20+ years	clinical	clinic/ treatment centre		both		Yes
22	05/12/2018	OT		20+ years	clinical	hospital		psychotherapy		
23	05/11/2018	OT		6 - 10 years	clinical	private practice		psychotherapy		Yes
24	05/10/2018	OT		20+ years	clinical	private practice		psychotherapy		Yes
25	05/08/2018	OT		20+ years	clinical	hospital		not applicable	thorough however not applicable to me at his time or in the future	Yes
26	05/07/2018	OT		20+ years	clinical	community		not applicable		Yes

	A	B	C	D	E	F	G	H	I	J
2	**Date**	**Description**	**Other Description**	**Years of Practice**	**Nature of Practice:**	**Practice Setting:**	**Other Practice Setting**	**Currently Performing Psychotherapy?**	**Comments about the Regulation**	**Do you support the proposed regulation?**
27	05/06/2018	OT		20+ years	clinical	hospital		both	The outline of the regulation seems clear. At times it is confusing to understand what is counselling vs psychotherapy - though COTO has put out documents on this. Also there is literature on providing brief psychotherapy which is effective. I think what I have read from COTO is that it tends to happen over a period of many sessions, but it is possible to provide (in my understanding) psychotherapy over just a few sessions. Also, it may help to clarify what psychotherapy is not. For example, in teaching coping I have given the job to a student OTA to assist with filling out some handouts such as a stress symptom inventory or a one day routine to follow on discharge - with clear guidelines laid out for the student. I beleive this 1 - is counselling and not psychotherapy and 2 therefore is not a delegation of psychotherapy.	Yes
28	05/04/2018	OT								
29	05/04/2018	OT		0 - 5 years	clinical	hospital		not applicable		Yes
30	05/03/2018	OT		11 - 20 years	clinical	other (please specify)	Corrections	the controlled act of psychotherapy		Yes
31	05/02/2018	OT		20+ years	clinical	community		psychotherapy		
32	05/01/2018	OT		20+ years	non-clinical	rehab hospital/ centre		not applicable		Yes
33	05/01/2018	OT		0 - 5 years	clinical	hospital		both	It is still unclear to me when I can use the psychotherapy title with these draft regulations. If I have had the relevant training from one position, with supervision from mentors, and I move into private practice, without supervision, can I still use the psychotherapist title? Can I still practice the controlled act of psychotherapy as long as I can prove my competence?	I don't know.
34	04/30/2018	OT		20+ years	clinical	hospital		psychotherapy		Yes
35	04/29/2018	OT		0 - 5 years	clinical	private practice		the controlled act of psychotherapy		
36	04/28/2018	OT		20+ years	mixed	rehab hospital/ centre		psychotherapy		
37	04/28/2018	OT		0 - 5 years	clinical	community		psychotherapy		
38	04/28/2018	OT		20+ years	clinical	rehab hospital/ centre		not applicable	The proposed regulation content makes sense. Examples for 1 A) to clarify what would it would look like to provide psychotherapy for purposes "outside the scope of occupational therapy", would be helpful.	Yes
39	04/28/2018	OT		6 - 10 years	clinical	community		not applicable		Yes

	A	B	C	D	E	F	G	H	I	J
2	**Date**	**Description**	**Other Description**	**Years of Practice**	**Nature of Practice:**	**Practice Setting:**	**Other Practice Setting**	**Currently Performing Psychotherapy?**	**Comments about the Regulation**	**Do you support the proposed regulation?**
40	04/28/2018	OT		11 - 20 years	clinical	rehab hospital/ centre		not applicable		Yes
41	04/27/2018	OT		0 - 5 years	clinical	clinic/ treatment centre		psychotherapy		
42	04/27/2018	OT		0 - 5 years	clinical	private practice		not applicable		Yes
43	04/27/2018	OT		20+ years	clinical	community		psychotherapy		Yes
44	04/27/2018	OT		0 - 5 years	clinical	clinic/ treatment centre		not applicable		
45	04/27/2018	OT		11 - 20 years	clinical	hospital		not applicable	Occupational Therapists are trained to have high degree of skills that are transferrable across continuum's of care. We are the ideal profession to assist with health care burdens by utilizing our skills and work in advanced practice roles.	Yes
46	04/27/2018	OT		11 - 20 years	mixed	private practice		the controlled act of psychotherapy	I appreciate a the attention that the College has taken to support OT's continued work in the field of mental health. I have been practicing in this field for almost two decades and the advocacy on the part of the College is commendable.	Yes
47	04/27/2018	OT		0 - 5 years	clinical	hospital		psychotherapy		I don't know.
48	04/26/2018	OT		0 - 5 years	mixed	private practice		the controlled act of psychotherapy		Yes
49	04/26/2018	OT								
50	04/26/2018	OT		11 - 20 years	clinical	community		psychotherapy		Yes
51	04/26/2018	OT		11 - 20 years	clinical	hospital				
52	04/26/2018	OT		20+ years	clinical	private practice		both		

	A	B	C	D	E	F	G	H	I	J
2	**Date**	**Description**	**Other Description**	**Years of Practice**	**Nature of Practice:**	**Practice Setting:**	**Other Practice Setting**	**Currently Performing Psychotherapy?**	**Comments about the Regulation**	**Do you support the proposed regulation?**
53	04/26/2018	OT		20+ years	non-clinical	other (please specify)	LHIN	not applicable	While I am currently working in a non-clinical role, I have worked in mental health for many years previously. Psychotherapy presents many risks, to both the recipient and to the therapist. It would be helpful for the regulation to be more specific in the experience/educational requirements required to provide psychotherapy. Further, as mentoring or experience are indicated as potential requirements, the accountability associated with therapists who are in this training period should be more specifically outlined - who can mentor, in what context and setting is experience sufficient, who is accountable for the treatment plan and it's implementation during the experiential period. While this may be similar to the accountability associated with occupational therapy students, it would be helpful to have this explicitly stated. It would also be helpful for a statement regarding the documentation of psychotherapy provision. Must OT's who are providing psychotherapy explicitly document this as a treatment plan? I question this as there is overlap in the application of the therapeutic relationship implicit in delivering mental health care and the planned explicit use of psychotherapeutic techniques. Further there is a risk that OT's may dabble in psychotherapy by employing aspects of the treatment without explicitly providing the treatment. This also leads to the topic of informed consent and the importance of documenting consent to use a technique with known risks to the client in plain terms in the clinical record. The regulation begins to address informed consent but does not indicate that it must be explicitly recorded and given the nature of this treatment I feel that the regulation should indicate that consent for "psychotherapy" was given and that the process and risks were specifically discussed with the client	I don't know.
54	04/26/2018	OT		20+ years	clinical	private practice		both	makes sense to me. I'm hoping somewhere there's a definition to identify when counselling crosses the line to psychotherapy.	Yes
55	04/26/2018	OT		11 - 20 years	clinical	hospital		not applicable		
56	04/26/2018	OT		0 - 5 years	mixed	community		not applicable	I think the proposed regulation is clear and concise. In terms of logical organization of the sub-points, it might make sense to organize the points starting with self-assessment (B), then assessment with the client (C/D, E) then completing the intervention itself (A, F). For conciseness and clarity, points C and D could be combined (e.g., "The occupational therapist has the knowledge, skill, and judgment to determine whether the individual's condition warrants performance of the controlled act, having considered: i. the known risks...). Thank you for all your excellent work on this!	Yes
57	04/26/2018	OT		20+ years	clinical	rehab hospital/ centre		not applicable	I think the standard of having the knowledge skill and ability to perform psychotherapy is critical	Yes
58	04/26/2018	OT		0 - 5 years	non-clinical	hospital		not applicable		Yes

	A	B	C	D	E	F	G	H	I	J
2	**Date**	**Description**	**Other Description**	**Years of Practice**	**Nature of Practice:**	**Practice Setting:**	**Other Practice Setting**	**Currently Performing Psychotherapy?**	**Comments about the Regulation**	**Do you support the proposed regulation?**
59	04/26/2018	OT		11 - 20 years	mixed	community		not applicable		
60	04/26/2018	OT		20+ years	clinical	private practice		not applicable		Yes
61	04/26/2018	OT		11 - 20 years	mixed	other (please specify)	out of country practice of OT (Nepal)	psychotherapy	I have no major qualms with anything written in the proposed regulation. My major point of reflection and challenge relates to determining that I meet requirement 1.B adequately to meet expectations of an external review. This idea is consistent with work in any area of practice. I am always required to work in the capacity that my knowledge, skill and judgement allow, but with this regulation, I feel more compelled to be able to prove this with extra external certification etc. (though I realize this is not explicitly stated). It is hard for me to know when I've completed 'enough' training or had 'enough' supervision to meet this regulation's expectations. Some of the certification processes require quite intensive and expensive types of supervision and I am not sure whether I should be engaging in this kind of supervision to be considered competent and safe in my practice of psychotherapy. My situation relates to providing play therapy for children with relational and emotional struggles. More specifically, I am not clear what is meant by the statement 'This provision provides an objective test'. I appreciate all attempts to provide personal support and information to therapists trying to apply this regulation to their occupational practice.	Yes
62	04/25/2018	OT		0 - 5 years	clinical	community		not applicable		
63	04/25/2018	OT		11 - 20 years	mixed	community		not applicable	I don't fully understand the rationale for the proposed Act Regulation. The College already has a Standard for Psychotherapy, and most of the items in this regulation are included in the Standard. Can you give an example of when an OT provides psychotherapy outside the scope of OT? I don't fully understand bullet A. I think it is also important to capture when to end exercising the controlled act or end the provision of psychotherapy in the regulation or in the Standard (e.g. when the client is getting worse from the sessions). The importance of building therapeutic rapport, using therapeutic use of self, and developing a safe, therapeutic milieu should also be captured somewhere in the regulation or in the Standard. I feel that one document should suffice in setting practice standards around psychotherapy/controlled act of psychotherapy. Thank you.	No
64	04/25/2018	OT		0 - 5 years	clinical	community		psychotherapy		Yes
65	04/25/2018	OT		0 - 5 years	clinical	clinic/ treatment centre		psychotherapy		
66	04/25/2018	OT		0 - 5 years	clinical	community		psychotherapy		Yes

	A	B	C	D	E	F	G	H	I	J
2	**Date**	**Description**	**Other Description**	**Years of Practice**	**Nature of Practice:**	**Practice Setting:**	**Other Practice Setting**	**Currently Performing Psychotherapy?**	**Comments about the Regulation**	**Do you support the proposed regulation?**
67	04/25/2018	OT		0 - 5 years	clinical	rehab hospital/ centre		not applicable		Yes
68	04/25/2018	OT		20+ years	non-clinical	hospital		not applicable		
69	04/25/2018	OT		20+ years	clinical	clinic/ treatment centre		psychotherapy		Yes
70	04/25/2018	OT		6 - 10 years	clinical	rehab hospital/ centre		not applicable		
71	04/25/2018	OT		6 - 10 years	clinical	rehab hospital/ centre		not applicable		Yes
72	04/25/2018	OT		6 - 10 years	clinical	rehab hospital/ centre		not applicable		Yes
73	04/25/2018	OT		20+ years	clinical	private practice		both	I think 1A needs to be more specific. How does one determine what is outside the scope? For example, if I am trained as a psychotherapist and am also an OT and people come to me for the reasons of counselling/psychotherapy is that not within the scope of OT? It seems a bit too vague.	No
74	04/25/2018	OT		20+ years	non-clinical	hospital		not applicable		Yes
75	04/25/2018	OT		6 - 10 years	clinical	hospital		both	Clarification is required regarding the definition of the practice of psychotherapy outside the scope of occupational therapy. Considering how vague and circular the definition of psychotherapy is right now (psychotherapy is practiced through psychotherapeutic means is extremely circular), this aspect needs clarification, because unfortunately there are interventions that are very occupation-based that are considered psychotherapeutic.	I don't know.
76	04/25/2018	other regulated health professional								I don't know.
77	04/25/2018	OT		0 - 5 years	clinical	hospital		psychotherapy		Yes
78	04/25/2018	OT		11 - 20 years	mixed	hospital		not applicable		Yes

	A	B	C	D	E	F	G	H	I	J
2	**Date**	**Description**	**Other Description**	**Years of Practice**	**Nature of Practice:**	**Practice Setting:**	**Other Practice Setting**	**Currently Performing Psychotherapy?**	**Comments about the Regulation**	**Do you support the proposed regulation?**
79	04/25/2018	OT		20+ years	clinical	private practice		not applicable		
80	04/25/2018	OT		11 - 20 years	mixed	community		psychotherapy		I don't know.
81	04/25/2018	OT		20+ years	clinical	hospital		psychotherapy		
82	04/25/2018	OT		11 - 20 years	clinical	community		not applicable		
83	04/25/2018	OT		20+ years	clinical	clinic/ treatment centre		psychotherapy	1.A: where are the inclusion and exclusion criteria that describe when psychotherapy is "outside of the practice of occupational therapy"? 1.B Where is the "objective test" for competence?	Yes
84	04/25/2018	OT		20+ years	mixed	hospital		both		
85	04/25/2018	OT		0 - 5 years	clinical	other (please specify)	mental health outpatient clinic in mental health hospital	psychotherapy		
86	04/25/2018	OT		11 - 20 years	non-clinical	clinic/ treatment centre		not applicable		Yes
87	04/25/2018	OT		6 - 10 years	non-clinical	non-health setting		not applicable		
88	04/25/2018	OT		20+ years	mixed	community		not applicable		
89	04/25/2018	OT		0 - 5 years	clinical	clinic/ treatment centre		both		Yes
90	04/25/2018	OT		0 - 5 years	clinical	hospital		both		
91	04/25/2018	OT		0 - 5 years	clinical	community		not applicable		Yes
92	04/25/2018	OT		11 - 20 years	mixed	hospital		not applicable		
93	04/25/2018	OT		20+ years	non-clinical	community		not applicable		Yes

	A	B	C	D	E	F	G	H	I	J
2	**Date**	**Description**	**Other Description**	**Years of Practice**	**Nature of Practice:**	**Practice Setting:**	**Other Practice Setting**	**Currently Performing Psychotherapy?**	**Comments about the Regulation**	**Do you support the proposed regulation?**
94	04/25/2018	OT		0 - 5 years	mixed	non-health setting		not applicable		Yes
95	04/25/2018	OT		6 - 10 years	mixed	other (please specify)	Hospital and private	the controlled act of psychotherapy		Yes
96	04/25/2018	OT		0 - 5 years	clinical	clinic/ treatment centre		psychotherapy	Clear, understandable and appropriate.	Yes
97	04/25/2018	OT								
98	04/23/2018	OT		20+ years	clinical	hospital		psychotherapy		
99	04/15/2018	OT		6 - 10 years	clinical	community		the controlled act of psychotherapy		
100	04/12/2018	OT		20+ years	clinical	hospital		both		Yes
101	04/12/2018	OT		20+ years	non-clinical	community		not applicable	This appears to be clear in outlining what expectations are for an OT performing this act. It addresses the most pertinent areas that OT's should be considering when performing any interventions but particularly when the intervention is a controlled act.	Yes
102	04/10/2018	OT		6 - 10 years	clinical	hospital		not applicable		
103	04/10/2018	OT		0 - 5 years	clinical	clinic/ treatment centre		not applicable		Yes
104	04/10/2018	OT		11 - 20 years	clinical	community		not applicable	I find the regulation and requirements clear. I like the statement about accountability and responsibility (section E).I agree that the performance of this controlled act should not be delegated to others (section F).	Yes
105	04/09/2018	OT		6 - 10 years	clinical	non-health setting		not applicable		Yes
106	04/09/2018	OT		20+ years	clinical	other (please specify)	My office is at a hospital (employer) but my practice setting is in the community.	psychotherapy	simple, straight forward and reasonable.	Yes

	A	B	C	D	E	F	G	H	I	J
2	**Date**	**Description**	**Other Description**	**Years of Practice**	**Nature of Practice:**	**Practice Setting:**	**Other Practice Setting**	**Currently Performing Psychotherapy?**	**Comments about the Regulation**	**Do you support the proposed regulation?**
107	04/09/2018	OT		11 - 20 years	clinical	hospital		psychotherapy		
108	04/07/2018	OT		20+ years	non-clinical	rehab hospital/ centre		not applicable	Adequately outlines roles, responsibilities of therapist and risk	Yes
109	04/05/2018	OT		20+ years	clinical	private practice		the controlled act of psychotherapy		Yes
110	04/05/2018	OT		20+ years	mixed	private practice		not applicable		
111	04/05/2018	OT		0 - 5 years	clinical	clinic/ treatment centre		psychotherapy	I am wondering how to manage having OT fieldwork students under the new regulation. Would students have to be directly supervised by an OT competent to perform psychotherapy at all times?	Yes
112	04/05/2018	other regulated health professional							I am unaware of the type of psychotherapy practiced by occupational therapists or the nature of their education in this field. Assuming it is of equal quality to that provided to other practitioners (psychologists, psychiatrists) I would have no concerns in having OTs practice psychotherapy. I do believe that there should be inclusion in regulation 1.B of maintenance of certification and more requirements regarding continuing education in or to maintain certification in psychotherapy as exists in other regulated health professions.	I don't know.
113	04/04/2018	OT		11 - 20 years	clinical	community		psychotherapy	I believe that OT's need examples of how Psychotherapy would be in the OT scope of practice. Perhaps examples within a PREP module.	Yes
114	04/04/2018	OT		20+ years	clinical	hospital		not applicable	It lacks any specific criteria with respect to training required. I'm not aware of the current OT curriculum providing thorough training - academic and experiential - in psychotherapy. I don't believe that a newly qualified OT or one who doesn't have additional specified training and mentorship has the required skills to practice competently.	No
115	04/04/2018	OT		20+ years	clinical	community		not applicable		Yes
116	04/04/2018	OT		11 - 20 years	clinical	community		not applicable		Yes
117	04/04/2018	OT		11 - 20 years	clinical	hospital		both	My concern is that the proposed regulation isn't sufficiently strict in terms of necessitating the OT to be able to provide evidence of appropriaye training. Far too many OTs practice psychotherapy in the context of little or no training, and to be frank do so much harm. They trvialise their potential to harm the client through their lack of insight and or training. In my opinion the standards of training need to be ekevated and there to be stricter controls on which OTs are to be allowed to practice psychotherapy. In my experience as an OT and manager of OT's very few of my colleagues and supervisees have the capacity to conduct (the controlled act of psychotherapy) safely and/or effectively.	No

	A	B	C	D	E	F	G	H	I	J
2	**Date**	**Description**	**Other Description**	**Years of Practice**	**Nature of Practice:**	**Practice Setting:**	**Other Practice Setting**	**Currently Performing Psychotherapy?**	**Comments about the Regulation**	**Do you support the proposed regulation?**
118	04/03/2018	OT		20+ years	clinical	private practice		not applicable	Concern regarding clinical supervision of therapists offering psychotherapy. OTs in gatekeeping roles overseeing the services provided by OTs offering psychotherapy should be regulated to be qualified to do so. Many therapists with minimal to no experience in psychotherapy are in position to influence how practice is being delivered and offered by those more qualified then them. The non psychotherapy trained OTs have the authority to influence decisions about delivery of care of those qualified to offer a controlled act. The college of psychotherapists of Ontario does not allow this. This puts patient care at risk. Supervising non psychotherapy trained OTs of OTs offering psychotherapy should be required to declare their lesser qualifications to stakeholders and not be free to make potentially destructive recommendations or influence funding or cause damage to the reputations of more qualified therapists due to their lack of knowledge and depth of understanding of the therapeutic process.	I don't know.
119	04/03/2018	OT		11 - 20 years	mixed	clinic/ treatment centre		both	I definitely agree in the proposed regulation as far I know, Occupational Therapist can truly provide excellent psychotherapy especially with clients with Brain Injury as O.T's are providing cognitive stimulation program and understand well the "Brain"function and manifestation of behaviour of each part of the brain injury. I highly recommends that Occupational Therapists can perform psychotherapy treatments.	Yes
120	04/03/2018	OT		11 - 20 years	mixed	clinic/ treatment centre		not applicable	It reads clearly. I like the rationale portion of the chart, although in one place (1 A) the rationale did not provide any further insight. The regulation, as it is worded above makes sense and seems very reasonable and is easy to understand.	Yes
121	04/03/2018	OT								
122	04/25/2018	OT		11 - 20 years	clinical	hospital		the controlled act of psychotherapy		
123	04/03/2018	OT		20+ years	clinical	hospital		both	It’s an accurate reflection of implementation of the psychotherapy practice and the entitlement of being able to practice as a psychotherapist	Yes
124	04/03/2018	OT		20+ years	non-clinical	community		not applicable		Yes
125	04/03/2018	professional working in regulation								
126	04/03/2018	OT		0 - 5 years	clinical	community		the controlled act of psychotherapy	Looks good! Makes a lot of sense, very straightforward.	Yes
127	04/03/2018	OT		6 - 10 years	clinical	hospital		not applicable		

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2	**Date**	**Description**	**Other Description**	**Years of Practice**	**Nature of Practice:**	**Practice Setting:**	**Other Practice Setting**	**Currently Performing Psychotherapy?**	**Comments about the Regulation**	**Do you support the proposed regulation?**
128	04/03/2018	OT		11 - 20 years	clinical	community		the controlled act of psychotherapy	I agree with the proposed regulation. My opinion is that is that it would be helpful to briefly outline the types of training that are acceptable to enable the OT to practice psychotherapy. I have found that clients and referral sources often want to know what type of training the OT has to enable practice of psychotherapy. I think the rationale for section B has to be more clear.	Yes
129	04/03/2018	OT		20+ years	mixed	private practice		psychotherapy		
130	04/03/2018	other regulated health professional								
131	04/03/2018	OT		11 - 20 years	clinical	clinic/ treatment centre		the controlled act of psychotherapy	seems fine.	
132	04/03/2018	OT		11 - 20 years	clinical	community		not applicable		
133	04/03/2018	OT		0 - 5 years	clinical	community		not applicable		
134	04/03/2018	OT		20+ years	mixed	private practice		not applicable		
135	04/03/2018	professional working in regulation								
136	04/03/2018	member of the public								

College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

AGENDA ITEM 9.2

COUNCIL BRIEFING NOTE

Date: June 26, 2018
To: Council
From: Practice Issues Subcommittee
Subject: Revised Standards for Psychotherapy

Recommendation

THAT *Council approves the revised Standards for Psychotherapy..*

Background

In 2007, amendments to the *Regulated Health Professions Act* (RHPA, 1991) provided authorization to OTs to perform the controlled act of Psychotherapy once proclaimed into force. Proclamation of the controlled act of psychotherapy occurred on December 30, 2017.

In alignment with the College's document review framework and in preparation for the proclamation of this controlled act, the Practice Issues Subcommittee (PISC) reviewed the current Standards for Psychotherapy.

Following a comprehensive review, the following changes were made to the Standards for Psychotherapy:

1. **Definition of Psychotherapy –** the definition of psychotherapy was reviewed and revised to better reflect occupational therapy scope of practice.
2. **Integration of Standards** – Certain standards and performance indicators were merged to reduce duplication.
3. **New Standards –** Subcommittee recommended that the following standards be created or separated to stand alone for clarification:
    - ***Use of Title Psychotherapist*** *– Outlines the appropriate use of the Psychotherapist Title*
    - ***Competence*** *– Outlines the requirements for competence (knowledge and experience) to practice psychotherapy*
    - ***Maintaining Competence*** *– Outlines the expectations for ongoing competence in psychotherapy practice*
    - ***Supervision of Practice*** *– Outlines the expectations for OTs to obtain formal supervision for their psychotherapy practice*
    - ***Supervision of OTs and Other Practitioners*** *– Outlines the expectations for OTs who will supervise the practice of OTs and other practitioners in the provision of psychotherapy services*
    - ***Students –*** *Outlines the expectations when OTs are supervising students*
    - ***Support Personnel –*** *Emphasizes that psychotherapy cannot be delegated or assigned to Support Personnel (now changed to Occupational Therapist Assistants)*

4. **Appendix 1 –** Updated the table on the general characteristics of Psychotherapy and Counselling.
5. **Appendix 2 –** Outlines considerations for a sample supervision agreement.
6. **References –** References were updated.
7. **Decision Support Resource –** with support from OTs practicing psychotherapy, the Performing Psychotherapy: A Decision Tree for Occupational Therapists was created to help provide clarification for OTs.

In January 2018, Council approved the draft revision of the Standards for Psychotherapy to be circulated for stakeholder consultation.

Summary of Stakeholder Consultation Results

The survey was administered over a 4-week period. The College received 93 online responses to the consultation, and 4 written responses including one from the Ontario College of Social Workers and Social Service Workers (OCSWSSW). The OCSWSSW commented the revised standards were clear and concise and performance indicators provided useful clarification for OTs in Ontario. The only suggestion from OCSWSSW was to make explicit the fact that sexual relationships are personal relationships.

General Survey Results

Demographics

- 94% of respondents were OTs
- Respondents' nature of practice was 38% hospital, 17% private practice, 17% community, 7% clinic treatment centre, 5% rehab hospital, 2% non-health care setting, 1% public, 12% other (combination of private, and/or community and research)
- 22% of respondents indicated they practice psychotherapy, 10%, the controlled act of psychotherapy, 26% stated both, and 42% did not answer this question

Overall Impressions

In response to the survey questions:

- 73% of respondents indicated that the standards clearly outlined the expectations for OTs who are practicing psychotherapy
- 75% of respondents noted that the standards reflect current practice
- 80% of the respondents indicated that the decision tree was helpful
- *Emerging Themes requiring Clarification*:
    - Definition of Psychotherapy is too broad
    - Controlled act definition requires additional clarification "serious/seriously and psychotherapeutic technique/means"
    - Need to clearly outline OT interventions that do and do not fall under psychotherapy
    - Additional competence requirements are unnecessary as OTs have mental health education
    - Clarification required for the Supervision of Practice requirements and agreements

  Below is a selection of the summarized comments provided by respondents:
    - There is no clear delineation between occupational therapy intervention in mental health and psychotherapy

- OTs working in mental health are working with clients with serious psychological disorders, most clients are not coming to OT for psychotherapy but to work on occupational therapy performance goals
- Definition of the controlled act is too broad – the word serious is too vague
- More examples are needed to clarify what interventions are considered psychotherapy
- If an OT is applying a combination of psychotherapy approaches (CBT strategies and motivational theory techniques, mindfulness) is this considered psychotherapy and do the standards apply
- What about experienced OT's and supervision when do you reach competency (define competency)?
- 3 years is reasonable experience to be a supervisor – five years too much
- Can an OT obtain supervision from another discipline?
- Obtaining competency is too rigorous, why does an OT who is practicing psychotherapy require an additional year in mental health to be able to practice psychotherapy, no other area of OT practice is held to these expectations
- There are too many variables within each point of the decision tree
- more specificity on the distinction between the controlled act and psychotherapy that falls outside of the controlled act is required

Incorporation of Feedback into the Standards

Amendments to the Standards included revising the language to promote clarity of expectations and removing performance indicators that do not reflect current practice. All comments were reviewed and where appropriate, the feedback was incorporated into the revised Standards as follows:

- Definition of psychotherapy – content revised to clarify OT interventions that are not considered psychotherapy
- Competence – removal of the one and two-year mental health experience requirement prior to practicing psychotherapy
- Supervision of Practice
  - Title changed to Psychotherapy Supervision to assist with clarifying that it is the psychotherapy that is being supervised
  - Addition of a new performance indicator outlining the expectations for psychotherapy supervision related to the level of the OT's psychotherapy experience
- Maintaining Competence – removal of certain performance indicators that do not reflect current practice
- Supervision of OTs and Other Practitioners
  - Title changed to OTs Acting as Supervisors
  - Under the section of maintaining supervisory notes, there is a new requirement to record fees charged for the supervision
  - The requirement to maintain the supervisory notes in a secure and confidential manner for the duration of the supervision agreement was included under this standard as opposed to the record keeping standard
  - Professional Boundaries – the expectation to comply with the Standards for Professional Boundaries and the Prevention of Sexual Abuse was added as a new performance indicator
  - Includes specific language prohibiting personal or sexual relations during or following psychotherapy treatment
- Appendix 2 – title changed to Supervision Agreement Considerations

- Minor changes were applied to the Psychotherapy Decision Tree to align with the revisions of the Standards

Discussion

Council is asked to review the revised Standards for Psychotherapy and provide comment on any additional revisions required.

Attachments

1. Draft Revised Standards for Psychotherapy (June 2018)
2. Draft Revised Standards for Psychotherapy approved for consultation (January 2018)
3. Determining When the Standards for Psychotherapy Apply Decision Tree (June 2018)

College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

Standard

Standards for Psychotherapy

Draft Revision June 2018

Originally Issued 2010

Introduction

The purpose of this document is to ensure the safe, effective, and ethical delivery of psychotherapy services including the controlled act by occupational therapists (OTs) in Ontario. The Standards for Psychotherapy describe the minimum expectations for OTs to provide competent and safe psychotherapy intervention within the scope of practice of the profession of occupational therapy.

The College defines psychotherapy as follows:

> *Psychotherapy refers to planned and structured interventions aimed at influencing behaviour and function, by psychotherapeutic means[1]. Psychotherapy is delivered through a therapeutic relationship to change an individual's disorder of thought, cognition, mood, emotional patterns, perception, or memory that may impair the individual's judgement, insight, behaviour, communication, or social functioning as it relates to the performance of daily activities.*

The College recognizes that this definition may not conform to all the published models or philosophies of psychotherapy and mental health care. The Standards for Psychotherapy are not based on any one psychotherapy theory or approach. This definition of psychotherapy is intended to apply in all circumstances in which OTs are practising psychotherapy.

Psychotherapy concentrates on the client's emotional problems for the purpose of changing defeating patterns of thought, emotion, and behaviour. Psychotherapy through a therapeutic relationship aims at promoting positive personality change, growth and development, and re-organizing the personality. Psychotherapists frequently work with a variety of theories or combinations of theories and may use one or more procedures or models to try to achieve desired results.[2] Psychotherapy intervention can be delivered in individual, group, family, or, couple formats. Psychotherapy may be a long-term intensive process that identifies emotional issues and their cause with a focus on a deep, fundamental process of change, and the development of insight about thoughts, feelings and behaviours.

The practice of psychotherapy is broad and can be performed in different clinical settings with diverse client populations. The Ministry of Health & Long-Term Care (MOHLTC) directed the College of Registered Psychotherapists of Ontario (CRPO) to make regulations prescribing therapies involving the practice of psychotherapy including the development of policies, guidelines and other supporting resources that outline the activities that are not considered to be part of the controlled act of psychotherapy. The practice of psychotherapy is broad and can be performed in different clinical settings with diverse client populations. For this reason, in the provision of occupational therapy service, the following are examples of activities considered to fall outside the practice of psychotherapy: advocacy; providing education; counselling and support; teaching and problem solving; learning and re-learning skills to carry out activities of daily living. The College acknowledges that OTs perform many

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[1] *Adapted from the World Health Organization,2001*
[2] *Corsini et. Al, 2008*

interventions with their clients; an OT who performs these interventions in the absence of having a formal psychotherapeutic relationship is considered not to be performing psychotherapy[3].

Appreciating that psychotherapy can pose an increased risk to clients with serious disorders, a subset of psychotherapy has been defined as a controlled act under the *Regulated Health Professions Act, 1991* (RHPA). The controlled act of psychotherapy can only be performed by certain regulated health professionals including OTs.

Controlled Act

Controlled acts are procedures or activities which may pose a risk to the public if not performed by a qualified practitioner. The *Regulated Health Professions Act*, *1991* (RHPA) grants OTs the authority to perform the controlled act of psychotherapy. The controlled act of psychotherapy is defined in the RHPA as follows:

> *"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 judgment, insight, behavior, communication or social functioning."*

The following elements must be present for a psychotherapy activity or intervention to fall within the controlled act of psychotherapy:

1. You are treating a client
2. You are applying a psychotherapy technique
3. You have a therapeutic relationship with the client
4. The client has a ***serious*** disorder of thought, cognition, mood, emotional regulation, perception or memory
5. This disorder may ***seriously*** impair the client's judgment, insight, behaviour, communication or social functioning

The Standards for Psychotherapy apply to all psychotherapy practice and are not limited to the controlled act. OTs are required to perform all psychotherapy in accordance with the laws, regulations and standards of practice. For assistance in understanding when these standards may apply in a specific practice context, refer to the resource "Determining When the Standards for Psychotherapy Apply".

Psychotherapy and Counselling

Psychotherapy and counselling are often viewed as interrelated. Whether the OT is practising psychotherapy or counselling with a client, the OT must understand that there are some distinctive differences[4] in the level of risk between the two approaches.

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[3] College of Registered Psychotherapists of Ontario. (2018). Controlled Act Task Group Consultation Documents
[4] Appendix 1

Counselling can involve education, guidance, encouragement, supportive problem-solving or informational advice. Counselling formats vary and can include: individual, group, family or couple. Counselling can be used in all areas of occupational therapy and is typically considered a lower risk activity for the client. The focus of counselling is on specific problems or changes in life that can impact occupational performance.[5] Counselling may or may not require grounding in a specific theory.

Although there is some overlap between counselling and psychotherapy, it is important for OTs to be able to identify when they are practising psychotherapy given the increased level of risk posed to the client. See Appendix 1 for additional information.

Application of the Standards for Psychotherapy

- The following **standards** describe the minimum expectations for OTs when performing psychotherapy.
- The **performance indicators** listed below each standard describe more specific behaviours that demonstrate the Standard has been met.
- It is not expected that all performance indicators will be evident all the time. It is expected performance indicators could be demonstrated if requested.
- There may be some situations where the OT determines that a performance indicator has less relevance due to client factors or environmental factors.
- It is expected that OTs will always use their clinical judgement to determine how to best meet client needs in accordance with the standards of the profession.
- It is expected that OTs will be able to provide reasonable rationale for any variations from the Standard.

In the event of any conflict or inconsistency in these Standards for Psychotherapy with any other College standards, the standards with the most recent issued or revised date prevail.

College publications contain practice parameters and standards which all OTs practising in Ontario should consider in the care of their clients and in the practice of the profession. College Standards are developed in consultation with OTs and describe current professional expectations. College Standards may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

Pursuant to the RHPA, the College is authorized to make regulations in relation to professional practice. The College's Professional Misconduct Regulation establishes that "contravening, by act or omission, a standard of practice of the profession or failing to maintain a standard of the profession" constitutes grounds for professional misconduct.

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[5] *Psychotherapy & Counselling Federation of Australia*

Overview of the Standards for Psychotherapy

1. Scope of Practice
2. Use of Title Psychotherapist
3. Competence
4. Psychotherapy Supervision
5. Maintaining Competence
6. OTs Acting as Supervisors
7. Supervision of Students
8. Occupational Therapist Assistants
9. Consent
10. Risk Management
11. Record Keeping
12. Professional Boundaries
13. Discontinuation of Service

1. Scope of Practice

Standard 1

The OT will perform psychotherapy within the scope of practice of the profession of occupational therapy.

Performance Indicators

An OT will**:**	
1.1	Determine whether psychotherapy can be effectively applied within their specific role and occupational therapy scope of practice;
1.2	Perform psychotherapy in accordance with the standards of practice and the Code of Ethics;
1.3	Refer to other qualified providers if the client requires treatment beyond the scope of practice of occupational therapy, or beyond the limits of the OT`s knowledge and skill;
1.4	Ensure the client clearly understands when psychotherapy will be used within the treatment plan;

1.5	Understand and apply relevant legislation pertaining to the practice of psychotherapy;
1.6	Not delegate or assign components of the controlled act of psychotherapy.

2. Use of Title Psychotherapist

In Ontario, there are protected titles that only regulated health professionals are legally permitted to use. The protected title "occupational therapist", the designation “OT Reg. (Ont.)” or any variation or abbreviation can only be used by individuals registered with the College of Occupational Therapists of Ontario. Occupational therapists (OTs) who practice psychotherapy in accordance with the Standards for Psychotherapy are also permitted to use the protected title “psychotherapist” (RHPA, s. 33.1(1)). When using the title “psychotherapist”, OTs are responsible for making sure people understand they are accountable to the College of Occupational Therapists of Ontario.

If choosing to use the “psychotherapist” title, OTs must use the protected title “occupational therapist” or identify themselves as a member of the College before the title “psychotherapist” in both oral and written communication.

While OTs have legal authority to use the title psychotherapist, they are not required to use this title. Alternative means for conveying this area of practice may be: *Andrew James, OT Reg. (Ont.), practising in the area of psychotherapy.*

Standard 2

The OT will use the protected title for occupational therapists in Ontario or identify themselves as a member of the College first when also choosing to use the title “psychotherapist”.

Performance Indicators

An OT will:	
2.1	When **speaking** to a client, use the title “occupational therapist”, or the full name of the College first, before using the title, “psychotherapist”. For example, *Andrew James, Occupational Therapist, Psychotherapist* Or *Andrew James, member of the College of Occupational Therapists of Ontario, Psychotherapist*

2.2	When communicating **in writing**, write their name as it appears on the public register and the title “occupational therapist” or the designation “OT Reg. (Ont.)” immediately before writing the title, psychotherapist. For example, *Andrew James, OT Reg. (Ont.), Psychotherapist* OR *Andrew James, Occupational Therapist, Psychotherapist*
2.3	When communicating in **writing** and choosing to use the name of the College or the profession instead of the “occupational therapist” protected title or the designation “OT Reg. (Ont.)”, write the name of the College or the profession in full, not the abbreviation, before the title “psychotherapist”. For example, *Andrew James, College of Occupational Therapists of Ontario, Psychotherapist* OR *Andrew James, Occupational Therapy, Psychotherapist*

3. Competence

OTs will ensure that they have adequate knowledge, training, skills, and judgement to perform psychotherapy interventions safely and effectively. OTs are expected to have completed training and coursework in psychotherapy. This may include recognized psychotherapy courses, training offered to OTs at their work sites, and professional development activities. Psychotherapy training programs must contain both theoretical and practical components and be taught by an individual who is qualified to practise psychotherapy.

Standard 3

The OT must have successfully completed training in psychotherapy and demonstrate competence prior to practising psychotherapy.

Performance Indicators

An OT will:

3.1	Have formal psychotherapy training that includes: instructional, theoretical, and practical components;

3.2	Be competent in assessing clients as candidates for psychotherapy based on knowledge of current literature and effectiveness of the psychotherapy intervention;
3.3	Know the evidence for the relevance and effectiveness of the psychotherapy interventions used and appropriately select, apply and evaluate these interventions based on the client's needs;
3.4	Monitor outcomes of the psychotherapy intervention and outcomes of the therapeutic relationship;
3.5	Understand the indications, contraindications, benefits, and limitations of various psychotherapy techniques and approaches;
3.6	Decline to perform psychotherapy if the performance of the intervention is outside of the OT's knowledge, training, skills, and abilities;
3.7	Understand the effects of any medications, drugs, and substances that the client is taking, and their potential impact on the client's ability to participate in psychotherapy.

4. Psychotherapy Supervision

Psychotherapy supervision is a process where an individual is professionally supported by another psychotherapy practitioner who has a minimum of 5 years of psychotherapy practice experience and is qualified to practise psychotherapy. In this supervisory relationship, the supervising OT or other psychotherapy practitioner will discuss decision-making processes and provide support for complex or stressful situations to protect the client's well-being and facilitate the OT's professional growth in psychotherapy practice.

Standard 4

The OT must engage in psychotherapy supervision that is appropriate to their level of competence and aligns with their psychotherapy approach for the duration of their psychotherapy practice.

Performance Indicators

An OT will:	
4.1	Assume full responsibility to seek out a supervisor of practice qualified to practise psychotherapy and provide supervision;
4.2	Request a level of supervision appropriate to the OT's training and experience in psychotherapy. 4.2.1 Supervision for OTs with **less than 3 years** psychotherapy experience: OTs will engage in regular supervision with a qualified practitioner of psychotherapy, appropriate to their level of experience to enhance psychotherapy skills 4.2.2 Supervision for OTs with **more than 3 years** psychotherapy experience: OTs currently practising psychotherapy, with more than 3 years of experience are expected to engage in self reflective processes to determine whether they require a more structured supervision process or a less formal consultative process;
4.3	Establish a supervision agreement with the supervisor for the duration of the supervision considering the roles and responsibilities of the supervisor and supervisee, the scope of the supervision to be provided and the accountability for the clinical services provided to clients (See Appendix 2);
4.4	Establish a written supervision plan in collaboration with the supervisor, ensuring the frequency and duration of the supervision corresponds with the OT's experience, clientele, and requirements of the psychotherapy approach used;
4.5	Maintain meeting notes, including, but not limited to: the date of meeting, issues or questions discussed with supervisor, and the recommendations and action plan;
4.6	Inform the client of the existence of the supervision process and address any questions regarding the supervision process;
4.7	Identify when the OT may be ready to transition to a less formal or consultative model for ongoing peer support. The move to the peer consultation model will be determined by the OT's skill development, personal reflection processes, and the supervisor's recommendation.

5. Maintaining Competence

OTs are expected to maintain competency through ongoing professional development as it relates to the psychotherapy services being provided. Maintaining competency enables OTs to refine and build on the skills developed through training.

Standard 5

The OT will maintain competence by engaging in ongoing psychotherapy-based learning activities.

Performance Indicators

An OT will:

5.1	Participate in professional development activities that ensure the maintenance of knowledge, skills, and abilities to perform psychotherapy including, but not limited to: workshops, conferences, peer supervision, consultation, personal reflection, reading, case reviews, mentors, support networks, recognized education programs, online teaching modules, and/or research, while continually updating knowledge of current psychotherapy approaches.

6. OTs Acting as Supervisors

The College expects that OTs who agree to perform a supervisory role for OTs and other practitioners will possess the knowledge, training, skills, experience and judgement to safely, effectively and ethically provide psychotherapy guidance. OTs who are providing psychotherapy supervision must be clear that they are not taking accountability for client care; the supervisee remains responsible for the psychotherapy provided to their client(s).

Standard 6

The OT will ensure they have the knowledge, skills and required experience to safely and effectively provide psychotherapy supervision to OTs and other practitioners who are performing psychotherapy.

Performance Indicators

An OT acting as a supervisor will:	
6.1	Have a minimum of 5 years psychotherapy practice experience with no restrictions on their practice;
6.2	Have the knowledge and skills to provide consultation, support, resources and direction appropriate for the psychotherapy approach utilized to ensure the well-being of the client;
6.3	Ensure the OTs and other practitioners requesting supervision are performing psychotherapy safely, ethically, and effectively;
6.4	Be accountable for the information and guidance provided during the provision of supervision;
6.5	Maintain and retain supervisory notes in a secure manner, maintaining privacy and confidentiality for the duration period of the supervision. The supervisory notes may include: • Meeting dates • Summary of any ethical, or professional issues related to the supervisee's performance of psychotherapy • Any direction, recommendations, feedback provided to the supervisee • Supervisee areas of strength and areas requiring additional development • A record of any fees charged for the supervision; • **Note**: Supervisory notes are not considered part of the clinical record.

7. Supervision of Students

Student Occupational Therapists

Student OTs may be included in the delivery of psychotherapy as part of their student placement. However, due to the sensitive nature of some psychotherapy treatments, it may not always be in the client's best interest or be appropriate for a student to be present in the session. As student OTs are often in placements for a short period, they may be present for only a portion of the psychotherapy intervention. OTs should use clinical judgement to determine when it is appropriate for students to be included in their psychotherapy sessions. Student OTs may participate in psychotherapy sessions with the client's consent and may take part in post-session discussions and case reviews. Student OTs who participate in the psychotherapy treatment with clients must be directly supervised by the OT, or another qualified member of the team during the session. OTs supervising students must comply with the Standards for the Supervision of Students.

Other Students

In a multidisciplinary setting, where the OT may participate in the supervision of students from other professions in the process of providing psychotherapy, the performance indicators below also apply.

Standard 7

The OT will, when performing psychotherapy, ensure they have the knowledge, skills and abilities to safely and effectively supervise students and will not assign or delegate psychotherapy to students.

Performance Indicators

An OT will:	
7.1	Have the knowledge, skills, and judgement necessary to undertake the supervisory role for students;
7.2	Have knowledge of the student's level of skill, experience and competence, prior to involving students in psychotherapy interventions;
7.3	Provide direct supervision for the student during psychotherapy to ensure psychotherapy is completed in a safe and therapeutic manner;
7.4	Manage student supervision in a collaborative manner when the student is involved in a psychotherapy session with another qualified health care professional;
7.5	Ensure that informed consent is obtained from the client for the participation of student(s) in the psychotherapy sessions.

8. Occupational Therapist Assistants

Due to the knowledge, training, skills, and judgement required in the practice of psychotherapy, an OT may **not** assign or delegate components of psychotherapy to

occupational therapist assistants (OTAs). OTAs may be involved with clients in mental health programs, carrying out other interventions.

Standard 8

The OT will not delegate the whole or parts of the controlled act of psychotherapy or assign psychotherapy interventions to occupational therapist assistants.

Performance Indicators

An OT will:	
8.1	Not delegate or assign psychotherapy interventions to occupational therapist assistants.

9. Consent

OTs practising psychotherapy are expected to comply with the Standards for Consent. Consent is an ongoing process to be re-evaluated throughout the intervention process.

Standard 9

The OT will ensure that informed and ongoing consent is obtained from the client to perform psychotherapy, in accordance with the Standards for Consent.

Performance Indicators

An OT will:	
9.1	Determine client capacity to consent and participate in psychotherapy;
9. 2	Obtain informed consent for psychotherapy ensuring the client or referral source understands the practice of psychotherapy within the occupational therapy scope of practice

9.3	Respect the client's choice not to proceed with psychotherapy and offer alternative courses of action.

10. Risk Management

OTs practising psychotherapy should take reasonable measures to recognize and minimize the risks to client safety. OTs should be aware of contraindications and be responsive in managing adverse reactions that may occur during psychotherapy. OTs should also have training in recognizing and managing suicidal, aggressive, or violent behaviour, including the practice of crisis intervention and de-escalation techniques. When considering alternative methods of delivering psychotherapy interventions, such as telepractice, OTs should have a process in place to manage any risks, or unexpected events.

Standard 10

The OT will be responsible for recognizing, minimizing, and managing the risks associated with performing psychotherapy.

Performance Indicators

An OT will:

10.1	Practise psychotherapy within the occupational therapy scope of practice adhering to principles, standards and guidelines intended to minimize risks to client safety;
10.2	Establish and/or apply policies and procedures for recognizing and managing adverse reactions during, or resulting from psychotherapy;
10.3	Recognize, assess, and manage any potential physical or emotional risks of harm to the client or others associated with the performance of psychotherapy;
10.4	Discuss the potential risk of temporary worsening of the client's condition if painful feelings or experiences are reopened, as part of the therapy process;
10.5	Be aware of contraindications and negative treatment effects based on the client's issues and model of psychotherapy used;

10.6	Determine if the delivery of psychotherapy intervention by telepractice is appropriate;
10.7	Have training in recognizing and managing suicidal, aggressive, or violent behaviour including the practice of crisis intervention and de-escalation techniques;
10.8	Be aware of any legal authority that permits or requires an OT to disclose personal health information for the purpose of eliminating or reducing a significant risk of serious bodily harm to an individual or a group of persons;
10.9	Recognize and take action when the intervention is not effective and where the client's status may deteriorate;
10.10	Recognize and will not practise psychotherapy beyond their training or competence.

11. Record Keeping

OTs practising psychotherapy are expected to comply with the Standards for Record Keeping.

Standard 11

The OT will document the provision of psychotherapy in accordance with the Standards for Record Keeping.

Performance Indicators

An OT will:	
11.1	Maintain client records in accordance with the Standards for Record Keeping noting a rationale for the psychotherapy approach and model used;

12. Professional Boundaries

Professional boundaries are crucial to the maintenance of a respectful client-therapist relationship. OTs should adhere to the Standards for Professional Boundaries when providing psychotherapy to their clients. Due to the OT's position of authority and professional knowledge related to the client's health status, vulnerability, unique circumstances, and personal history the client-therapist relationship has a power imbalance in favour of the OT. The power imbalance exists because the of the OTs ability to influence a client's access to care or services. A client's desire to improve his or her health results in trust being established much more quickly and completely than might occur otherwise. OTs should be aware of this power imbalance during the provision of psychotherapy treatment. It is not appropriate to

develop a personal relationship with a client at any time during psychotherapy treatment or once psychotherapy is discontinued. There may be situations where an OT may encounter a client in the community; however, these casual contacts are not considered personal relationships.

In relation to the topic of professional boundaries, transference and counter-transference are important considerations. Transference is generally defined as the set of expectations, beliefs, and emotional responses that a client brings to the therapist-client relationship. Countertransference is the emotional reaction of the OT to the client's behaviours It is important that OTs are consciously aware of these feelings and emotions and reflect on what may be the result of transference/countertransference and what response may be warranted to the situation.

Standard 12

The OT will take full responsibility to establish and maintain appropriate professional boundaries in accordance with the Standards for Professional Boundaries.

	Performance Indicators
An OT will:	
12.1	Comply with the Standards for Professional Boundaries and Standards for the Prevention of Sexual Abuse;
12.2	Never develop a personal relationship or engage in sexual relations at any time with a client or former client, during or following psychotherapy treatment;
12.3	Refrain from entering into a dual relationship, such as providing psychotherapy to individuals whom the OT has a pre-existing relationship (friends, colleagues, business associates);
12.4	Provide and document a clear rationale in the situation where the model of psychotherapy may indicate an action that may be perceived as a boundary crossing (for example, meeting the client out of their usual therapeutic setting to address phobic behaviours);
12.5	Refrain from disclosing their own personal information, unless carefully considered as part of the treatment process (for example, safe and effective use of self);
12.6	Recognize and effectively manage transference and countertransference.

13. Discontinuation

The OT's decision to discharge a client from psychotherapy begins with the referral and is an ongoing consideration throughout the intervention process. It is recognized that an unplanned, unanticipated, or unintended end to the client-therapist relationship can also occur, prior to the completion of the intended treatment plan. This is termed discontinuation of service as outlined in the Guide to Discontinuation of Service.

The OT's practice of discontinuation will vary according to the psychotherapy approach and the context in which the service is being delivered. Although, psychotherapy can be temporarily interrupted or prematurely discontinued due to factors that impact a client's ability to participate in treatment; unintended discontinuation of psychotherapy intervention can be detrimental to the client. The OT should consider the level of risk when considering discontinuation, ensuring that the client can access the appropriate resources in a timely manner. Where possible, there should be an agreement between the client and OT that the client has achieved what can reasonably be expected from psychotherapy before discontinuation of psychotherapy intervention. Additionally, the OT should consider if the client would benefit from a referral to another qualified practitioner.

Standard 13

The OT will discontinue psychotherapy in a safe and ethical manner.

Performance Indicators

An OT will:	
13.1	Establish clear expectations for psychotherapy intervention at the onset of service;
13.2	Establish a process for discontinuation of psychotherapy, based on the psychotherapy approach, client status and goals;

13.3	Discontinue treatment for the following reasons: • psychotherapy is no longer appropriate due to a change in the client's status; • Further treatment would not produce additional benefits; • The client has withdrawn consent; • Treatment goals have been met; • The client has been given reasonable opportunity to achieve set client goals but has been unsuccessful due to a lack of engagement, readiness, or motivation for the psychotherapy process; • The client is engaging in threatening, harassing, assaultive or other negative behaviours posing danger to the OT; • The OT does not feel competent to provide the necessary treatment for the condition; • When the client-therapist relationship has become compromised; • The OT is engaging in a conflict of interest • Discontinuation has been chosen as a constructive, therapeutic strategy; • The available service resources have been exhausted; • The client is unable to meet agreed upon terms of payment for services provided; • The OT is ceasing practice, changing practice or moving to a different type of practice.
13.4	Discuss the reason for discontinuation with the client, including the arrangement of referrals to another qualified health care professional if further treatment is indicated;
13.5	Document: • Reasons for discontinuing services; • The condition of the client; • The availability of alternate services, as appropriate; • The post discharge plan • All correspondence relevant to the discontinuation of psychotherapy service.

Appendix 1- General Characteristics of Psychotherapy and Counselling

Psychotherapy	Counselling
• Frequently a long-term process, however there are short-term models (i.e. 8-12 sessions); • Treatment can range from a few months to years.	• Most often a short-term process; • Visits may range from 1 to 12 sessions • Some models of counselling can carry on over a longer period of time.
• Generally associated with a higher level of risk in treatment as the focus may be on past unresolved issues, unpleasant emotions or behaviours.	• Generally associated with a lower level of risk in treatment as the focus may be on overcoming obstacles to personal growth.
• Examines thoughts, feelings, and actions of chronic and more severe emotional conditions. • Encourages changing defeating patterns of behaviour and promotes personality change.	• Examines specific problems or changes in life adjustment. • Encourages behaviour change. • Supports the client to perform day-to-day activities.
• Goals may include gaining self-knowledge, dealing with defenses which are no longer working or useful, behaviour change, change in lifestyle or personality.	• Goals may include wellness, personal growth, healing, problem solving, adjustment to life situations, the development of coping skills.
• Examples of techniques may include Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT), and Solution Focused Brief Therapy.	• Examples of counselling may include health teaching, providing information, encouragement and support, giving advice and suggestions.
• Requires a greater depth of training and supervision. • Practicing with individuals with a serious disorder of thought, cognition, mood or emotional regulation falls under the Controlled Act.	• May be practiced by non-health professionals or those experienced in the nature of the specific problem (i.e. addictions, eating disorders) • Practice is not a controlled act.

Appendix 2: Supervision Agreement Considerations

The considerations below are intended to be used as a resource to facilitate discussions about the supervision agreement between the supervisor and supervisee. Not all elements of an agreement are captured below. This resource should be used in conjunction with the Standards for Psychotherapy and any components appropriate to the psychotherapy approach.

In developing a supervision agreement, the supervisor and the supervisee should consider the following:

1. The responsibilities of the supervisor and supervisee;
2. The scope of the supervision
3. The accountability for client care
4. Supervisory notes and agreements for confidentiality
5. Anticipated length of supervisory relationship
6. Fees associated with supervision

7. an alternate plan in case of an emergency and the supervisor is unavailable;

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Standard

Standards for Psychotherapy

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Introduction

The purpose of this document is to ensure the safe, effective, and ethical delivery of psychotherapy services by occupational therapists (OTs) in Ontario. The Standards for Psychotherapy describe the minimum expectations for OTs to provide competent and safe psychotherapy intervention within the scope of practice of the profession of occupational therapy. These Standards are intended to apply to all psychotherapy performed by OTs.

The College defines psychotherapy as follows:

> *Psychotherapy refers to planned and structured interventions aimed at influencing behaviour, by psychotherapeutic means[1]. Psychotherapy is delivered through a therapeutic relationship to change an individual's disorder of thought, cognition, mood, emotional patterns, perception, or memory that may impair the individual's judgement, insight, behaviour, communication, or social functioning as it relates to the performance of daily activities.*

The College recognizes that this definition may not conform to all the published models or philosophies of psychotherapy and mental health care. The Standards for Psychotherapy are not based on any one psychotherapy approach.

Controlled Act

Controlled acts are procedures or activities which may pose a risk to the public if not performed by a qualified practitioner. With the passing of the *Psychotherapy Act, 2007*, the *Regulated Health Professions Act*, *1991* (RHPA) grants OTs the authority to perform the controlled act of psychotherapy. This will permit OTs to perform psychotherapy with clients who have a **serious** disorder of thought, cognition, mood, emotional regulation, perception, or memory. The controlled act of psychotherapy is defined in the RHPA as follows:

> *"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 judgment, insight, behavior, communication or social functioning."*

The following elements must be present for a psychotherapy activity or intervention to fall within the controlled act of psychotherapy:

1. You are treating a client
2. You are applying a psychotherapy technique
3. You have a therapeutic relationship with the client

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[1] *World Health Organization,2001*

4. The client has a ***serious*** disorder of thought, cognition, mood, emotional regulation, perception or memory
5. This disorder may ***seriously*** impair the client's judgment, insight, behaviour, communication or social functioning

OTs are required to perform all psychotherapy in accordance with the laws, regulations and standards of practice.

Whether an OT is performing the controlled act of psychotherapy or providing psychotherapy to clients with less serious disorders, OTs must comply with the Standards for Psychotherapy.

Psychotherapy and Counselling

Psychotherapy and counselling are often viewed as interrelated. Whether the OT is practising psychotherapy or counselling with a client, the OT must understand that there are some distinctive differences[2] in the level of risk between the two approaches.

Counselling can involve education, guidance, encouragement, supportive problem-solving or informational advice. Counselling formats vary and can include: individual, group, family or couple. Counselling can be used in all areas of occupational therapy and is typically considered a lower risk activity for the client. The focus of counselling is on specific problems or changes in life that can impact occupational performance.[3] Counselling may or may not require grounding in a specific theory.

Psychotherapy concentrates on the client's emotional problems for the purpose of changing defeating patterns of behaviour, promoting positive personality change, growth and development, and re-organizing the personality. Psychotherapists frequently work with a variety of theories or combinations of theories, and may use one or more procedures or models to try to achieve desired results.[4] Psychotherapy intervention can be delivered in individual, group, family, or, couple formats. Psychotherapy may be a long-term intensive process that identifies emotional issues and their cause. Compared to counselling, psychotherapy may focus on a deeper, more fundamental process of change, and the development of insight about thoughts, feelings and behaviours. Clients engaged in psychotherapy may have more serious mental health issues and conditions than those requiring or seeking counselling.

Although there is some overlap between counselling and psychotherapy, it is important for OTs to be able to identify when they are practising psychotherapy given the increased level of risk posed to the client. See Appendix 1 for additional information.

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[2] *Appendix 1*
[3] *Psychotherapy & Counselling Federation of Australia*

[4] *Corsini et. Al, 2008*

Application of the Standards for Psychotherapy

- The following **standards** describe the minimum expectations for OTs when performing psychotherapy.
- The **performance indicators** listed below each standard describe more specific behaviours that demonstrate the Standard has been met.
- It is not expected that all performance indicators will be evident all the time. It is expected performance indicators could be demonstrated if requested.
- There may be some situations where the OT determines that a performance indicator has less relevance due to client factors or environmental factors.
- It is expected that OTs will always use their clinical judgement to determine how to best meet client needs in accordance with the standards of the profession.
- It is expected that OTs will be able to provide reasonable rationale for any variations from the Standard.

In the event of any conflict or inconsistency in these Standards for Psychotherapy with any other College standards, the standards with the most recent issued or revised date prevail.

College publications contain practice parameters and standards which all OTs practising in Ontario should consider in the care of their clients and in the practice of the profession. College Standards are developed in consultation with OTs and describe current professional expectations. College Standards may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

Pursuant to the RHPA, the College is authorized to make regulations in relation to professional practice. The College's Professional Misconduct Regulation establishes that "contravening, by act or omission, a standard of practice of the profession or failing to maintain a standard of the profession" constitutes grounds for professional misconduct.

Overview of the Standards for Psychotherapy

1. Scope of Practice
2. Use of Title Psychotherapist
3. Competence
4. Supervision of Practice
5. Maintaining Competence
6. Supervision of OTs and Other Practitioners
7. Supervision of Students
8. Support Personnel
9. Consent
10. Risk Management
11. Record Keeping
12. Professional Boundaries
13. Discontinuation of Service

1. Scope of Practice

Standard 1

The OT will perform psychotherapy within the scope of practice of the profession of occupational therapy.

Performance Indicators

An OT will**:**	
1.1	Determine whether psychotherapy can be effectively applied within their specific role and occupational therapy scope of practice;
1.2	Perform psychotherapy in accordance with the standards of practice and the Code of Ethics;
1.3	Refer to other qualified providers if the client requires treatment in addition to or beyond the scope of practice of occupational therapy, or beyond the limits of the OT`s knowledge and skill;
1.4	Ensure the client clearly understands when psychotherapy will be used within the occupational therapy treatment plan;

1.5	Understand and apply relevant legislation pertaining to the practice of psychotherapy;
1.6	Not delegate or assign components of the controlled act of psychotherapy.

2. Use of Title Psychotherapist

One of the central elements of the *Regulated Health Professions Act, 1991* (RHPA), and the *Occupational Therapy Act,1991* is the protection of title. In Ontario, the title 'occupational therapist' or 'OT' or any variation or abbreviation of them, is reserved for individuals registered with the College. Title protection is one mechanism that is used to help the public readily identify individuals who are registered with the College, and therefore deemed qualified to practice.

College Regulation (O. Reg. 226/96: General Regulation, S.43) states, "a member who uses an abbreviation indicating that the member is registered or is recognized as an occupational therapist shall use the abbreviation 'OT Reg. (Ont.)' in English or 'Erg. Aut. (Ont.)' in French." By using this title, registrants are accountable for the delivery of occupational therapy service that meets the established standards of the profession.

Under section 33.1 of the RHPA, OTs also have legal authority to use the title "Psychotherapist" orally or in writing when first identifying themselves as an occupational therapist or a member of the College. By using the title "Occupational Therapist", before using the title "Psychotherapist", an OT helps the public to readily identify themselves as an individual who is registered with the College of Occupational Therapists of Ontario, who practices psychotherapy. In addition, declaring the occupational therapist title first, orally or in writing, conveys the message that the OT is accountable for delivery of psychotherapy that meets the established Standards for Psychotherapy for occupational therapists.

OTs are not required to use the title "psychotherapist". Alternative means for conveying this area of practice may be:

Jane Doe, OT Reg. (Ont.),
Practising in Psychotherapy

Standard 2

The OT will use the protected title, "Occupational Therapist" or the designation "OT Reg. (Ont.)" first, before using the title, "Psychotherapist", both orally and in writing.

Performance Indicators

An OT will:	
2.1	When communicating **orally**, use the title “Occupational Therapist”, or the full name of the College **first**, before using the title, “Psychotherapist”. For example: *John Doe, Occupational Therapist, Psychotherapist* This is the recommended version, but the legislation allows other options: *John Doe, OT, Psychotherapist* Or *John Doe, member of the College of Occupational Therapists of Ontario, Psychotherapist;*
2.2	When communicating **in writing**, set out their name as it appears in the public register and use the protected title “Occupational Therapist” or the designation, “OT Reg. (Ont.)”, to indicate they are registered as an occupational therapist, before writing the title, “Psychotherapist”. For example: *John Doe, OT Reg. (Ont.), Psychotherapist* OR *John Doe, Occupational Therapist, Psychotherapist* Or use the name of the profession *John Doe, Occupational Therapy, Psychotherapist* *OR* When choosing to use the name of the College instead of the restricted title, “OT Reg. (Ont.)”, “Occupational Therapist” or Occupational Therapy, mention the name of the College in full before the title Psychotherapist, For example: *Jane Doe, College of Occupational Therapists of Ontario, Psychotherapist.*

3. Competence

OTs will ensure that they have adequate knowledge, training, skills, and judgement to perform psychotherapy interventions safely and effectively. OTs are expected to have completed training and coursework in psychotherapy. This may include psychotherapy accredited courses, training offered to OTs at their work sites, and professional development activities. Psychotherapy training programs must

contain both theoretical and practical components and be taught by an individual who is qualified to practise psychotherapy.

Standard 3

The OT must have the required occupational therapy practice experience and formal training in psychotherapy prior to practising psychotherapy.

	Performance Indicators
An OT will:	
3.1	Have a minimum of one year of occupational therapy practice experience in mental health prior to practising psychotherapy in a facility or team based environment;
3.2	Have a minimum of two years of full time mental health occupational therapy practice experience prior to practising psychotherapy in a private/independent practice setting;
3.3	Have formal psychotherapy training that includes: instructional, experiential, and theoretical components; course work and on the job training in psychotherapy;
3.4	Have access to regular supervision and peer mentoring from an individual who is qualified to practise in the type(s) of psychotherapy approaches being offered to clients;
3.5	Be competent in assessing clients as candidates for psychotherapy based on knowledge of current literature and effectiveness of the psychotherapy intervention;
3.6	Know the evidence for the relevance and effectiveness of the psychotherapy interventions used and appropriately select, apply and evaluate these interventions based on the client's needs;
3.7	Monitor outcomes of the psychotherapy intervention and outcomes of the therapeutic relationship;
3.8	Understand the indications, contraindications, benefits, and limitations of various psychotherapy techniques and approaches;
3.9	Decline to perform psychotherapy if the performance of the intervention is

	outside of the OT's knowledge, training, skills, and judgement;
3.10	Know various psychotherapeutic modalities and their effect on specific populations;
3.11	Understand the effects of any medications, drugs, and substances that the client is taking, and their potential impact on the client's ability to participate in psychotherapy.

4. Supervision of Practice

Supervision in psychotherapy is a formalized process where an individual is monitored by another professional who has 5 years of psychotherapy practice experience and is qualified to practise psychotherapy. In this supervisory relationship, the supervising clinician will discuss decision-making processes, provide support during complex or stressful situations, protect the client's well-being and facilitate the OT's professional growth in psychotherapy.

Standard 4

The OT must engage in formal supervision appropriate to the psychotherapy approach until competency is established and will continue to engage in a level of supervision required to maintain ongoing competence for the duration of their psychotherapy practice.

Performance Indicators

An OT will:	
4.1	Establish a formal written supervision agreement in collaboration with the supervisor and retain the agreement for two years following the date of the last supervisory contact; (See Appendix 2)
4.2	Establish a written supervision plan with the supervisor, ensuring the frequency and duration of the supervision corresponds with the OT's experience, client population, and requirements of the psychotherapy approach;
4.3	Assume full responsibility to seek out supervision or consultation, support, and resources on an ongoing basis;

4.4	Inform the client of the existence of the supervision process and obtain consent for the discussion of their case with the supervisor;
4.5	Identify when it may be appropriate to move from a more formal model of supervision to a less formal or consultation model for ongoing peer support. The move to the peer consultation model will be determined by the OT's skill development, personal reflection processes, and the supervisor's recommendation.

5. Maintaining Competence

OTs are expected to maintain competency through ongoing professional development as it relates to the psychotherapy services being provided. Maintaining competency enables OTs to refine and build on the skills developed through training.

Standard 5

The OT will maintain competence by consistently engaging in ongoing psychotherapy-based learning activities.

Performance Indicators

An OT will:

5.1	Continue to participate in psychotherapy learning opportunities that include a combination of formal and informal supervision activities and continuing education methods for the duration of the OT's psychotherapy practice;
5.2	Demonstrate their competency to perform psychotherapy in accordance with current/relevant practice models;
5.3	Maintain the knowledge, training, skills, and judgement required to continue to provide quality care when providing psychotherapy as part of their occupational therapy practice;
5.4	Participate in professional development activities that ensure the maintenance of knowledge, training, skill, and judgement to perform psychotherapy including, but is not limited to: workshops, conferences, peer supervision, consultation, personal reflection, reading, case reviews, mentors, support networks, online teaching modules,

	and/or research, while continually updating knowledge of current psychotherapy approaches.

6. Supervision of OTs and Other Practitioners

The College expects that OTs who agree to perform a supervisory role for OTs and other practitioners will possess the knowledge, training, skills, experience and judgement to safely, effectively and ethically oversee the practice of psychotherapy for other professionals.

Standard 6

The OT will ensure they have the knowledge, skills and required experience to safely and effectively supervise OTs and other practitioners when performing psychotherapy.

Performance Indicators

An OT will:	
6.1	Ensure OTs and other practitioners requesting supervision have the competence and required training to perform psychotherapy safely and effectively;
6.2	Have a minimum of 5 years psychotherapy practice experience and be registered with the College with no restrictions on their practice;
6.3	Be competent to perform the psychotherapy intervention that is being supervised;
6.4	Have the skills to provide consultation, support, resources and direction appropriate for the psychotherapy approach utilized to ensure the well-being of the client;
6.5	Ensure a written supervision agreement is in place, appropriate to the practitioner's experience and requirements of the psychotherapy approach, including: the responsibilities of the supervisor and supervisee, frequency of meetings, contact information for an alternate supervisor in the event the absence or unexpected occurrence; (*See Appendix 2)*
6.6	Maintain supervisory notes that include:

- Meeting dates
- Summary of the cases discussed, redacting any client identifiers
- Summary of any ethical, or professional issues related to the OTs performance of psychotherapy
- Any direction, recommendations, feedback provided to the supervisee
- Areas of strength and areas requiring additional development
- Reasons for termination of the agreement.

7. Supervision of Students

Student Occupational Therapists

Student OTs may be included in the delivery of psychotherapy as part of their student placement. However, due to the sensitive nature of some psychotherapy treatments, it may not always be in the client's best interest or be appropriate for a student to be present in the session. As student OTs are often in placements for a short period, they may be present for only a portion of the psychotherapy intervention. OTs should use clinical judgement to determine when it is appropriate for students to be included in their psychotherapy sessions. Student OTs may participate in psychotherapy sessions with the client's consent, and may take part in post-session discussions and case reviews. Student OTs who participate in the psychotherapy treatment with clients must be directly supervised by the OT, or another qualified member of the team during the session. OTs supervising students must comply with the Standards for the Supervision of Students.

Other Students

In a multidisciplinary setting, the OT may participate in the supervision of a variety of students in the process of providing psychotherapy interventions.

Standard 7

The OT will ensure they have the knowledge, skills and abilities to safely and effectively supervise students when performing psychotherapy and will not assign or delegate psychotherapy to students.

Performance Indicators

An OT will:

7.1	Have the knowledge, skills, and judgement necessary to undertake the supervisory role for students;

7.2	Have knowledge of the student's level of skill, experience and competence, prior to involving students in psychotherapy interventions;
7.3	Supervise the student who is providing psychotherapy at all times. Be present during the entire process of psychotherapy, to ensure psychotherapy is completed in a safe and therapeutic manner;
7.4	Manage student supervision in a collaborative manner when the student is involved in a psychotherapy session with another qualified health care professional;
7.5	Ensure that informed consent is obtained from the client for the participation of students in the psychotherapy sessions.

8. Support Personnel

Support Personnel

Due to the knowledge, training, skills, and judgement required in the practice of psychotherapy, an OT may **not** assign components of psychotherapy to support personnel. Support personnel may be involved with clients in mental health programs, carrying out other interventions.

Standard 8

The OT will not delegate the whole or parts of the controlled act of psychotherapy or assign psychotherapy interventions to support personnel.

Performance Indicators

An OT will:

8.1	Not delegate or assign psychotherapy interventions to support personnel.

9. Consent

OTs practising psychotherapy are expected to comply with the Standards for Consent. Consent is an ongoing process to be re-evaluated throughout the intervention process.

Standard 9

The OT will ensure that informed and ongoing consent is obtained from the client to perform psychotherapy, in accordance with the Standards for Consent.

Performance Indicators

An OT will:

9.1	Comply with the Standards for Consent (2017)*;*
9.2	Determine client capacity to consent and participate in psychotherapy;
9.3	Assume responsibility to make the client or referral source aware of any limitations to the practice of psychotherapy within the scope of occupational therapy practice;
9.4	Respect the client's choice not to proceed with psychotherapy, and offer alternative courses of action.

10. Risk Management

OTs practising psychotherapy should take reasonable measures to recognize and minimize the risks to client safety. OTs should be aware of contraindications, and be responsive in managing adverse reactions that may occur during psychotherapy. OTs should also have training in recognizing and managing suicidal, aggressive, or violent behaviour, including the practice of crisis intervention and de-escalation techniques. When considering alternative methods of delivering psychotherapy interventions, such as telepractice, OTs should have a process in place to manage any risks, or unexpected events.

Standard 10

The OT will be responsible for recognizing, minimizing, and managing the risks associated with performing psychotherapy.

Performance Indicators

An OT will:

10.1	Practise psychotherapy within the scope of practice of the profession of occupational therapy, adhering to principles, standards and guidelines intended to minimize risks to client safety;
10.2	Establish and/or apply policies and procedures for recognizing and managing adverse reactions during, or resulting from psychotherapy;
10.3	Recognize, assess, and manage any potential physical or emotional risks of harm to the client or others associated with the performance of psychotherapy;
10.4	Discuss the potential risk of temporary worsening of the client's condition if painful feelings or experiences are reopened, as part of the therapy process;
10.5	Be aware of contraindications and negative treatment effects based on the client's issues and model of psychotherapy used;
10.6	Determine if the delivery of psychotherapy intervention by telepractice is appropriate;
10.7	Have training in recognizing and managing suicidal, aggressive, or violent behaviour including the practice of crisis intervention and de-escalation techniques;
10.7	Be aware of any legal authority that permits an OT to disclose personal health information for the purpose of eliminating or reducing a significant risk of serious bodily harm to an individual or a group of persons;
10.8	Recognize and take action when the intervention is not effective and where the client's status may deteriorate;
10.9	Recognize and will not practise psychotherapy beyond their training or competence.

11. Record Keeping

OTs practising psychotherapy are expected to comply with the Standards for Record Keeping.

Standard 11

The OT will document the provision of psychotherapy in accordance with the Standards for Record Keeping.

Performance Indicators

An OT will:	
11.1	Maintain client records in accordance with the Standards for Record Keeping noting a rationale for the psychotherapy approach and model used;
11.2	Record observations in progress notes with a focus on the client's problems and progress towards goals, providing a rationale for professional opinions and judgement;
11.3	Manage the retention, storage and destruction of supervisory notes in a secure manner, maintaining privacy and confidentiality; **11.3.1** Retain supervisory notes for a period of 2 years from the date of the last supervisory meeting; **Note**: Supervisory notes are not considered part of the clinical record.

12. Professional Boundaries

The concept of professional boundaries is crucial to the maintenance of a respectful client-therapist relationship. OTs should adhere to the Standards for Professional Boundaries when providing psychotherapy to their clients. Due to the OT's position of authority and professional knowledge related to the client's health status, vulnerability, unique circumstances, and personal history the client therapist relationship has a power imbalance in favour of the OT. The power imbalance exists because the of the OTs ability to influence a client's access to care or services. A client's desire to improve his or her health results in trust being established much more quickly and completely than might occur otherwise. OTs should be aware of this power imbalance during the provision of psychotherapy treatment. It is not appropriate to develop a personal relationship with a client at any time during psychotherapy treatment or once psychotherapy is discontinued. There may be situations where an OT may encounter a client in the community, these casual contacts are not considered personal relationships.

In relation to the topic of professional boundaries, transference and counter-transference are important considerations. Transference is generally defined as the set of expectations, beliefs, and emotional responses that a client brings to the therapist-client relationship. Countertransference is the emotional reaction of the OT to the client's attitudes. It is important that OTs are consciously aware of these feelings and emotions and reflect on what may be the result of transference/countertransference and what response may be warranted to the situation.

Standard 12

The OT will take full responsibility to establish and maintain appropriate professional boundaries in accordance with the Standards for Professional Boundaries.

Performance Indicators

An OT will:	
12.1	Never develop a personal relationship at any time with a client, during or following psychotherapy treatment;
12.2	Refrain from entering a dual relationship, such as providing psychotherapy to a family member of a client, friends of a client or where there was a prior relationship/friendship with the client;
12.3	Provide and document a clear rationale in the situation where the model of psychotherapy may indicate an action that may be perceived as a boundary crossing (for example, meeting the client out of their usual therapeutic setting to address phobic behaviours);
12.4	Refrain from disclosing their own personal information, except when using that information as a specific part of the treatment process (for example, safe and effective use of self);
12.5	Recognize and effectively manage the presence of transference and countertransference.

13. Discontinuation

The OT's decision to discharge a client from psychotherapy begins with the referral and is an ongoing consideration throughout the intervention process. It is recognized that an unplanned, unanticipated, or unintended end to the client-therapist relationship can also occur, prior to the completion of the intended treatment plan. This is termed discontinuation of service as outlined in the Guide to Discontinuation of Service.

The OT's practice of discontinuation will vary according to the model of psychotherapy intervention and the context in which the service is being delivered. Although, psychotherapy can be temporarily interrupted or prematurely discontinued due to factors that impact a client's ability to participate in treatment; unintended discontinuation of psychotherapy intervention can be detrimental to the client. The OT should consider the level of risk when considering discontinuation, ensuring that the client can access the appropriate resources in a timely manner. Where possible, there should be an agreement between the client and OT that the client has achieved what can reasonably be expected from psychotherapy, before discontinuation of psychotherapy intervention. Additionally, the OT should consider if the client would benefit from a referral to another qualified practitioner.

Standard 13

The OT should discontinue psychotherapy, as part of the therapeutic process, that would be reasonably regarded as appropriate.

Performance Indicators

An OT will:	
13.1	Establish clear expectations for psychotherapy intervention at the onset of service;
13.2	Establish a process for discontinuation of psychotherapy, based on the psychotherapy approach, client status and goals;
13.3	Discontinue treatment for the following reasons: • The client is no longer appropriate for psychotherapy intervention due to a change in the client's status; • Further treatment would not produce additional benefits; • The client has withdrawn consent; • Treatment goals have been met; • The client has been given reasonable opportunity to achieve set client goals but has been unsuccessful due to a lack of engagement, readiness, or motivation for the psychotherapy process; • The client is engaging in threatening, harassing, assaultive or other negative behaviours posing danger to the OT; • The OT does not feel competent to provide the necessary treatment for the condition; • When the client-therapist relationship has become compromised; • Discontinuation has been chosen as a constructive, therapeutic strategy; • The available service resources have been exhausted; • The client is unable to meet agreed upon terms of payment for services provided; • The OT is ceasing practice, changing practice or moving to a different type of practice.
13.4	Discuss the reason for discontinuation with the client, including the arrangement of referrals to another qualified health care professional if further treatment is indicated;

13.5

Document:

- Reasons for discontinuing services;
- The condition of the client;
- The availability of alternate services, as appropriate;
- All correspondence relevant to the discontinuation of psychotherapy service.

Appendix 1- General Characteristics of Psychotherapy and Counselling

Psychotherapy	Counselling
• Frequently a long-term process, however there are short-term models (i.e. 8-12 sessions); • Treatment can range from a few months to years.	• Most often a short-term process; • Visits may range from 1 to 12 sessions • Some models of counselling can carry on over a longer period of time.
• Generally associated with a higher level of risk in treatment as the focus may be on past unresolved issues, unpleasant emotions or behaviours.	• Generally associated with a lower level of risk in treatment as the focus may be on overcoming obstacles to personal growth.
• Examines thoughts, feelings, and actions of chronic and more severe emotional conditions. • Encourages changing defeating patterns of behaviour and promotes personality change.	• Examines specific problems or changes in life adjustment. • Encourages behaviour change. • Supports the client to perform day-to-day activities.
• Goals may include gaining self-knowledge, dealing with defenses which are no longer working or useful, behaviour change, change in lifestyle or personality.	• Goals may include wellness, personal growth, healing, problem solving, adjustment to life situations, the development of coping skills.
• Examples of techniques may include Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT), and Solution Focused Brief Therapy.	• Examples of counselling may include health teaching, providing information, encouragement and support, giving advice and suggestions.
• Requires a greater depth of training and supervision. • Practicing with individuals with a serious disorder of thought, cognition, mood or emotional regulation falls under the Controlled Act.	• May be practiced by non-health professionals or those experienced in the nature of the specific problem (i.e. addictions, eating disorders) • Practice is not a controlled act.

Appendix 2: Supervision of Practice

OTs are accountable for meeting practice standards. To maintain ongoing competency in the performance of psychotherapy, OTs are required to participate in a Supervision of Practice. This supervisor/supervisee relationship enables the supervisee to build on skills developed through training, review cases or session events and obtain support to guide future interactions.

This sample is intended to be used as a resource to facilitate discussions about the supervision agreement between the supervisor and supervisee. Not all elements of an agreement are captured below. This resource should be used in conjunction with the Standards for Psychotherapy and any components appropriate to the psychotherapy approach.

Sample Supervision Agreement Content

In developing a supervision agreement, the supervisor and the supervisee should consider the following:

1. The responsibilities of the supervisor and supervisee;
2. Dated and signed and any restrictions or limitations to the agreement clearly outlined;
3. Include an alternate plan in case of an emergency and the supervisor is unavailable;
4. Documentation should include:
    - Date of meeting
    - Summary of the discussions of each case discussed, redacting any client identifiers
    - Summary of any ethical, or professional issues related to the OTs performance of psychotherapy
    - Any direction, recommendations, feedback provided to the OT supervisee
    - Areas of strength and areas requiring additional development
    - Reasons for termination of the agreement

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Determining When the Standards for Psychotherapy Apply

This decision tree is intended to help OTs determine when they must apply the Standards for Psychotherapy and to ensure they meet the requirements to provide psychotherapy safely, effectively and ethically within the scope of occupational therapy practice.

Scope of Practice in Clinical Context

- ☐ My role and scope of practice includes planned and structured interventions aimed at influencing behaviour and function, through psychotherapeutic means, delivered through a therapeutic relationship to change an individual's disorder of thought, cognition, mood, emotional patterns, perception, or memory that may impair the individual's judgement, insight, behaviour, communication, or social functioning as it relates to the performance of daily activities.
- ☐ I use one or more psychotherapy theories, models and/or approaches in my practice (e.g. Cognitive Behavioural Therapy)

Yes / No

If your intervention goals are not aimed at influencing behaviour or function through psychotherapeutic means, or you are not using a psychotherapy approach your practice does not meet the definition of psychotherapy.

Competence

- ☐ I have the knowledge, skills and judgement to practice psychotherapy safely, effectively and ethically.
- I have successfully completed psychotherapy training that includes: instructional, theoretical, and practical components
- I am prepared to manage any adverse events or outcomes related to my psychotherapy practice.
- I participate in regular professional development activities in psychotherapy to maintain my competence.
- I have established a supervisory relationship and/or process for my psychotherapy practice.
- I refer clients to other providers if the client requires treatment beyond the limits of my abilities or the scope of practice for occupational therapy.

Yes / No

You must attain and maintain the required competencies prior to performing psychotherapy. Additional education and training may be required.

Psychotherapy Approaches & Techniques

- ☐ I know the indications, contraindications, risks, benefits, and limitations of the psychotherapy approach & techniques.
- ☐ There is evidence to support that using the selected psychotherapy approach and techniques is effective for my client population.
- ☐ I have methods in place to evaluate psychotherapy outcomes with my clients.

Yes / No

Psychotherapy may not be the best intervention to address treatment goals at this time.

Client Factors (Risk Management)

Assess the nature of and severity of the client's issues to determine if psychotherapy is an appropriate intervention. When assessing the client consider if:

- ☐ This client has a disorder of thought, cognition, mood, emotional patterns, perception, or memory that may impair their judgement, insight, behaviour, communication, or social functioning as it relates to their performance of daily activities.
- ☐ There is evidence to support the psychotherapy intervention will be effective for this client.
- ☐ This client meets the eligibility criteria for the specific psychotherapy modality.
- ☐ This client is able to participate fully in psychotherapy.
- ☐ This client is ready, willing and able to participate in psychotherapy and has provided informed consent.
- ☐ The necessary support systems and ongoing monitoring processes are available for client safety.

Yes / No

Psychotherapy should not be performed if there is no evidence to support the client will benefit from the intervention or if informed consent has not been obtained.

I have met all the requirements to competently perform psychotherapy for this client, in this practice setting, and, my practice complies with the Standards for Psychotherapy.

Revised June 2018

College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

AGENDA ITEM 9.3

COUNCIL BRIEFING NOTE

Date: June 26, 2018
To: Council
From: Patient Relations Committee
Subject: Revised Standards for the Prevention of Sexual Abuse

Recommendation
THAT *Council approves the revised Standards for the Prevention of Sexual Abuse.*

Background
The passing of the *Protecting Patients Act, 2017* in May 2017 resulted in significant changes to the *Regulated Health Professions Act, 1991* including legislative changes to the definition of patient for the purposes of determining sexual abuse. In May 2018, regulations outlining additional criteria for determining whether an individual is a patient of a registrant were passed and came into force.

Anticipating passing of the regulations, Patient Relations Committee reviewed and revised the Standards for the Prevention of Sexual Abuse in February 2018 and referred the revised Standards to Council for approval to circulate for consultation. On March 29, 2018, Council approved the Standards for consultation as amended by Council. The consultation was deferred until the proposed regulations were passed to ensure respondents were provided with the most complete and accurate version of the Standards upon which to provide feedback. The consultation survey was launched May 2, 2018, remained open for one month and closed on June 4, 2018.

Survey Results
Respondent Demographics
There were 63 responses to the survey. All but one of the respondents were OTs with 50% of the OTs having greater than 20 years of practice experience. The distribution of the respondent's nature of practice (clinical, mixed, non-clinical) is consistent with the overall demographics of registrants as is the distribution of respondent's practice settings.

Summary of Responses
- 96% of respondents indicated the Standards clearly describe the responsibilities of OTs in preventing and reporting sexual abuse
- 13% of respondents provided feedback that some of the standards or indicators required clarification – all areas where clarification was requested have been addressed through the revision of language or the provision of an example
- 96% of respondents indicated there was nothing missing from the Standards that would assist OTs in understanding or applying the Standards to their current practice

In reviewing the comments, the primary theme pertained to requests for clarification of specific language in a few specific areas of the document. All comments were addressed in the revisions put before Patient Relations Committee on June 14, 2018. Amendments recommended by Patient Relations Committee

have been incorporated into the version of the revised Standards for Prevention of Sexual Abuse put forward to Council for approval.

Discussion

Council is asked to review the revised Standards for the Prevention of Sexual Abuse and provide feedback on any additional revisions required.

Attachments

1. Revised Standards for the Prevention of Sexual Abuse Draft June 2018

**Please refer to the website to view the current Standards* https://www.coto.org/resources/standards-for-the-prevention-of-sexual-abuse

College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

Standard

Standards for the Prevention of Sexual Abuse

Draft Revision June 2018

Reformatted July 2016

Revised May 2013

Originally Issued June 2007

Introduction

Sexual relations between an occupational therapist (OT) and client are ***always*** unethical and abusive, are considered a serious breach of trust, and involve a fundamental abuse of power.

The College of Occupational Therapists of Ontario has adopted a position of zero tolerance toward all forms of sexual abuse within the client-therapist relationship. The client-therapist relationship is based on mutual trust, respect, professional boundaries, collaboration and communication. **Maintaining a professional relationship with a client is the only way an OT can remain objective when providing service and is necessary for the OT to ensure clients receive safe, effective, ethical care.** Any act of sexual abuse is a misuse of power and a betrayal of the client-therapist relationship. Accordingly, the College will hold all OTs accountable for their behaviour with clients at all times. Any form of sexual abuse of the client under any circumstances is unacceptable and will not be tolerated.

As set out in the *Regulated Health Professions Act, 1991* (RHPA), it is considered sexual abuse and against the law for occupational therapists to have sexual relations with clients.

What is sexual abuse?

Sexual abuse of a client by a regulated health professional ~~-~~is defined in the RHPA ~~(Health Professions Procedural Code, Section 1(3))~~ as:

- Sexual intercourse or other forms of physical sexual relations between the member and the client;
- Touching, of a sexual nature, of the patient by the member; or
- Behaviour or remarks of a sexual nature by the member towards the client.

"Sexual nature" does not include touching, behaviour or remarks of a clinical nature appropriate to the services provided.

Who is the client?

The College uses the term "client" to refer to individuals who receive occupational therapy services from an OT. Client is used to reflect the client-centred principles of the profession. Under the RHPA, the term "patient" is used to refer to the recipient of health care service provided by a regulated health professional. For the purpose of these Standards, the terms "client" and "patient" have the same meaning.

Under the RHPA ~~(Health Professions Procedural Code, Section 1(6))~~, for the purpose of sexual abuse, a "patient" is defined as:

a) an individual who was a member's patient within one year or such longer period of time as may be prescribed from the date on which the individual ceased to be the member's patient, and

b) an individual who is determined to be a patient in accordance with the criteria in any regulations ~~made under clause 43 (1) (o) of the *Regulated Health Professions Act, 1991*; ("patient").~~

This means **a client remains a client for one year after the date the client-therapist relationship ended**.

In addition to the definition of patient, there are other criteria in regulations under the RHPA for determining whether an individual is a patient of a regulated health professional:
~~Patient is further defined under Ontario Regulation 260/18: Patient Criteria Under Subsection 1(6) of the Health Professions Procedural Code as follows:~~

~~1. The following criteria are prescribed criteria for the purposes of determining whether an individual is a patient of a member for the purposes of subsection 1 (6) of the Health Professions Procedural Code in Schedule 2 to the Act:~~

1. An individual is a patient of a member if there is direct interaction between the member and the individual and **ANY** of the following conditions are satisfied:

    i. The member has, in respect of a health care service provided by the member to the individual, charged or received payment from the individual or a third party on behalf of the individual.
    ii. The member has contributed to a health record or file for the individual.
    iii. The individual has consented to the health care service recommended by the member.
    iv. The member prescribed a drug for which a prescription is needed to the individual.

2. ~~Despite paragraph 1, A~~an individual is not a patient of a member if **ALL** of the following conditions are satisfied:

    i. There is, at the time the member provides the health care services, a sexual relationship between the individual and the member.
    ii. The member provided the health care service to the individual in emergency circumstances or in circumstances where the service is minor in nature.
    iii. The member has taken reasonable steps to transfer the care of the individual to another member or there is no reasonable opportunity to transfer care to another member.

Notwithstanding these ~~prescribed~~ criteria, there are situations where an individual may not meet some or all of these prescribed criteria, and where the individual may still be deemed to be a patient.

OTs like all health practitioners, are in a unique relationship of trust and authority with their clients. The client-therapist relationship is inherently unequal, which results in a power imbalance in favour of the OT. The client is relying on the OT's clinical judgement and experience to address health-related issues, the OT knows the client's personal information and has the ability to influence the client's

access to other resources and services. The impact of OT power and influence can be broad as the OT operates within a system where client information provided by an OT, in the form of documentation, for example, has the potential to influence the perceptions of other service providers. If an OT uses this position of authority to violate boundaries, this is an abuse of power. OTs are responsible for setting and managing boundaries to ensure that the trust a client has placed in the OT is not betrayed.

OTs are fully responsible for managing and maintaining professional boundaries with clients. A client's consent or willingness to participate in a sexual relationship or engage in sexual relations will not be accepted as a defence for inappropriate behavior or sexual abuse.

The Standards for the Prevention of Sexual Abuse describe expectations of conduct for occupational therapists in managing the client-therapist relationship, specifically related to the prevention of sexual abuse.

The values and principles outlined in the College's Code of Ethics provide a framework for the expectations of the relationships between an occupational therapist and their clients. Occupational therapists (OTs) can look to these values and principles in their efforts to promote appropriate professional relationships and prevent sexual abuse. OTs must also refer to the Standards for Professional Boundaries which outline additional expectations for the preservation of appropriate boundaries between the OT and the client in all circumstances.

The College will formally investigate all sexual abuse complaints or reports made against an OT. When warranted, appropriate disciplinary action will be taken against the OT pursuant to the legislation and standards of the profession. Disciplinary action may include mandatory revocation of the OT's certificate of registration meaning the OT will no longer be entitled to practice.

Application of the Standards for the Prevention of Sexual Abuse

The following **standards** describe the minimum expectation for OTs in the prevention of sexual abuse.

- The **performance indicators** listed below each standard describe more specific behaviours that demonstrate the standard has been met.
- It is not expected that all performance indicators will be evident all the ~~time, but~~time but could be demonstrated if requested.

- There may be some situations where the OT determines that a particular performance indicator has less relevance due to client factors and/or environmental factors. Such situations may call for the OT to seek further clarification.
- It is expected that OTs will always use their clinical judgement to determine how to best meet client needs in accordance with the standards of the profession.
- It is also expected that OTs will be able to provide justification for any variations from the standard.

Pursuant to the *Regulated Health Professions Act, 1991* (RHPA), the College is authorized to make regulations in relation to professional practice. Ontario Regulation 95/07: Professional Misconduct, establishes that "contravening, by act or omission, a standard of practice of the profession or failing to maintain a standard of the profession," constitutes ground for professional misconduct.

College publications contain practice parameters and standards which should be considered by all Ontario OTs in the care of their clients and in the practice of the profession. College standards are developed in consultation with OTs and describe current professional expectations. College standards may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

Overview of the Standards for the Prevention of Sexual Abuse

1. Establishing and Maintaining Professional Boundaries
2. Consent for Touching
3. Respecting Privacy & Dignity
4. No Treatment of Spouses
5. Mandatory Reporting
6. Consequences of Sexual Abuse – Mandatory revocation

Standard 1 – Establishing and Maintaining Professional Boundaries

This standard describes the requirement for OTs to maintain professional boundaries with their clients for the purpose of preventing sexual abuse. In this context, the occurrence of sexual abuse is limited to the direct relationship between the OT and the client. However, OTs must ensure they maintain professional boundaries not only with the client but also with individuals with whom the client has a significant personal relationship such as a substitute decision-maker or parent. Expectations regarding OTs responsibilities for managing these relationships are outlined in the Standards for Professional Boundaries.

Standard 1

An occupational therapist~~OT~~ will take full responsibility to establish and maintain professional boundaries with clients at all times.

Performance Indicators

An OT will:

1.	Never sexually abuse a client or engage in any sexually abusive behaviours including: • Sexual intercourse or other forms of physical sexual relations between the OT and the client; • Touching, of a sexual nature, of the patient by the OT; or • Behaviour or remarks of a sexual nature by the OT towards the client;
2.	Not engage in sexual relations or enter into a sexual relationship with a **former** client, unless: • **at least one year** has elapsed since the client-therapist relationship ended, and • the power imbalance in the therapeutic relationship between the occupational therapist and the client no longer exists.
3.	Never engage in sexual relations or a sexual relationship with a former client in any of the following circumstances where: • the client is especially vulnerable resulting in an increased power imbalance in the client-therapist relationship in favour of the OT; or • ~~the nature of~~ the client-therapist relationship involved intensive interventions based on relevant factors such as the nature of the treatment, the frequency and duration of treatment, whether treatment was ongoing, the dependency of the client on the therapist and other relevant factors specific to the client; or • the client's occupational therapy involved psychotherapy; or • the client has ongoing needs related to the occupational therapy services provided.
4.	Understand the power imbalance that exists in favour of the OT in all client-therapist relationships;
5.	Identify the potential risks within their practice in relation to professional relationships

	and implement strategies for the management of professional boundaries;
6.	Recognize their own personal beliefs, values, biases and their position of influence with clients;
7.	Identify the scope of relationships with clients and avoid exploiting these relationships for personal gain or advantage.

Standard 2 – Consent for Touching

Standard 2

An occupational therapist will obtain informed consent prior to initiating ~~-~~assessment or treatment with the client that involves touching, behaviour or remarks of a clinical nature that may be misinterpreted to be of a sexual nature.

Performance Indicators

An occupational therapist will:

1.	Obtain informed consent including an explanation of the clinical nature and purpose of touching the client prior to proceeding;
2.	Document the discussion of obtaining informed consent;
3.	Never rely on a client's consent or willingness to participate in sexual relations as a defen~~s~~ce for inappropriate behavior or sexual abuse.

Standard 3 – Respecting Privacy & Dignity

Standard 3

An occupational therapist will respect the privacy and dignity of the client at all times.

Performance Indicators

An occupational therapist will:	
1.	Ensure assessment and treatment spaces offer appropriate privacy which may include the use of curtains or dividers;
2.	Ensure appropriate use of draping and garments to minimize unnecessary exposure;
3.	Provide options or alternatives for potentially sensitive situations, for example, a third person observer;
4.	Use an appreciation and understanding of cultural diversity to address the potential impact of factors such as culture, religion, race, ethnicity, gender, or language on maintaining professional boundaries and preventing sexual abuse.

Standard 4 – No Treatment of Spouses

Under the RHPA, spouses are not exempt from the definition of patient and therefore an OT is not permitted to treat their spouse as this would be considered sexual abuse.

Spouse is defined as:

a) a person who is the member's spouse as defined in section 1 of the *Family Law Act*, or
b) a person who has lived with the member in a conjugal relationship outside of marriage continuously for a period of not less than three years.

Standard 4

An occupational therapist will not treat their spouse except in the case of an emergency.

** There are no performance indicators for Standard 4.*

For example, if an OT's spouse fell while on a hike, the OT would be permitted to apply a temporary splint to assist with pain management until her spouse could access medical care.

Standard 5 - Mandatory Reports

Under the RHPA, a mandatory report must be made by a regulated health professional who, in the course of practising his or her profession, acquires information giving reasonable grounds to

believe that another regulated health professional sexually abused a patient. A mandatory report must also be made by the operator of the health facility. The report must be made in writing to the alleged abuser's college within thirty days after the obligation to report arises, unless the person who is required to file the report has reasonable grounds to believe that the health professional will continue to abuse the client or will abuse other clients. In that case, the report must be filed immediately. OTs are subject to a fine of not more than $50,000 for failing to make this mandatory report. Facilities who fail to report are subject to a fine of not more than $50,000 in the case of an individual and $200,000 in the case of a corporation.

If the College finds that an OT failed to make a report under the mandatory reporting requirements of the RHPA, the College may find the OT to have engaged in an act of professional misconduct.

Standard 5

An occupational therapist will make a mandatory report if they have reason to believe that another regulated health professional sexually abused a client.

	Performance Indicators
An occupational therapist will:	
1.	Make a written report to the college of the regulated health professional believed to have sexually abused a client within 30 days of becoming aware of the information, or, immediately, if the OT believes the abuser will continue to abuse the client or other clients;
2.	Provide information to the client about the obligation for a mandatory report if the OT becomes aware of the possible sexual abuse through a disclosure made by a client;
2.	Obtain the client's written consent to disclose the client's name to the regulator, if the OT became aware of the alleged sexual abuse from the client; OR Withhold the name of the client from the mandatory report if consent for disclosure is not obtained from the client;
3.	If becoming aware of the possible abuse by a regulated health professional while providing psychotherapy to that professional, make a report and ~~to an abusing practitioner,~~ provide an opinion concerning whether or not the abusing practitioner may sexually abuse clients in the future. The OT will ~~and~~ also make a report if they ~~OT~~ stop providing ~~ceases to provide~~ psychotherapy to the abusing

practitioner.

Consequences Related to Sexual Abuse of a Client

A discipline hearing is the most serious proceeding that a regulated health professional can face under the RHPA and carries with it the risk of loss of registration. ~~Section 51(5) of the Health Professions Procedural Code being Schedule 2 to T~~the RHPA sets out the penalties for an OT who has been found guilty of committing an act of professional misconduct by sexually abusing a client. If a panel of the Discipline Committee finds a OT has committed an act of professional misconduct by sexually abusing a patient, the panel shall do the following:

1. Reprimand the OT. A record of the reprimand is to be placed on the Register and be made available to the public.
2. Suspend the OT's certificate of registration if the sexual abuse does not consist of or include conduct that would result in revocation of the OT's certificate of registration.
3. Revoke the OT's certificate of registration if the sexual abuse consisted of, or included, any of the following:
    i. Sexual intercourse.
    ii. Genital to genital, genital to anal, oral to genital or oral to anal contact.
    iii. Masturbation of the member by, or in the presence of, the patient.
    iv. Masturbation of the patient by the member.
    v. Encouraging the patient to masturbate in the presence of the member.
    vi. Touching of a sexual nature of the patient's genitals, anus, breasts or buttocks.
    vii. Other conduct of a sexual nature prescribed in regulations.

Notwithstanding the above penalties, depending on the seriousness of the substantiated allegation, under ~~section 51(2) of the Health Professions Procedural Code being Schedule 2 to~~ the R~~egulated Health Professions Act, 1991,~~ HPA a panel of the Discipline Committee may also make any one or more of the following orders:

1. Revoke the member's certificate of registration.

2. Suspend the member's certificate of registration for a specified period of time.

3. Impose specified terms, conditions and limitations on the member's certificate of registration for a specified or indefinite period of time.

4. Require the member to appear before the panel to be reprimanded.

5. Require the member to pay a fine of not more than $35,000 to the Minister of Finance.

5.1 If the act of professional misconduct was the sexual abuse of a patient, requiring the member to reimburse the College for funding provided for that patient under the program required under section 85.7.

5.2 If the panel makes an order under paragraph 5.1, requiring the member to post security acceptable to the College to guarantee the payment of any amounts the member may be required to reimburse under the order under paragraph 5.1. 1991, c. 18, Sched. 2, s. 51 (2); 1993, c. 37, s. 14 (2).

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AGENDA ITEM 9.4

COUNCIL BRIEFING NOTE

Date: June 26, 2018
To: Council
From: Executive Committee
Subject: Guide to Discretionary Reporting of Fitness to Drive

Recommendation

THAT *Council approve the Guide to Discretionary Reporting of Fitness to Drive to be in effect July 1, 2018.*

Background

In 2015, the *Highway Traffic Act, 1990* was amended. The amendments gave the Ministry of Transportation the ability to grant authority for medical reporting to additional health practitioners, to revise the nature of the conditions that must be reported, and to introduce the authority for "discretionary" reports. These amendments are outlined in Section 203 and 204 of the *Highway Traffic Act, 1990*.

On February 23, 2018, the new regulations relating to the medical reporting requirements for drivers were published (Ontario Regulation 38/18: Drivers' Licences Amending O. Reg. 340/94) and occupational therapists were granted authority for discretionary reporting of potentially unsafe drivers directly to the Ministry of Transportation.

Highlights of the amended legislation include:

1. **Discretionary Reporting** - Occupational therapists have been granted authority and responsibility for discretionary reporting of potentially unsafe drivers. (*Highway Traffic Act*, *1990, Section 203)*

2. **New List of Conditions for Reporting** – The list defines the high risk medical conditions, functional impairments and visual impairments to be used for mandatory and discretionary reports. *(Ontario Regulation 38/18: Drivers' Licenses, Section 14.1)*

3. **New Medical Reporting Form** – A new medical reporting form for use by physicians, nurse practitioners and occupational therapists for both mandatory and discretionary reporting has been approved and will be online as of July 1, 2018.

These legislative changes have the potential to significantly impact occupational therapy practice across the province as reporting may become an expectation for OTs in various roles. Since the announcement of the regulations passing, the College received several questions from OTs about what this will mean for their practice. To clarify expectations and address current and anticipated questions about the impact of discretionary reporting on occupational therapy practice, the development of an interim guide was recommended, to provide timely guidance until Council would be able to meet to review and approve it.

Development of the Interim Guide to Discretionary Reporting of Fitness to Drive

In April 2018, Executive Committee approved the proposed content and key messages for the development of an Interim Guide to allow the College to provide OTs with initial direction. It is recognized that practice related to discretionary reporting will evolve as OTs and organizations determine how this legislation will be adopted within specific practice settings, so this document may need to be revised in the future.

In the development of the Interim Guide, College staff consulted key stakeholders including the Ministry of Transportation, OTs with certification in driver rehabilitation, academics with research foci in aging and driving and the Practice Issues Subcommittee. Consideration was also given to the related questions received by the Practice Resource Service.

Given the early indications of interest in this topic, College staff elected to host a webinar on May 29, 2018 to launch the Interim Guide. The intention was to launch the Interim Guide well in advance of the July 1, 2018 implementation date so OTs understand what will be expected when the legislation comes into force. The Ministry of Transportation was invited to co-present to provide OTs with a clear understanding of the Ministry processes associated with medical reporting. Webinar registration and participation numbers were the highest of any webinar in the College's history with 784 OTs registered and 508 attendees.

Based on questions from the webinar, questions received by the Practice Resource Service and feedback on the Interim Guide, the section on Consent, Privacy and Access was revised.

Discussion

Council is asked to review the Interim Guide for Discretionary Reporting of Fitness to Drive including revisions to the Consent, Privacy and Access section and provide comment and feedback. Once this is approved by Council, it will no longer remain interim.

Attachment(s)

1. Interim Guide to Discretionary Reporting of Fitness to Drive (June 2018)

College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

Guide

~~Interim~~ Guide to Discretionary Reporting of Fitness to Drive

Effective July 1, 2018

Introduction

Effective July 1, 2018, occupational therapists (OTs) have the authority to report concerns regarding a client's fitness to drive directly to the Ministry of Transportation of Ontario (MTO). Under the *Highway Traffic Act*, *1990* (HTA), OTs are identified as "prescribed persons" who may report a person who is at least 16 years old who has or appears to have a medical condition, functional impairment or visual impairment that may make it dangerous for a person to operate a motor vehicle (section 203(2)).

This ~~Interim~~ Guide summarizes the discretionary reporting expectations for OTs and provides direction for the application of the legislation into occupational therapy practice. This document is not intended to give specific legal advice, but rather to provide an overview of the HTA, highlight OTs' roles and responsibilities, and indicate where to obtain further information.

~~This Guide is interim in recognition that the legislation has just been passed, discretionary reporting is a new process, and expectations for occupational therapy practice may evolve. The College will monitor the situation closely, seek feedback from stakeholders and revise the Guide as necessary in response to new information that may become available.~~

Overview of the Guide

1. Medical Reporting Provisions under the *Highway Traffic Act, 1990*
2. Responsibilities of OTs for Discretionary Reporting of Fitness to Drive
3. National Medical Standards and Resources Related to Reporting Fitness to Drive
4. Occupational Therapy Assessment and Discretionary Reporting
5. Conscious Decision Making and Fitness to Drive
6. Consent, Privacy, and Access
7. Documentation and Reporting of Fitness to Drive
8. Interprofessional Collaboration

Medical Reporting Provisions under the *Highway Traffic Act, 1990*

Amendments to the *Highway Traffic Act, 1990* (HTA) outline the requirements for medical reporting of persons who have conditions or impairments that may impact their driving ability. Section 203 of the HTA defines two types of medical reporting, mandatory and discretionary.

Mandatory reporting is a legal requirement to report that pertains to physicians, nurse practitioners, and optometrists:

> 203(1) Every prescribed person **shall report** to the Registrar [of Motor Vehicles]* every person who is at least 16 years old who, in the opinion of the prescribed person, has or appears to have a prescribed medical condition, functional impairment or visual impairment.
> **Registrar refers to* *Registrar of Motor Vehicles*
>
> **Prescribed Medical Conditions**
> Under the legislation, physicians, nurse practitioners and opticians **must** report the following prescribed medical conditions, functional impairments and visual impairments:
>
> 1. Cognitive Impairment
> 2. Sudden Incapacitation
> 3. Motor and Sensory Impairment
> 4. Visual Impairment
> 5. Substance Use Disorder
> 6. Psychiatric Illness

Discretionary reporting is not a legal requirement but gives authority for reporting to **occupational therapists**, physicians, nurse practitioners and optometrists:

> 203(2) A prescribed person **may report** to the Registrar [of Motor Vehicles] a person who is at least 16 years old who, in the opinion of the prescribed person, has or appears to have a medical condition, functional impairment or visual impairment that may make it dangerous for the person to operate a motor vehicle.

Discretionary reporting is intended to 1) allow OTs to report concerns about a client's fitness to drive if they choose, and 2) to allow OTs, physicians, nurse practitioners and optometrists to report anything that is not listed in the prescribed medical conditions, functional impairments or visual impairments but, in a particular circumstance, raises concerns regarding fitness to drive.

Discretionary Reporting Rules for OTs

The HTA describes the expectations for discretionary reporting. For specific legislative references please see **Appendix A**. The discretionary reporting rules that apply to OTs are summarized as follows:

- OTs have the **authority to report concerns** about a client's fitness to drive directly to the Ministry of Transportation (Ontario Regulation 340/94: Drivers' Licences)
- OTs may report a driver but are **not legally required** to do so (Ontario Regulation 340/94: Drivers' Licences, section 14.2).
- OTs are permitted to make a report **without client consent** if the OT believes on reasonable grounds that the disclosure of information is necessary to prevent or reduce risk of harm to the client or others (*Highway Traffic Act, 1990*, section 203(3)).
- OTs can only report a client if they have **met the client**, either for an assessment or for the provision of OT services (*Highway Traffic Act, 1990*, section 203(4)).
- OTs must **submit discretionary reports in the form and manner specified** by the MTO. A standardized form, available on the MTO website, is used for both mandatory and discretionary reporting and is to be faxed or mailed to the MTO.

- OTs may report any of the **prescribed** medical conditions, functional impairments and visual impairments but are not limited to prescribed conditions and may report **any other medical conditions, functional impairments or visual impairments** that raise concerns regarding fitness to drive (*Highway Traffic Act, 1990*, section 203(2)).
- Prescribed medical conditions are defined as follows:
    1. **Cognitive impairment**: a disorder resulting in cognitive impairment that,
        i. affects attention, judgment and problem solving, planning and sequencing, memory, insight, reaction time or visuospatial perception, and
        ii. results in substantial limitation of the person's ability to perform activities of daily living.
    2. **Sudden incapacitation**: a disorder that has a moderate or high risk of sudden incapacitation, or that has resulted in sudden incapacitation and that has a moderate or high risk of recurrence.
    3. **Motor or sensory impairment**: a condition or disorder resulting in severe motor impairment that affects co-ordination, muscle strength and control, flexibility, motor planning, touch or positional sense.
    4. **Visual impairment**:
        i. A best corrected visual acuity that is below 20/50 with both eyes open and examined together.
        ii. A visual field that is less than 120 continuous degrees along the horizontal meridian, or less than 15 continuous degrees above and below fixation, or less than 60 degrees to either side of the vertical midline, including hemianopia.
        iii. Diplopia that is within 40 degrees of fixation point (in all directions) of primary position, that cannot be corrected using prism lenses or patching.
    5. **Substance use disorder**: a diagnosis of an uncontrolled substance use disorder, excluding caffeine and nicotine, and the person is non-compliant with treatment recommendations.
    6. **Psychiatric illness**: a condition or disorder that currently involves acute psychosis or severe abnormalities of perception such as those present in schizophrenia or in other psychotic disorders, bipolar disorders, trauma or stressor-related disorders, dissociative disorders or neurocognitive disorders, or the person has a suicidal plan involving a vehicle or an intent to use a vehicle to harm others.
- Conditions and impairments that are not prescribed in legislation are referred to as **discretionary**.
- OTs are NOT expected to report concerns about a person whose impairment is, in the OT's opinion:
    - of a distinctly **transient or non-recurrent nature** (Ontario Regulation 340/94: Drivers' Licences, Section 14(1)4)

  - **modest or incremental changes in ability** that, in the prescribed persons opinion, are attributable to a process of natural aging, unless the cumulative effect of the changes constitutes a condition or impairment described in subsection (3). (Ontario Regulation 340/94: Drivers' Licences, Section 14(1)5)

- An OT who makes a discretionary report in good faith is **protected from legal actions** or proceedings being brought against them for making the report. (*Highway Traffic Act, 1990*, Section 204(2)).

Responsibilities of OTs for Discretionary Reporting of Fitness to Drive

When an OT makes a discretionary report they are not making a determination about a person's driving privileges. Discretionary reports made by OTs provide the MTO with information needed to make a decision about about the status of an individual's licence. In some cases, the information provided by an OT will be sufficient for the MTO to make a decision while in other cases, the MTO may request additional information prior to issuing a decision.

Driving is a complex instrumental activity of daily living (IADL) that if performed by a person who is not fit to drive, presents a significant risk of danger to the driver and to others. In assessing a client's functional abilities, OTs may identify concerns about fitness to drive. In these situations, OTs must understand what they are expected to do and what options are available to address such concerns. The authority for discretionary reporting offers OTs one option to address fitness to drive concerns.

Legal Requirements and Professional Obligations

OTs are not legally required to make discretionary reports, however, if an OT identifies a potential safety issue with a client, such as a concern about fitness to drive, the OT has a professional obligation to take action to address the concern. This action may or may not include making a discretionary report to the MTO.

Within their scope of practice, OTs routinely address safety concerns. Addressing a concern about a client's fitness to drive aligns with the expectation that OTs must address client safety concerns that arise within their practice. For example, if an OT were to identify that a client was at risk for self-harm after the client expressed thoughts of suicidal ideation during a treatment session, it would be expected that the OT would take steps to address the risk. Similarly, an OT would be expected to take action if they believed a client's substitute decision maker (SDM) was physically or financially abusing a client. The options available to the OT to address safety concerns will vary depending on the circumstances.

OT Responsibility for Assessing Fitness to Drive

With the authority for discretionary reporting, many OTs have asked whether all OTs are now required to assess fitness to drive. The short answer is no. The legislation does not require OTs to assess or

report fitness to drive concerns to the MTO. The College also does not prescribe the nature and types of assessments that OTs must perform. However, OTs working with clients who are at least 16 years of age should determine if assessing fitness to drive is relevant to their clients and their current scope of practice and, if so, should be incorporated into their occupational therapy practice. The introduction of discretionary reporting for OTs provides an opportunity to reflect on their current practice and consider whether they should make any modifications to ensure the issue of driving is addressed.

In determining relevance of fitness to drive within their practice, OTs should consider the following:

- Does your role involve addressing a client's ability to perform ADLs and IADLs in the community?
- Are many of your clients currently driving or will they be returning to driving? Do they want to drive?
- Do your clients or the client populations you work with have medical conditions, functional and/or visual impairments known to have an impact on fitness to drive?
- What is your current process for addressing fitness to drive concerns when they arise?
- Do 'red flags' frequently present in your assessment findings that would lead you to believe that clients may not be fit to drive?

OTs working with clients 16 years of age or older should ensure they have an understanding of medical conditions, functional impairments and visual impairments that may affect driving and be prepared to address fitness to drive concerns when they arise. According to the Canadian Council of Motor Transport Administrators (CCMTA, 2017), "the functions necessary for driving can be categorized as either cognitive, motor or sensory (vision and hearing). Sensorimotor functions are a combination of sensory and motor functioning and are considered as a subset of motor functions". For a detailed list of the functions needed for driving including a description of the function and an example of the function in the driving context, refer to the *CCMTA Determining Medical Fitness in Canada, Part 1: A Model for the Administration of Driver Fitness Programs (2017).*

National Medical Standards and Resources Related to Reporting of Fitness to Drive

The MTO assesses driver fitness against national medical standards developed by the Canadian Council of Motor Transport Administrators (CCMTA). When determining if a client has or appears to have a medical condition, functional impairment or visual impairment, OTs should consider the *CCMTA Medical Standards for Drivers*[1].

In addition to these standards, the legislation also recommends prescribed persons including OTs, physicians, nurse practitioners and opticians, consider using the resource *Determining Medical Fitness*

[1] *Canadian Council of Motor Transport Administrators. CCMTA Medical Standards for Drivers. (2017).*

to Operate Motor Vehicles (9th edition)[2] which can assist in decision-making regarding fitness to drive. This resource is available for a fee from the Canadian Medical Association.

Occupational Therapy Assessment and Discretionary Reporting

Driving is an essential part of out-of-home mobility for many clients and allows them to engage in meaningful occupations. Addressing fitness to drive is important for maintaining the safety of the driver in question and other road users.

OTs work in diverse practice areas and settings where they are involved in a client's care in varying capacities. As such, OTs may assume different responsibilities in assessing and reporting fitness to drive based on their competence and experience with addressing the issue of driving. To assist in understanding how an OT may address this issue, the College has identified three types of approaches to assessing fitness to drive, informed by the three-tier expertise framework endorsed by the Canadian Association of Occupational Therapists (CAOT, 2009; Korner-Bitensky, Toal-Sullivan & von Zweck, 2007). The type of approach undertaken will depend on the scope and nature of the OT's role and their competence with addressing fitness to drive.

Assessment findings will provide information necessary to inform an OT's decision for how to proceed with respect to reporting.

Types of Approaches for Assessing Fitness to Drive:

- **General Functional Assessment**
  Refers to the usual process undertaken by an OT when completing an assessment with a client in the context of their practice. During this process, an OT may identify medical conditions, functional impairments or visual impairments that raise concerns about a client's fitness to drive. For example, when conducting an assessment within a client's home, an OT may identify that a client has significant difficulty ambulating due to loss of sensation in his/her right foot. If the client is currently driving, this sensory impairment may raise concerns about the client's fitness to drive.

- **Driving Specific Functional Assessment**
  Refers to the process where the OT assesses specific functions known to affect fitness to drive using evidence informed methods. This process of assessment typically requires enhanced knowledge of best practices for assessing and addressing fitness to drive. OTs may benefit from additional training to develop this competency.

[2] *Canadian Medical Association. Determining Medical Fitness to Operate Motor Vehicles, 9th edition. (2017).*

- **Comprehensive Driving Evaluation (CDE)**
  Refers to the process used by an OT who is practicing in the area of driver assessment and rehabilitation. These assessments are usually performed by OTs who have specific training recognized by the MTO and who work in MTO approved Functional Assessment Centres. This type of assessment uses both clinic-based and on-road assessments combined with expert clinical judgement supported by evidence. Clinical assessment of driving and on-road assessment or behind-the-wheel assessment should be completed by an OT with advanced training and experience in driving assessment.

When assessing a client's ability to drive, the OT should not get into a vehicle with the client. On road assessments of a client's fitness to drive should only be performed by OTs who are trained to conduct such assessments, which usually involves a qualified driving instructor.

An OT may use one or more of the above assessment approaches in their practice depending on their level of competence. There College does not specify any defined training requirements for each type of assessment approach. Specific training may be required by the MTO for OTs practising in approved Functional Assessment Centres. Every OT must practice within their own competence and limitations.

Conscious Decision-Making and Fitness to Drive

Although having the legislative authority for discretionary reporting is new for OTs, addressing fitness to drive issues has been an ongoing issue in occupational therapy practice. Deciding how to proceed when a client's fitness to drive is questioned can be challenging and the decision to report a concern about a client is never easy.

OTs should always use their judgement when determining whether to make a discretionary report and be able to describe and document their rationale for any action or inaction. Using a conscious decision-making process allows the OT to identify all available options. The College document, Conscious Decision-Making in Occupational Therapy, outlines the steps an OT can take when deciding whether to make a discretionary report.

Based on the OT's level of competence in assessing fitness to drive, the assessment approach used and the assessment findings, the OT may identify one or more possible options to address fitness to drive concerns including but not limited to:

- Discussing driving concerns with the client/family/or other care providers
- Discussing driving concerns with interprofessional colleagues on the client's care team
- Collaborative exploration with client about alternate out-of-home transportation plans to address temporary or permanent medical conditions or functional impairments
- Seeking a client's agreement to cease or self-limit driving

- Consulting with an OT colleague who practices in the area of driver assessment and rehabilitation
- Referring a client for further driving assessment (i.e., Comprehensive Driving Evaluation)
- Making a discretionary report to the MTO
- Recommending and/or initiating a referral for driver rehabilitation, adaptive driving equipment or vehicle modifications – may require additional reporting to the MTO and should only be performed by an OT with training and experience in driver rehabilitation.

If making a decision to make a discretionary report, whenever possible, the OT should collaborate with the client to develop a plan for alternate transportation arrangements for out-of-home mobility to assist the client to continue to engage in necessary and meaningful occupations.

Consent, Privacy, and Access

OTs are expected to obtain client consent for assessment and treatment and for the collection, use and disclosure of personal health information. OTs should consider their practice and use their clinical judgement to implement consent processes that comply with health care consent and privacy legislation as well as the College's Standards for Consent. In doing so, OTs need to think about the primary purpose of their assessment or treatment. It is not always possible to predict what issues will arise during assessment or treatment. For example, an OT completing a falls risk assessment may not be able to anticipate that concerns regarding fitness to drive may arise. Consent is an ongoing process and provides OTs an opportunity to address new issues and changes to assessment and treatment plans when they arise. If the purpose of the assessment is to make a determination regarding a client's fitness to drive or based on information available to the OT, the OT intends to address driving as part of their assessment, the OT should consider including a discussion related to driving and the potential for the need to report in the consent process.

Clients or their substitute decision makers (SDM) are always entitled to refuse or withdraw consent for assessment and treatment. If a client does not want to participate in assessment or treatment, their decision must be respected. Consent for assessment and treatment is different from consent to collect, use and disclose personal health information and depending on the circumstances, a client may not have the choice to withdraw consent for disclosure of information obtained during assessment or treatment if it relates to the risk of harm to the client or others. In the case of fitness to drive, if an OT believes a client has a medical condition, functional impairment or visual impairment that may make if dangerous for the client to drive, the OT is permitted to report this information to the MTO without client consent (HTA, section 203(3)).

~~OTs are expected to obtain informed consent for assessment and treatment and for the collection, use and disclosure of personal health information. OTs should consider their practice and use their clinical judgement to implement consent processes that comply with health care consent and privacy legislation as well as the College's Standards for Consent.~~

~~Appreciating that a client's ability to consent or withdraw consent for the disclosure of information related to reporting of fitness to drive may be limited if concerns are identified, OTs should be transparent with clients about the assessment and reporting process. If there is a likelihood an assessment may result in a discretionary report, OTs should inform clients about the possible outcomes of the assessment at the outset of service, so clients understand an OT may have to make a report. Clients can refuse to participate in assessment or treatment, however, once an assessment has been completed and concerns identified, the client may not have the option to withdraw consent for disclosure of the assessment findings if there is a risk to the client or others.~~

~~Section 203(3) of the *Highway Traffic Act* states that the authority of a prescribed medical professional making a report to the MTO overrides the duty of that professional to maintain a client's confidentiality. This means if, in the opinion of the OT, a client should not be driving due to a medical condition, functional impairment or visual impairment, the OT can report the client to the MTO and without the client's consent.~~ Even though OTs are not required to obtain consent, OTs should advise their clients that a report is being made. The College expects that an OT will disclose their intention to submit a report to the MTO to their client and discuss the possible implications of the report. If an OT has a concern that telling a client that a report will be or has been made, could result in risk of harm to the client, the OT or others, the information about the filing of the discretionary report may be withheld by the OT.

Under the *Freedom of Information and Privacy Protection Act, 1990*, the MTO is required to provide the client with a copy of any report if requested unless there is evidence that release of the information would threaten the safety of the client, OT or others. OTs should inform their clients that copies of reports can be requested and must notify the MTO if they are concerned that releasing the report may threaten anyone's safety.

Documentation and Reporting of Fitness to Drive

OTs should ensure that the client record includes documentation of any concerns related to a client's ability to drive, including observations of the client, assessment findings, discussions with the client, and any action taken (i.e. if a discretionary report is made to the MTO). OTs should also document any referrals that are made to other health care providers in relation to a client's driving abilities. When sending any correspondence regarding a client, such as a discretionary report, a copy should be retained in the client's record.

Reporting

When submitting a discretionary report, OTs are not making the decision to suspend or remove driving privileges. OTs are providing information that the MTO will use in making a decision regarding the status of an individual's driver's licence. OTs should be aware and inform clients that the submission of a discretionary report to the MTO does not automatically result in the client's licence being suspended or revoked. However, if the OT reports that the client presents with one of the mandatory prescribed medical conditions, functional impairments or visual impairments, a suspension will be issued, unless

additional information is included that indicates the CCMTA medical standards have been met. Where information is provided in the discretionary reporting section, the MTO will determine if any further information is needed before a decision is made.

Forms

OTs are to use the standardized form provided by the MTO when making a discretionary report. This form is available on the MTO's website (include link). Once completed the form must be faxed or mailed to the address indicated on the form. The MTO has published a Fact Sheet on how to complete and submit this form.

Interprofessional Collaboration and Fitness to Drive

It is important for OTs who work with other professionals who have mandatory or discretionary reporting authority to determine who will be responsible to make a report and who will determine whether a report for a particular client should be made.

When working within an interprofessional team, team members can provide information to assist an OT in determining whether to make a discretionary report concerning a client's fitness to drive. In the event there is a difference of opinion among interprofessional team members regarding reporting a particular client, where consensus cannot be achieved, the OT should consider the level of risk and determine if the OT should proceed with a discretionary report. If choosing to proceed, the OT should ensure to communicate to team members that the report has been made.

At times, OTs may have to rely on other professionals to make a mandatory or discretionary report when the information required for reporting is outside an OT's scope of practice. For example, if there are concerns about a client's ability to drive based on an episodic condition such as a seizure disorder, it would not be within the OT's scope of practice to provide the diagnosis or prognosis required for reporting. In this circumstance, the OT should confirm that the appropriate health care professional is aware of the circumstances and the OT's concerns regarding the client's fitness to drive. If another prescribed person is not involved in the client's care, the OT may consider, with the client's consent, making a referral to a health care provider with authority to diagnose and report.

Summary

Being granted authority for discretionary reporting within the legislation is an indication that OTs' contributions to the field of fitness to drive are valued. OTs working with clients who want to drive, are currently driving, or want to return to driving have the ability to address the issue of fitness to drive and have a responsibility to take action if they observe a concern with a client within their practice. Discretionary reporting provides OTs with a mechanism to report identified fitness to drive issues

directly to the MTO in a timely manner ensuring risk of harm is minimized for their clients and members of the public.

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Ministry of Transportation www.ontario.ca/driverimprovement

Ontario Regulation 340/94: Drivers' Licences. www.ontario.ca/laws/regulation/940340

Ontario Regulation 38/18: Drivers' Licences. www.ontario.ca/laws/regulation/r18038

Appendix A – Legislative References

Highway Traffic Act, 1990

Medical reports
Mandatory reports
203 (1) Every prescribed person shall report to the Registrar every person who is at least 16 years old who, in the opinion of the prescribed person, has or appears to have a prescribed medical condition, functional impairment or visual impairment. 2015, c. 14, s. 55.

Discretionary reports
(2) A prescribed person may report to the Registrar a person who is at least 16 years old who, in the opinion of the prescribed person, has or appears to have a medical condition, functional impairment or visual impairment that may make it dangerous for the person to operate a motor vehicle. 2015, c. 14, s. 55.

Authority to make discretionary report prevails over duty of confidentiality
(3) The authority to make a report under subsection (2) prevails over any duty of confidentiality imposed on the prescribed person by or under any other Act or by a standard of practice or rule of professional conduct that would otherwise preclude him or her from providing the information described in that subsection to the Registrar. 2015, c. 14, s. 55.

Required to meet the person
(4) Subsections (1) and (2) only apply if the prescribed person actually met the reported person for an examination or for the provision of medical or other services, or in the circumstances prescribed by regulation. 2015, c. 14, s. 55.

Authority to make discretionary report is not a duty
(5) Subsections (2) and (3) do not impose a duty on a prescribed person to report to the Registrar. 2015, c. 14, s. 55.

General rules respecting medical reports
Contents
204 (1) A report required or authorized by section 203 must be submitted in the form and manner specified by the Registrar and must include,
(a) the name, address and date of birth of the reported person;
(b) the condition or impairment diagnosed or identified by the person making the report, and a brief description of the condition or impairment; and
(c) any other information requested by the form. 2015, c. 14, s. 55.

No liability for compliance
(2) No action or other proceeding shall be brought against a prescribed person required or authorized to make a report under section 203 for making such a report or for reporting to the Registrar in good faith with the intention of reporting under that section. 2015, c. 14, s. 55.

Ontario Regulation 340/94: Drivers' Licences

Prescribed Persons
14.1 (1) For the purposes of subsection 203 (1) of the Act, the following are the prescribed persons who shall report under that subsection: an optometrist, a nurse practitioner and a physician. O. Reg. 38/18, s. 3.
(2) For the purposes of subsection (1), an optometrist is prescribed only with respect to visual impairments. O. Reg. 38/18, s. 3.

Prescribed Medical Conditions
(3) For the purposes of subsection 203 (1) of the Act, the following are the prescribed medical conditions, functional impairments and visual impairments that a prescribed person under subsection (1) shall report:

1. Cognitive impairment: a disorder resulting in cognitive impairment that,
    a. affects attention, judgment and problem solving, planning and sequencing, memory, insight, reaction time or visuospatial perception, and
    b. results in substantial limitation of the person's ability to perform activities of daily living.
2. Sudden incapacitation: a disorder that has a moderate or high risk of sudden incapacitation, or that has resulted in sudden incapacitation and that has a moderate or high risk of recurrence.
3. Motor or sensory impairment: a condition or disorder resulting in severe motor impairment that affects co-ordination, muscle strength and control, flexibility, motor planning, touch or positional sense.
4. Visual impairment:
    a. A best corrected visual acuity that is below 20/50 with both eyes open and examined together.
    b. A visual field that is less than 120 continuous degrees along the horizontal meridian, or less than 15 continuous degrees above and below fixation, or less than 60 degrees to either side of the vertical midline, including hemianopia.
    c. Diplopia that is within 40 degrees of fixation point (in all directions) of primary position, that cannot be corrected using prism lenses or patching.
5. Substance use disorder: a diagnosis of an uncontrolled substance use disorder, excluding caffeine and nicotine, and the person is non-compliant with treatment recommendations.
6. Psychiatric illness: a condition or disorder that currently involves acute psychosis or severe abnormalities of perception such as those present in schizophrenia or in other psychotic disorders, bipolar disorders, trauma or stressor-related disorders, dissociative disorders or neurocognitive disorders, or the person has a suicidal plan involving a vehicle or an intent to use a vehicle to harm others. O. Reg. 38/18, s. 3.

(4) A person prescribed under subsection (1) is not required under subsection 203 (1) of the Act to report a person whose impairment is, in the prescribed person's opinion, of a distinctly transient or non-recurrent nature. O. Reg. 38/18, s. 3.

(5) A person prescribed under subsection (1) is not required under subsection 203 (1) of the Act to report modest or incremental changes in ability that, in the prescribed person's opinion, are attributable to a process of natural aging, unless the cumulative effect of the changes constitutes a condition or impairment described in subsection (3). O. Reg. 38/18, s. 3.

(6) When considering whether a person has or appears to have a prescribed medical condition, functional impairment or visual impairment that is described in subsection (3), a prescribed person under subsection (1) may take into consideration,

(a) the *CCMTA Medical Standards for Drivers* described in subsection 14 (4); and

(b) the document entitled *Determining Medical Fitness to Operate Motor Vehicles* (9th edition), published by the Canadian Medical Association and dated 2017, as it may be amended from time to time, that is available on the Internet through the website of the Canadian Medical Association. O. Reg. 38/18, s. 3.

14.2 For the purposes of subsection 203 (2) of the Act, the following are the prescribed persons who may report under that subsection: an occupational therapist, an optometrist, a nurse practitioner and a physician. O. Reg. 38/18, s. 3.

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AGENDA ITEM 10.1

COUNCIL BRIEFING NOTE

Date: June 26, 2018
To: Council
From: Executive Committee
Subject: Evaluation of Officer Nomination Process - Roundtable discussion.

Recommendation

This item is for discussion and confirmation of actions going forward.

Issue

As the nomination process for Executive was changed this year, an evaluation of the changes was undertaken. Executive has reviewed the feedback and made recommendations for the process for next year.

Background

In 2017, Council received feedback during the nominations and elections processes for Executive/Officer positions that some improvements could be made. The concerns were related to two identified issues.

1. Some Council members do not know each other well enough to make an informed decision when voting at the Election for Executive.
2. The process is not transparent enough to assist with good decision making. This was because Council members only find out the slate of nominees during the election meeting.

Based on this feedback, Executive gave direction to the Nominations Committee to make some changes. These changes were to introduce a candidate statement, and to distribute these statements and the slate of nominees by email, prior to Council day.

This process was implemented for the first time in 2018 and Executive decided to evaluate the changes. To that end, a brief survey was distributed to each Council member who participated in the election. The questions of the survey asked how well the new process worked, if it should continue and any comments about the process.

Results

The survey was sent to 17 Council members and 16 Council members replied.

Issue 1. To achieve our goal of ensuring Council members have enough information to make an informed choice, please rate how well you think including a statement of candidacy into the process worked.

Results:12/16 felt this really helped, 3/12 felt it helped somewhat and one person was neutral.

Everyone felt we should continue with this process and had a few suggestions;

- Ensure everyone adheres to the word limit (it was 250 words)
- Add the remaining length of each candidate's term at the College to the slate of nominations

- One person suggested the new Council members should not participate as they cannot make an informed decision

Issue 2. To achieve our goal of increasing the transparency of the process for Council members, the slate of nominees was shared by email before election day. Please rate how well this worked.

Results: 11/16 felt this really helped, 5/16 felt it helped somewhat.

Everyone felt we should continue this process and a few suggestions were made:

- Provide a format for the statements and enforce the word limit.

Finally, some great suggestions and comments were added.

- A new person thought the process worked effectively
- "I felt much more informed this time. Thank you!"
- Someone suggested a limited term to be on Executive as a point for discussion.
- Some fine improvement points related to process, especially for a new member.
    - "Tell us how to write the name – is there a chance that the ballot will be spoilt?"
    - "Have the slate up on the screen, so I can see the spelling of the names and don't have to remember who I can vote for."

Discussion

Based on the review of the information provided through the survey, the changes to the process were successful in meeting the goals established for making these changes. Conclusion - the changes should continue.

Points to Consider:

Executive Committee considered the following suggestions for improvement and made some recommendations for discussion.

1. Fine tune some of the election processes.
    - more instructions related to how to complete the ballot. I.e., First name is fine. (unless 2 candidates of same name) Spelling won't spoil the ballot. Legibility will.
    - Staff will implement the use of the large screen to communicate the candidates for each position.

2. Word limit enforcement. A way to limit the number of words on the statement of candidacy will be investigated by staff for next year. A space limit on a survey style process might achieve this.

3. Structuring the Statement of Candidacy. During the nomination process this year, the nomination committee discussed structuring the statement of candidacy and felt it was best to leave it open for each person to address as they saw fit. The only parameters that was given was to "describe why you would be a suitable candidate for an executive position." A discussion on this point may be helpful.

4. The point raised about new Council members being excluded from voting at the first election in their term should be discussed. Both governance and legal parameters would need to be explored if this issue is of general concern. However, it might be hard to determine at what point council members would have enough information about each candidate to make an informed choice. There are many circumstances that may arise where members do not know each other

well. In addition, what type of information would be needed to make this choice? Could this information be added to the statement of candidacy?

5. Executive discussed whether to limit terms for executive positions. This is a governance topic which would require bylaw changes to enact and enforce. Preliminary thinking is that the election process itself limits terms. If Council members think a change on Executive Committee is needed, they will vote for different members the next year.

College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

AGENDA ITEM 12.1

COMMITTEE REPORT TO COUNCIL

Committee: Executive
Chair: Winston Isaac
Date: June 26, 2018

Tasks completed since the last Council Meeting

Executive has met twice since the March Council meeting. The first meeting included a comprehensive orientation to the role of Executive and included: applicable legislation, Executive Committee Terms of Reference, the Code of Conduct, Confidentiality, Conflict of Interest/Bias, Human Rights considerations, and the role of Executive related to the Strategic Planning processes of the College. In addition, this meeting included development of the Committee Work Plan for 2018-2019 and the following items:

- Review of the Annual Council Evaluation Summary
- Council Education Session – discussion of possible topics
- Discretionary Medical Reporting of Fitness to Drive – Approval of Key Messages
- Appointment of Committee Chairs
- Approval of the Statutory Committee Composition
- Appointment of Committee Liaison to Practice Issues – Julie Entwistle
- Appointment of Committee Liaison to Public Appointments Secretariat – Jeannine Girard-Pearlman
- Review of the March 29, 2018 Council Meeting Evaluation Summary

The second Executive meeting on June 6, 2018 included the following items:

- Approval of the topic for the Council Education Session in October 2018
- Review and approval of the March 2018 Financial Report
- Review of the Reserve Funds for Year-end 2017-2018
- Review of the Projected 2018-2019 Budget
- Review of Audit Process with the Auditor – Mr. Peter Pang
- Discussion about the Annual Registrar Evaluation Process - in camera
- Review of the Strategic Priority Performance Report
- Review of the Risk Management Program
- Standards for Psychotherapy – Recommend Council Approval
- Interim Guide to Discretionary Reporting of Fitness to Drive – Recommend Council Approval
- Evaluation of Officer Nomination Process – Recommend Council discuss
- Draft Bylaw Amendments – Recommend Council approval
- Controlled Act of Psychotherapy Regulations – Recommend Council Approval
- Developed the Council Agenda for the June 26, 2018 Meeting.

Key Priorities

Working with the Auditor and facilitation of the audit process up to the approval of the College's year-end financial statements.

- Facilitation of the Council education session in October 2018

Leadership Priorities

1. **Confidence in occupational therapy regulation:**
    - Facilitate the Regulations for the Controlled Act of Psychotherapy
    - Monitor Governance Model changes initiated through the Ministry of Health and Long-Term Care
    - Monitor council policies
    - Monitor Risk Management Program

2. **Quality practice by occupational therapists:**
    - Monitor emerging practice issues through the Practice Issues Subcommittee

3. **System impact through collaboration**
    - Monitor the development of the single competency document for occupational therapy
    - Monitor the status of agreements with Third Parties for the National Certification Exam, Accreditation and ACOTRO.

Items for Decision/Discussion:

1. Finance
    a. 2018-19 Projected Budget
    b. Reserve Funds
2. Risk Management Program
3. Controlled Act of Psychotherapy Regulations
4. Standards for Psychotherapy
5. Discretionary Reporting of Fitness to Drive
6. Bylaw Amendments

College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

AGENDA ITEM 12.1.1

COMMITTEE REPORT TO COUNCIL

Committee: Practice Issues Subcommittee

Chair: Julie Entwistle

Date: June 26, 2018

Tasks completed since the last Council Meeting

Since the last Council Meeting, Practice Issues Subcommittee met on two occasions: one teleconference on May 11th, 2018 and one in-person meeting on June 5th, 2018. To begin the 2018-2019 year, Practice Issues Subcommittee received orientation and had an opportunity to review the committee terms of reference.

Key Priorities

The Subcommittee continues to work on priority items as identified in the Subcommittee's Workplan:

- Developing and updating practice resources
- Responding to new and evolving practice environments through identification and prioritization of issues impacting OT practice and service delivery

Leadership Priorities

1. **Confidence in occupational therapy regulation**
   - Subcommittee decisions are informed by Practice, ICRC and QA data as well as information collected through external scans.

2. **Quality practice by occupational therapists**
   - Committee recommended additional edits to the Standards for Psychotherapy following revisions made based on consultation feedback
   - Draft Practice Resource: Electronic Communication was reviewed by Committee and will be brought back to committee once recommended edits are incorporated
   - Committee provided comment on the Interim Guide for Discretionary Reporting based on the questions received from registrants

3. **System impact through collaboration**
   - The Ministry of Transportation was consulted in the development of the Interim Guide and invited to participate in the webinar

Items for Decision/Discussion

Standards for Psychotherapy
Interim Guide to Discretionary Reporting of Fitness to Drive

College of Occupational Therapists of Ontario
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AGENDA ITEM 12.2

COMMITTEE REPORT TO COUNCIL

Committee: Registration Committee
Chair: Donna Barker
Date: June 26, 2018

Tasks completed since the last Council Meeting

The Committee met once since the last Council meeting.

Cases Reviewed

None

Key Priorities

The Committee ensures applicants are competent and qualified to practice occupational therapy safely and ethically.

Leadership Priorities

1. **Confidence in occupational therapy regulation:**

Registration Committee Orientation

An orientation session was provided by the Chair of the Registration Committee and the Manager of Registration at the meeting. Topics covered included: code of conduct, mandate, authority, composition, entry-to-practice requirements, and types of case reviews.

A legal orientation to the Registration Committee and to the decision-making process was provided by College legal counsel at the meeting. Topics covered included: human rights considerations, requests for accommodation, bias, exemptions, and the Office of the Fairness Commissioner.

Education and Fieldwork – Canadian Education

Alison Douglas, Director of Standards, Canadian Association of Occupational Therapists (CAOT) provided a presentation on the CAOT accreditation process. Following the presentation, the Registration Committee approved amendments to the policy Education and Fieldwork – Canadian Education. The amendments confirm that programs accredited by CAOT are deemed by the Registration Committee to be equivalent to a Bachelor of Science degree or Master of Science degree in occupational therapy obtained in Ontario.

Formalizing this practice in policy increases defensibility of College decision making by applying a consistent approval process for Canadian occupational therapy programs. The policy amendments will ensure registration program staff are able to effectively carry out decisions of the Committee. The revisions will also clarify expectations for applicants and will enhance fairness, transparency, objectivity, and impartiality.

Items for Decision/Discussion:

None.

College of Occupational Therapists of Ontario
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AGENDA ITEM 12.3

COMMITTEE REPORT TO COUNCIL

Committee: Inquiries, Complaints and Reports Committee

Chair: Kurisummoottil (KS) Joseph

Date: June 26, 2018

Tasks completed since the last Council Meeting:

Since the last report to Council, the Committee held 1 in person meeting for the Committee as a whole. The Committee Chair also held a telephone conference with the Manager, Investigations and Resolutions, in advance of the group meeting, to discuss the Committee's panel composition, as well as the possibility of seeking to add a new non-council professional member with experience working in the auto-sector.

During the group meeting, the Committee engaged in a half day training session with legal counsel from Steinecke Maciura Le Blanc. In addition to orienting all members to the Committee, the training set out the role and jurisdiction of the Committee, highlighted recent legislative amendments affecting the Committee and, provided training on the Ontario Human Rights Code and its application to the work of the Committee. In addition to receiving training, the Committee reviewed a number of case files and also discussed whether it wished to explore the addition of a new non-council professional member. The Committee determined that as more than half of the complaints received at the College come from persons engaged in the Statutory Accident Benefits process, having two Committee members with auto-sector experience so that both panels have someone with such experience, would be beneficial to help the Committee effectively discharge its duties and functions. The Committee instructed College staff to do a call for non-council members with auto-sector experience, so that the Committee can explore this possibility further and possibly make a recommendation to Council in the future. A summary of the ICRC's case review is detailed in the table below:

Date of Meeting	Type of Case	Source of Case	Decisions
June 1, 2018 Entire Committee	7 complaints 1 Registrar's Report	5 complaints from client 1 complaint from child of client 1 complaint from ex-spouse 1 report based on mandatory report from former employer	2 No decision - require additional investigation 3 take no further action 2 advice/guidance 1 Remedial Agreement

New ICRC Panel Composition

ICRC	
Panel A	**Panel B**
KS Joseph	Julie Chiba Branson
Shaheeza Hirji	Ernie Lauzon
Leanne Baker	Hricha Rakshit
Teri Shackleton	Mathew Rose

Key Priorities

Continuing to ensure efficient and timely processing of complaints and reports.

Leadership Priorities

1. **Confidence in occupational therapy regulation:**
   During the Committee's group meeting, Committee members used the updated Risk Assessment Framework tool to help facilitate consistent and appropriate decision making.
2. **Quality practice by occupational therapists:** No new updates
3. **System impact through collaboration:** No new updates

Items for Decision/Discussion:

No items to be brought forward for Council discussion.

College of Occupational Therapists of Ontario
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AGENDA ITEM 12.4

COMMITTEE REPORT TO COUNCIL

Committee: Discipline Committee
Chair: Paula Szeto
Date: June 26, 2018

Tasks completed since the last Council Meeting

Since the last report to Council, the Committee has held no meetings, however, the Committee Chair and the Manager, Investigations and Resolutions, held a telephone conference to discuss the work of the Committee for the coming year. A Committee meeting is scheduled to occur in the next quarter where the Committee will undergo training with external legal counsel from Lerners LLP and will discuss policy work respecting the development of timelines and expectations for the handling of hearings, as well as to discuss revised Rules of Procedure for Discipline hearings.

There are no referrals pending from the Inquiries, Complaints and Reports Committee.

COTO v. Jalpa Bode - Update

As previously reported, this matter was heard by a panel of the Discipline Committee on December 18, 2017. The panel's Decision and Reasons is still pending. The Committee will provide a comprehensive summary of this matter following the release of the panel's Decision and Reasons.

Discipline Summary - Brenda Hanna

On April 20, 2018, the panel's Decision and Reasons issued in this matter. The entire decision is available for review by the public on CanLII (The Canadian Legal Information Institute, www.canlii.org). This is the first time the College has made a decision of the Discipline Committee available in this manner. All past Decision and Reasons, as well as the subject Decision and Reasons, are available to the public on request. A summary of them is also provided both on the College website and in the affected OTs' profiles on Find an Occupational Therapist, the College's public register.

On January 9, 2016, a panel of the Discipline Committee of the College of Occupational Therapists of Ontario found that Ms. Brenda Hanna committed acts of professional misconduct as defined in:

- subsections 51(1)(a) of the *Health Professions Procedural Code* (the "Code"), being Schedule 2 to the *Regulated Health Professions Act, 1991* (guilty of an offence that is relevant to the member's suitability to practise) ; and,
- 51(1)(c) of the Code, as defined in paragraph 1 (contravening a standard of the profession), 14 (signing or issuing a document that contains a false or misleading statement), 28 (falsifying a record), 34 (contravening an act); 39 (using a name other than the member's name as entered in the register); 48 (engaging in disgraceful, dishonourable or unprofessional conduct); and 49, (engaging in conduct unbecoming an occupational therapist) of section 1 of Ontario Regulation 95/07 made under the *Occupational Therapy Act, 1991.*

On or about March 2009, Ms. Hanna applied to the College for a certificate of registration and falsely answered “no” to the question “have you ever been found guilty of a criminal offense” on the College’s registration application form. Ms. Hanna signed the College’s application form and certified that the statements she made in it were complete and correct to the best of her knowledge. Ms. Hanna further certified that she understood that a false or misleading statement may disqualify her from registration or may be cause for revocation of any registration which may be granted to her.

Prior to Ms. Hanna’s application for registration, on or about September 2008, Ms. Hanna was convicted of conspiracy to distribute ecstasy in the United States District Court, Eastern District of Wisconsin. Ms. Hanna was sentenced to 3 years’ probation with 180 days of home confinement.

In 2010, 2011, 2012, 2013, 2014 and 2015, Ms. Hanna completed the College’s annual renewal forms and continued to falsely answer “no” to the question of whether she had ever been found guilty of a criminal offense. In each of these years, Ms. Hanna continued to certify that the statements made in the annual renewal forms were complete and correct.

In or about February 2013, Ms. Hanna was found guilty in the United States District Court, Eastern District of Michigan, of making a false statement to a border official. Ms. Hanna was sentenced to probation for 24 months. Ms. Hanna did not inform the College of this second conviction until February 2016.

In 2013, 2014, and 2015, when completing the College’s annual renewal form, Ms. Hanna answered “no” to the question of whether she had been found quilt of an offence not previously reported to the College.

In 2009, Ms. Hanna applied for and was granted a certificate of registration under the name “Brenda Fathalla” and this was the name entered on the College’s public register, Find an Occupational Therapist. Sometime in 2014, Ms. Hanna changed her name from “Brenda Fathalla” to “Brenda Hanna”. Ms. Hanna did not inform the College of her name change until August 2015. Ms. Hanna, through her LinkedIn account, advertised her practice as an occupational therapist under the name of “Brenda Hanna” prior to informing the College of her name change.

From September 2010 until June 2013, Ms. Hanna was employed at a rehabilitation facility in Windsor, Ontario. Ms. Hanna failed to notify the College that she no longer worked at this facility until August 2015.

At the hearing, counsel for the College advised the Panel that a Joint Submission on Penalty had been agreed upon. The Panel of the Discipline Committee accepted the penalty jointly proposed by Counsel for the College and Counsel for Ms. Hanna, as set out in the Joint Submission on Penalty. The Panel of the Discipline Committee ordered that where Ms. Hanna had entered into an undertaking with the College agreeing to resign and never reapply for registration, that she is required to appear before it to be reprimanded and is required to pay the College costs in the amount of $5,000.

Ms. Hanna waived her right to appeal the reprimand and accordingly, the Panel of the Discipline Committee proceeded to deliver its reprimand immediately following the hearing.

Key Priorities

The Discipline Committee hears and determines allegations of professional misconduct and/or incompetence. It also hears and determines reinstatement applications for certificates of registration that have been revoked or suspended as a result of disciplinary proceedings. The Committee wishes to

continue to ensure efficient and timely processing of all Discipline hearings and reinstatement applications.

Leadership Priorities

1. **Confidence in occupational therapy regulation:**
   In 2016 the Discipline Committee developed customized Rules of Procedure to help direct the process and procedure of discipline hearings. Due to legislative changes to the *Regulated Health Professions Act* in 2017, these rules require updating to ensure consistency and compliance with legislative requirements. Revised Rules of Procedure will be presented to the Committee for its review and approval at its next meeting in August 2018.

2. **Quality practice by occupational therapists:** No new update.

3. **System impact through collaboration:** No new update.

Items for Decision/Discussion:

None

Attachments

1. *The College of Occupational Therapists of Ontario v. Brenda Hanna*, Decision and Reasons of the Discipline Committee dated April 20, 2018

Discipline Committee of the
College of Occupational Therapists of Ontario

Citation: *Ontario (College of Occupational Therapists of Ontario)* v. *Hanna*, 2018 ONCOT 1
Date: 2018-04-20

IN THE MATTER of the *Regulated Health Professions Act, 1991*, S.O. 1991, c.18, as amended, and the regulations thereunder, as amended;

AND IN THE MATTER of the *Occupational Therapy Act, 1991*, S.O. 1991, c.33, as amended, and the regulations thereunder, as amended;

AND IN THE MATTER of allegations of professional misconduct before the Discipline Committee of the College of Occupational Therapists of Ontario as referred by the Inquiries, Complaints and Reports Committee against **Brenda Hanna**;

BETWEEN:	
COLLEGE OF OCCUPATIONAL THERAPISTS OF ONTARIO	**Robin McKechney** Counsel for the College
	Aoife Coghlan Attending for the College
- and -	
BRENDA HANNA (REGISTRATION # 209868)	**Lisa Hamilton** Counsel for the Member
	Brenda Hanna In Attendance
Panel Members: **Donna Barker, Chair, Academic Council Member** **Paula Szeto, Professional Council Member** **Kurisummoottil S. Joseph, Public Council Member** **Michelle Stinson, Non-Council Professional Member** **Ernie Lauzon, Public Council Member**	**Bonni Ellis** Independent Legal Counsel **Heard: January 9, 2018** **Decision Released: January 9, 2018** **Written Decision Date: April 20, 2018**

DECISION AND REASONS FOR DECISION

Introduction

[1] This matter came before a panel of the Discipline Committee ("Panel") for a hearing on January 9, 2018 at the office of the College of Occupational Therapists of Ontario at 20 Bay Street in

Toronto. Brenda Hanna ("the Member/Registrant") was present and was represented by legal counsel.

The Allegations

[2] The Allegations against the Member were set out in the Notice of Hearing (Exhibit #1), which alleges that the Member engaged in professional misconduct pursuant to:

a) s. 51 (1) (a) of the *Health Professions Procedural Code* for having been found guilty of an offence that is relevant to the Member's suitability to practise; and/or

b) the following paragraphs of s. 1 of Ontario Regulation 95/07:

i. Contravening, by act or omission, a standard of practice of the profession or failing to maintain the standard of practice of the profession (paragraph 1);

ii. Signing or issuing, in his or her professional capacity, a document that the Member knows or ought to have known contains a false or misleading statement (paragraph 14);

iii. Falsifying a record relating to the Member's practice (paragraph 28);

iv. Contravening, by act or omission, the Act, *the Regulated Health Professions Act, 1991* or the regulations under either of those Acts (paragraph 34);

v. Practising the profession using a name other than the Member's name as entered in the register (paragraph 39);

vi. Engaging in conduct or performing an act relevant to the practice of the profession that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional (paragraph 48); and/or

vii. Engaging in conduct that would reasonably be regarded by members as conduct unbecoming an occupational therapist (paragraph 49).

Agreed Statement of Facts and Admissions of Professional Misconduct

[3] Counsel for the College advised the Panel that an agreement had been reached on the facts, and introduced an Agreed Statement of Facts and Admission of Professional Conduct (Exhibit 2), which provides as follows:

False Statement on Registration Application Form

1. Brenda Hanna (the ("Registrant") applied for a Certificate of Registration with the College of Occupational Therapists of Ontario (the "College") in or about March 2009. The Certificate of Registration was granted on or about April 2009.

2. On the Registration Application Form, the Registrant answered "no" to the question "have you ever been found guilty of a criminal offense?".

3. The Registrant signed the Registration Application Form and certified that "the statements made by me on this application are complete and correct to the best of my knowledge and belief. I understand that a false or misleading statement may disqualify me from registration or may be cause for revocation of any registration which may be granted to me."

4. Prior to the Registrant's application for registration, on or about September 2008, the Registrant was convicted of conspiracy to distribute ecstasy in the United States District Court, Eastern District of Wisconsin. A sentence of 3 years' probation with 180 days of home confinement was imposed.

False Statement on Annual Renewal Form

5. In or about 2010, 2011, 2012, 2013, 2014 and 2015 the Registrant completed the College's Annual Registration Renewal Form.

6. In each of the above mentioned years, the Registrant answered "no" to the question of whether she had been found guilty of an offence not previously reported to the College.

7. In each of the above mentioned years, the Registrant certified that the statements made in the Annual Renewal Form were complete and correct and that a false or misleading statement may be cause for revocation.

8. As indicated above, the Registrant was in fact convicted of conspiracy to distribute ecstasy in or about September 2008.

Conviction for Making a False Statement to Border Official

9. In or about February 2013, the Registrant was found guilty in the United States District Court, Eastern District of Michigan, of making a false statement to a border official. The Registrant was sentenced to probation for 24 months.

Failure to Inform the College of Conviction for Making a False Statement to Border Official

10. The Registrant did not inform the College of the above noted conviction until February 2016.

False Statement on Annual Renewal Form

11. In or about 2013, 2014 and 2015 the Registrant completed the College's Annual Registration Renewal Form.

12. In each of the above mentioned years, the Registrant answered "no" to the question of whether she had been found guilty of an offence not previously reported to the College.

13. In each of the above mentioned years, the Registrant certified that the statements made in the Annual Renewal Form were complete and correct and that a false or misleading statement may be cause for revocation.

14. As indicated above, the Registrant was found guilty of making a false statement in or about 2013 but did not report that to the College until 2016.

Failure to Notify the College Regarding the Member's Change of Name

15. In and about 2009, the Registrant applied for and was granted a Certificate of Registration under the name "Brenda Fathalla". This was the name that was entered in the public registrar.

16. In and about 2014, the Registrant changed her name to "Brenda Hanna".

17. The Registrant did not inform the College that she had changed her name until on or about August 2015.

18. The Registrant advertised her practice as an occupational therapist under the name "Brenda Hanna" prior to informing the College of her name change.

Failure to Notify the College Regarding the Member's Change of Employer

19. The Registrant was employed at Bayshore Therapy and Rehab in Windsor, Ontario from on or about September 2010 until on or about June 2013.

20. The Registrant failed to notify the College that she was no longer employed by Bayshore and Rehab until on or about August 2015.

Admission of Professional Misconduct

21. It is admitted that the above conduct constitutes professional misconduct to:
    a. Clause 51 (1) (a) of the *Health Professions Procedural Code*, being Schedule 2 to the *Regulated Health Professions Act, 1991* (the "Code"): found guilty of an offence that is relevant to the member's suitability to practise; and

    b. Clause 51 (1) (c) of the Code, as defined in the following paragraphs of section 1 of Ontario Regulation 95/07 made under the *Occupational Therapy Act, 1991*:

i. paragraph 1: contravening by act or omission, a standard of practice of the profession or failing to maintain the standard of practice of the profession: and

ii. paragraph 14: signing or issuing, in his or her profession capacity, a document that the member knows or ought to have known contains false or misleading statement; and

iii. paragraph 28: falsifying a record relating to the member's practice; and

iv. paragraph 34: contravening: by act or omission, the O*ccupational Therapy Act, 1991,* the R*egulated Health Professional Act , 1991* or the regulations under either of those Acts, particularly s. 35(1) and (2) of Ontario Regulation 226/96; and

v. paragraph 39: practising the profession using a name other than the member's name as entered in the register; and

vi. paragraph 48: engaging in conduct or performing an act relevant to the practice of the profession that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional: and

vii. paragraph 49: engaging in conduct that would reasonably be regarded by members as conduct unbecoming an occupational therapist.

Member's Plea

[4] The Member admitted that she engaged in the conduct described in the Agreed Statement of Facts and that this conduct constitutes the types of misconduct she admitted to in that document. The Panel conducted an oral plea inquiry and was satisfied that the Member's admissions were voluntary, informed and unequivocal.

Findings of Professional Misconduct and Reasons for Findings

[5] After considering the Member's admissions, the evidence set out in the Statement of Agreed Facts and the submissions of counsel, the Panel found that the Member committed professional misconduct pursuant to:

a. Clause 51 (1) (a) of the *Health Professions Procedural Code,* being Schedule 2 to the *Regulated Health Professions Act, 1991* (the "Code"): being found guilty of an offence that is relevant to the Member's suitability to practise;

b. Clause 51 (1) (c) of the Code, as defined in the following paragraphs of section 1 of Ontario Regulation 95/07 made under the *Occupational Therapy Act, 1991*:

i. paragraph 1: contravening by act or omission, a standard of practice of the profession or failing to maintain the standard of practice of the profession:

ii. paragraph 14: signing or issuing, in his or her profession capacity, a document that the Member knew or ought to have known contains a false or misleading statement;

iii. paragraph 28: falsifying a record relating to the Member's practice;

iv. paragraph 34: contravening: by act or omission, the O*ccupational Therapy Act, 1991,* the R*egulated Health Professional Act , 1991* or the regulations under either of those Acts, particularly s. 35(1) and (2) of Ontario Regulation 226/96;

v. paragraph 39: practising the profession using a name other than the Member's name as entered in the register;

vi. paragraph 48: engaging in conduct or performing an act relevant to the practice of occupational therapy that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional: and

vii. paragraph 49: engaging in conduct that would reasonably be regarded by members as conduct unbecoming an occupational therapist.

[6] As part of his submissions, College Counsel provided the Panel with the relevant provisions of Ontario Regulations 226/96, according to which:

a. an applicant to the College is required to provide evidence of any findings of guilt for any criminal offence or any offence relating to the practice of occupational therapy [s. 35(1)1]; and
b. a member is required to provide the College, as a condition for a certificate of registration, of any findings of guilt in relation to any offence [s. 35(2)1(i)].

[7] College Counsel also drew the Panel's attention to Part 16 of the College's By-laws. Specifically, College Counsel noted that clause 16.01.2 of the by-law requires members to notify the College of any changes to various information within 30 days of the change occurring, including changes to the member's name and/or employer.

[8] The Panel found that the evidence set out in the Agreed Statement of Facts was sufficient to support these findings and, specifically, that the following paragraphs from the Agreed Statement of Facts supported the corresponding allegations:

- being found guilty of an offence relevant to her suitability to practice occupational therapy (paragraphs 4 and 9);

- contravening the standards of practice (paragraphs 1-4, 5-8, 11-14, 9-10, 15-18, 19,20);
- making a false statement on her registration application form (paragraphs 1-4);
- making a false statement on the annual renewal form (paragraphs 5-8 and 11-14);
- failure to inform the College of conviction for making a false statement to a border official (paragraphs 9 and 10);
- failure to notify the College regarding her name change (paragraphs 15-18);
- failure to notify the College regarding the Member's change of employer (paragraphs 19 and 20).

[9] The Panel further found that, together, and having regard to all the circumstances, these acts would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional. The Panel also made a finding that the Member's conduct was unbecoming of an occupational therapist. The convictions of drug distribution and making false statements to officials, in addition to contravening professional standards by making false statements on College forms and failing to notify the College of name and employer changes is evidence of the Member not upholding the fundamental occupational therapy values of respect and trust. The principles of honesty, transparency, and accountability were not maintained by the Member, undermining the public's trust in the Member and the profession. Protection of the public is paramount and requires all occupational therapists to uphold professional standards and to speak and act with integrity and within the law.

Joint Submission on Penalty and Costs

[10] The College and the Member submitted a Joint Submission on Penalty and Cost (Exhibit 3) which provides as follows:

> Whereas [the Registrant] has entered into an Understanding to Resign and Never Reapply, [the College] and [the Registrant] agree and jointly submit that the following would be an appropriate order as to penalty and costs in this matter;
>
> 1. The Registrant is required to appear before a panel of the Discipline Committee immediately following the hearing of this matter to be reprimanded, with the fact of the reprimand and the text of the reprimand to appear on the public register of the College.
>
> 2. The Registrant is required to pay to the College costs in the amount of $5000.00 payable as follows: $435 on January 9, 2018, and a further $415 on the first of each month from February 2018 to December 2018.

[11] College Counsel also presented to the Panel the Member's Acknowledgement and Undertaking to Resign and Never Reapply (Exhibit 4), which stated, in part, as follows:

> […]
>
> .

4. I acknowledge that if the current allegations against me were to proceed to a contested discipline hearing [the College] would be seeking revocation of my certificate of registration as well as substantial costs against me.

5. I acknowledge that it is in my interest to resolve these allegations by agreeing to a joint submission that will be placed before the Discipline Committee that includes a reprimand and payment of costs in the amount of $5000 (the "joint submission").

6. In exchange for [the College] agreeing to jointly submit the penalty referred to in paragraph 5 instead of seeking revocation of my certificate, I hereby acknowledge that, immediately following acceptance by the Discipline Committee of the joint submission, the resignation of my membership in and certificate of registration with [the College] will take effect. This undertaking constitutes instructions to [the College] to process my resignation immediately upon acceptance of the joint submission by the Discipline Committee. I acknowledge that if the joint submission is not accepted by the Discipline Committee, [the College] will seek revocation of my Certificate of Registration and costs order against me.

7. I hereby undertake never to reapply for membership, registration, licensure or similar status with [the College] as an occupational therapist.

8. I acknowledge that if I ever apply for membership, registration, licensure or similar status with [the College] in the future, [the College] will be entitled to rely upon this undertaking in any registration or other similar proceeding as reason to deny my application.

9. I further acknowledge that if I ever apply for membership, registration, licensure or similar status with [the College] in the future, [the College] will be entitled to prosecute me with respect to the [allegations referred to the Discipline Committee] as well as for the breach of this undertaking, and the COTO will be entitled to rely upon this undertaking for that purpose.

10. I acknowledge that once my resignation takes effect, I will not be entitled to use the title "occupational therapist" or any abbreviation thereof or equivalent in another language, I will not be entitled to hold myself out as a person who is qualified to practise in Ontario as an occupational therapist or in a specialty of occupational therapy, and I will not be entitled to imply that I am an occupational therapist in Ontario.

11. I acknowledge that [the College] is required to include on the public register the fact that I resigned and undertook never to reapply and that [the College] will be including the full text of this undertaking on the public portion of [the College] register on [the College] website.

12. I acknowledge that I have had the opportunity to obtain legal advice prior to entering into this undertaking.

13. I acknowledge that I am entering into this undertaking freely, voluntarily and without duress.

[12] In asking the Panel to accept the joint submission, Counsel for the College stated that the penalty was within the appropriate range of similar discipline cases within regulated health professions. He provided the Panel with a Brief of Authorities and summarized the cases within it [*Shaw* v. *Law Society of Upper Canada*, 2016 ONLSTH 182; *College of Nurses of Ontario* v. *Phillips*, 2007 CanLII 82752 (ON CNO); and *Todorovic* v. *Ontario (Superintendent of Financial Services)*, 2009 ONFST 3(CanLII)].

[13] College Counsel also outlined how the proposed penalty, in conjunction with the Acknowledgement and Undertaking to Resign and Never to Re-apply, serves the goals of public protection, general deterrence and specific deterrence.

[14] Counsel for the Member also reviewed with the Panel the cases as outlined in the Brief of Authorities, highlighting the reasons that resignation with no opportunity to re-apply (as agreed upon in the Undertaking), rather than revocation, was appropriate.

[15] College Counsel clarified that the College was not seeking revocation and was satisfied that resignation was appropriate in this case because the Member has been fully cooperative and has agreed to the Undertaking never to re-apply.

[16] Independent Legal Counsel (ILC) advised the Panel that the Undertaking was a contract between the College and the Member. As such, the Panel was not deciding whether to accept the Undertaking but would instead be deciding whether to accept the Joint Submission on Penalty and Costs in light of the Undertaking. ILC advised the Panel to consider the following when making their decision: (i) the impact of their Order on the Member, the profession, and the public; (ii) whether the proposed Order meets the goals of specific deterrence, general deterrence to the profession at large, remediation, the public interest, and the public's confidence that the Discipline Committee serves the public interest; and (iii) the seriousness of the Panel's findings and the conduct underlying those findings, including any aggravating and mitigating factors, the latter of which included the Member's admissions and the joint submission. ILC also suggested that the Panel consider whether the proposed Order is within the appropriate range of outcomes, as per the case law presented.

Panel's Decision on Penalty and Costs

[17] After carefully considering the joint submission, the cases referred to, the oral submissions made by Counsel for the College and Counsel for the Member, including in relation to the mitigating factors in this case, the Panel accepted the joint submission and makes an Order:

1. Requiring the Registrant to appear before the Panel to receive an oral reprimand immediately following the hearing, with the fact of the reprimand and the text of the reprimand to appear on the public register of the College.

2. Requiring the Registrant to pay to the College costs in the amount of $5000.00 payable as follows: $435 on January 9, 2018, and a further $415 on the first of each month from February 2018 to December 2018.

Reasons for Decision on Penalty and Costs

[18] The Panel understands that it should accept a joint submission, unless doing so would bring the discipline process into disrepute or would otherwise be contrary to the public interest.

[19] After deliberation, the Panel concluded that the proposed penalty, in conjunction with the Undertaking, is reasonable and in the public interest. The Panel notes that the Member has co-operated with the College and, by admitting to her misconduct and agreeing to the proposed Order, has accepted responsibility for her actions and avoided the expense that would have been incurred for a contested hearing had she not done so.

[20] The Panel based their decision on the following principles: 1) Protection of the Public, 2) General Deterrence, and 3) Specific Deterrence and notes the following:

- The Member's resignation and agreement never to re-apply for registration with the College protects the public because she will never again practice as an occupational therapist.
- The reprimand acts as a general deterrent for all practicing occupational therapists, as a summary of the reprimand will appear on the public register of the College.
- The Member's resignation and agreement never to re-apply for registration with the College also acts as a general deterrent, as it emphasizes the serious nature of the misconduct, including making a false statement on College documents and failing to notify the College of required information.
- The Member herself will be deterred insofar as the outcome of this proceeding prevents her from ever practising as an occupational therapist.

Reprimand by the Panel

[21] Prior to concluding the hearing, the Panel delivered the following oral reprimand to the Registrant:

Ms. Hanna, as part of this penalty order, this Discipline Panel has ordered you to attend today so that you can receive an oral reprimand.

This reprimand will be part of the public register of the College of Occupational Therapists of Ontario, and therefore, part of your record with the College. A copy of this reprimand will also be appended to this Discipline Panel's written decision and Reasons, which will be published on CanLII.

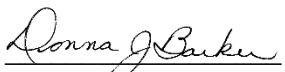
Although you will be given the opportunity to make a statement at the end of the reprimand, this is not an opportunity for you to review the decision of this Discipline Panel or the time for you to debate the merits of this Panel's decision and order.

This Panel finds that you engaged in professional misconduct. The Panel acknowledges that there were mitigating factors involved, however, of specific concern, is the fact that your actions would be regarded by Members and the Public as disgraceful, dishonourable, and unprofessional. Your conduct is unbecoming an occupational therapist.

The Public and the College expect members to self-report honestly to ensure self-regulation is effective in the protection of the Public. By dishonest reporting, you have brought discredit to the profession and to yourself. Public confidence in the profession has been put in jeopardy; moreover, the results of your misconduct are that you have let down your clients, the public, the profession of occupational therapy, and yourself.

We trust that this reprimand will serve to remind you and others of the importance of honesty and integrity and will serve you well in your future endeavors.

I, Donna Barker, Chair, sign this decision and reasons for the decision as Chairperson of this Discipline Panel and on behalf of the members of the Discipline Panel as listed below:



Chairperson

April 20, 2018
Date

Panel Members
Paula Szeto, Professional Council Member and Chair of the Discipline Committee
Kurisummoottil S. Joseph, Public Council Member
Michelle Stinson, Non-Council Professional Member
Ernie Lauzon, Public Council Member

College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

AGENDA ITEM 12.5

COMMITTEE REPORT TO COUNCIL

Committee: Fitness to Practise Committee
Chair: Jennifer Henderson
Date: June 26, 2018

Tasks completed since the last Council Meeting

On June 7, 2018, the Committee Chair held a telephone conference with the Manager, Investigations and Resolutions, to discuss the work of the Committee for the coming year. It was noted that there are currently no pending referrals from the Inquiries, Complaints and Reports Committee.

Key Priorities

No new updates since the Committee's last report to Council.

Leadership Priorities

1. **Confidence in occupational therapy regulation:** No new update

2. **Quality practice by occupational therapists:** No new update

3. **System impact through collaboration:** No new update

Items for Decision/Discussion

There are no items to discuss at this time.

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AGENDA ITEM 12.6

COMMITTEE REPORT TO COUNCIL

Committee: Quality Assurance Committee
Chair: Mary Egan
Date: June 26, 2018

Tasks completed since the last Council Meeting

- Committee had one in-person meeting March 28, 2018
- Committee reviewed two QA case files; one with an outcome of take no action, the other with an outcome of referral to Investigations, Complaints and Reports Committee (ICRC)
- Committee reviewed and approved the content of the 2018 Prescribed Regulatory Education Program (PREP) on Professional Boundaries and the Prevention of Sexual Abuse; PREP to be launched in MyQA in mid-June 2018
- Committee approved key decisions for the QA program redesign including: parameters for selection of OTs to participate in the CRE process; potential benefits of using a valid multi-step process; and, adoption of a coaching philosophy to permit more relevant and timely feedback to OTs participating in a peer-practice assessment.

Key Priorities

- Continued oversight of the development of the new CRE process
- Addressing registrant non-compliance with QA requirements as per policy; beginning July 2018
- Approval of the topic for the 2019 Prescribed Regulatory Education Program (PREP)
- Approval of an annual QA requirements deferral form

Leadership Priorities

1. **Confidence in occupational therapy regulation:**
   Committee decisions are evidence-informed based on the CRE program evaluation findings, feedback from OTs, and consultation with other regulatory organizations.
   Implementation of the new compliance policy supports Committee in meeting their accountability to monitor compliance under the RHPA.

2. **Quality practice by occupational therapists:**
   The Committee is dedicated to fulfilling a more prominent role in the monitoring and management of registrant non-compliance with the mandatory components of the QA Program, using real-time data available through MyQA, in support of quality practice by OTs.

3. **System impact through collaboration:** N/A

Items for Decision/Discussion:

Reappointment of a Professional Non-Council Committee Member to Quality Assurance Committee.

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AGENDA ITEM 12.7

COMMITTEE REPORT TO COUNCIL

Committee: Patient Relations
Chair: Jeannine Girard-Pearlman
Date: June 26, 2018

Tasks completed since the last Council Meeting

Patient Relations Committee met on one occasion for a teleconference on June 14, 2018 to review consultation feedback on the revised Standards for the Prevention of Sexual Abuse and the recommended revisions to the standards resulting from the feedback.

Key Priorities

Patient Relations Committee's key priorities are the implementation of the enacted provisions of the Protecting Patients Act, 2017, proactive planning for proposed regulations under the Act, and meeting the legislative mandate of the Committee as it pertains to the education of registrants, Council and staff on professional boundaries and the prevention of sexual abuse of clients.

Specific priorities for the next scheduled in-person meeting include:

- Committee Orientation
- Review of the 2018-19 Committee Work Plan
- Review of current College regulations (O. Reg 226/96: General) pertaining to funding for therapy and counselling and the definition of patient related to the performance of psychotherapy
- Citizen Advisory Group consultation on risk-based regulation

Leadership Priorities

1. **Confidence in occupational therapy regulation:**

2. **Quality practice by occupational therapists:**
   Standards for the Prevention of Sexual Abuse were updated to reflect the passing of the Protecting Patients Act, 2017.

3. **System impact through collaboration:**
   Continued collaboration with the CAG.

Items for Decision/Discussion:

The revised Standards for the Prevention of Sexual Abuse are before Council for review and approval.

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AGENDA ITEM 13.1

Council Meeting Evaluation

Meeting Date: June 26, 2018

Please assess how well Council adhered to the expectations we have set:

Item	Yes	Most of the time	No	Please provide comments to support your rating, as appropriate.
1. Council members were given an opportunity to declare any conflict of interest prior to the start of the meeting.				
2. Information was provided in a clear, succinct, and timely manner in advance of the meeting.				
3. An agenda was followed in the meeting. Council's time was spent on issues of public interest and safety. Furthermore, Council's focus was on outcomes or intended long term ends rather than on the means to attain those effects.				
4. Council deliberations were fair, open and thorough but also timely, orderly and kept to the point.				
5. Each Council member was given an adequate opportunity to participate in discussion and decision-making.				

Item	Yes	Most of the time	No	Please provide comments to support your rating, as appropriate.
6. The discussions and options considered for each agenda item were sufficient in breadth and quality to support effective decision-making.				
7. Diversity in viewpoints was not discouraged.				
8. The process for collective or group decision-making was made without undue influence of any individual Council member. Once decisions were made, the process supported speaking with one voice.				
9. Council's treatment of all persons was courteous, dignified and fair.				
10. Council adhered to a semblance of order in the meeting.				

Your suggestions for improvement

Understanding that effective leadership involves continual growth and development, what advice would you ask Council to consider in order to strengthen our effectiveness in the future?

Any additional comments?

Please provide any additional comments that you feel may be helpful to this evaluation process. For example, you may wish to highlight where our discussion and decision-making process worked well today and where it may not have been as effective.