Social Worker Services

Social Worker Standard of Practice

Document Developed by: Edy Cruz-Fuentes (MSW Student)
Edited by: Selina Mackie, Melanie Dunlop, Shannon Parsons, Anastasia Burns & Lethicia Foadjo

APRIL 2022

Algonquin & Lakeshore Catholic District School Board

Building communities of faith, service and life-long learning.

www.alcdsb.on.ca

Algonquin & Lakeshore
Catholic District School Board

Preface: Social Worker Services at ALCDSB

Table of Contents

Social Worker Role in ALCDSB

ALCDSB School Social Worker offers mental health support services to students in secondary schools and provides evidence-based individual/group psychotherapy. As part of their role, Social Workers coordinate referrals and work closely with school staff to collaborate with community agencies to provide appropriate mental health services. Social Workers are expected to adhere to professional standards of practice mandated by the Ontario College of Social Workers and Social Service Workers.

Service Outcomes

Through these services, students receive psychoeducation and therapeutic interventions to address mental health symptoms and increase functioning. Service outcomes are monitored on an onion basis throughout the intervention process. Screening tools (i.e: GAD, PHQ CUDIR), self-reporting, and other data collection methods (attendance, number of sessions) used.

Social Work Referral Guidelines

School staff can refer students to Social Work Services who may exhibit a range of presenting problems that may include but are not limited to: suicidal ideation, self-harm, anxiety, depression, trauma, difficulty with stress management, etc. Students over the age of 12, can refer themselves to social work services and do not require parental consent. Staff/Students who make a referral must fill out the ***Social Work Services Referral Form***. Social Workers can be available to consult with the referring individual to ensure appropriateness of the referral. If deemed inappropriate, Social Workers can refer students and their families to more suitable services. Once referred, the Social Worker will meet with the student to complete the consent process and conduct an assessment of needs/goals to inform treatment planning in the community. If it is deemed appropriate that the School Social Worker will support the student, Social Work intervention will commence, and the duration of the service will be determined by the severity of the presenting problem and appropriate treatment.

Referral Reference Steps:

1) Staff/Student/School identifies concerns
2) Consultation between referrer and Social Worker to determine if services are appropriate
3) Referral form is completed
4) Social Worker offers service to student/provides support to family
5) Consent forms completed
6) Service commences

Algonquin & Lakeshore
Catholic District School Board

Frequently Asked Questions Regarding Referrals

Which school staff members can make a Social Work referral?
Principals/Vice Principals, Youth Workers, Chaplains, and others in helping roles are able to make referrals with consent from the student. Although not employed by the school board, Substance Use Counsellors, Mental Health and Addiction Nurses and other community partners can also refer a student to Social Work Services.

Who can I refer?
Students who need clinical intervention and have mental health concerns that are impacting their well-being.

How old do the students need to be?
Currently, Social Workers are only allocated in secondary schools, therefore, only students of secondary schools and who are 12 years of age and older can self-refer.

Does the student's parent/guardian have to consent?
If a student is 12 years of age or older, they do not need parental consent. A copy of the consent for service form is placed on the student's OSR and the student's parent/guardian is legally allowed to access the OSR.

I have a few students in mind that could benefit from social work, are there group interventions?
Group interventions such as Dialectal Behaviour Therapy, Cognitive Behavioural Therapy and other need-specific topics, are offered at the discretion of the individual Social Worker as student population needs may indicate. The Social Worker will screen potential group participants for eligibility and readiness. As group interventions are mental health treatments, participating students must consent voluntarily.

What is considered an "appropriate" referral?
Students should be made aware that a referral is being submitted on their behalf prior to completing the referral. In discussing with the student and/or parent the potential for accessing Social Work services at school, there should be identifiable mental health symptoms impacting the student's functioning. These symptoms and resulting impact may be mild, moderate or severe. A student does not have to have a formal mental health diagnosis to receive services.

Can a student be referred if they are already in therapy elsewhere?
In an effort to avoid duplication of services, students who are already receiving mental health supports through avenues outside of ALCDSB (private therapy, community agency) should not be referred. However, there may be some circumstances where ALCDSB Social Work Services may be indicated such as a need for school safety planning, school-based case management, transition of therapy skills from outside therapy into the school environment, or an expected end to outside therapy.

I know a student who may benefit from Social Work Services but they aren't sure they want to engage in the services. What can I do?
The student can be introduced to the school Social Worker without any obligation to engage in services. This would allow students to gain further understanding on what the role of the Social Worker is.

If I can't refer to Social Work Services, where do I go?
You can still consult with Social Workers! Reach out directly to your school's Social Worker for information, resources and referrals to more appropriate services.

If you are made aware of a student experiencing a mental health crisis, please follow Urgent Consult procedure, contact the Mental Health Lead.

Consent to Receive Social Work Service
Social Workers are registered professionals regulated by the Ontario College of Social Workers and Social Service Workers (OCSWSSW). Social Workers adhere to the Code of Ethics mandated by the Canadian Association of Social Workers to obtain informed consent (see appendix). The OCSWSSW also enforces the code of ethics and it is the college who regulates our registration based on our adherence to it. No one using the title of Social Worker needs to be member of CASW but they do need to be a member of the OCSWSSW in Ontario (CASW, 2005).

Social Workers promote autonomy of students and encourage them to make informed decisions regarding services. These interventions can be provided via secured virtual, telephone or in-person sessions. Students must be informed of their rights and must not be coerced into receiving services; all services are voluntary.

Consent Reference Steps:
1) Social Worker will provide a brief overview of services being offered, explain limits of confidentiality, and student's right to withdraw from services at any time
2) Social Worker will review and have student complete the necessary consent form(s)
3) A copy of the completed consent for service form will be filed in the student's OSR and the original filed in the student's Social Work clinical file

4) Intervention can commence

File Storage

Social Workers follow strict guidelines set out by the Personal Health Information Protection Act (PHIPA). This act ensures that all personal health information is kept in private, secure and confidential (OCSWSSW, 2018). All Social Work client records MUST be stored in a locked filing cabinet on school board property. The school board is responsible for providing a locked filing cabinet in each school for this purpose. The student's file should remain at the school at which the student attends (or last attended). If the student moves to another school, the Social Worker file will be sent to their new school (within ALCDSB).

OCSWSSW Record keeping

Social Workers must take all reasonable steps to ensure the safe and secure storage of all files:

RE: OCSWSSW Code of Ethics
4.1 Record Content and Format
4.1.1 Recorded information conforms with accepted service or intervention standards and protocols within the profession of social work and social service work, relevant to the services provided, and is in a format that facilitates the monitoring and evaluation of the effects of the service/intervention (CASW, 2005).

Contents of the Social Work file:

a) Social Work Services referral form completed by school staff/student
b) Record of Informed Consent
c) Copy of Student's Index Card
d) Screening tools/Assessment forms (CUDIR, GAD, PHQ)
e) Social Work case notes are required to follow the OCSWSSW Code of Ethics and Standards of Practice Guidelines. All case notes must be signed and inserted in the Social Work file. Each entry must be dated and signed with credentials at the bottom of each page

Policies and Procedures

Social Workers are classified as Healthcare Information Custodians under the Personal Health Information Protection Act and as such, are required to meet all associated legislative requirements regarding collecting, storing, and dispersing personal health information. Social Workers provide year-round services and will follow the following procedure and expectations.

Social Work Procedure:

1. Ensure Social Worker file contents are up to date
2. Track referrals, closure of files, pending files
3. Digitally record statistical data on a monthly basis

OCSWSSW Confidentiality

In regards to confidentiality, Social Workers follow the OCSWSSW Code of Ethics and Standard of Practice manual. Social Workers are mandated by the college to not disclose the identity of the student receiving services to others (CASW, 2005).

OCSWSSW states that agencies with Social Workers, are to provide a private space for sessions where confidentiality is maintained. In compliance with the OCSWSW, ALCDSB Social Workers will inform students about the limits and extent of confidentiality. Social Workers will inform students that confidentiality will be broken only when it is required by law or when students give consent to the SW to disclose on their behalf.

Frequently Asked Questions Regarding Confidentiality

<u>If I refer a student, will I be notified if they are receiving therapy?</u>

Social Workers will not disclose whether the student is receiving clinical intervention. Social Workers follow ethics code 5.3.6: ***College members do not disclose the identity of and/or information about a person who has consulted or retained them unless the person consents. Disclosure without consent is justified if the disclosure is required or allowed by law (CASW, 2005).***

<u>I'm a staff member, shouldn't I be informed about anything concerning the student?</u>

Social Workers are members of a regulated profession and must adhere to the Standards of Practice and code of ethics that govern their practice.

5.3.1 When College members are employed by an agency or organization, College standards of confidentiality may conflict with the organization's policies and procedures concerning confidentiality. Where there is a conflict, College standards take precedence (CASW, 2005).

My child is receiving social work services. Can I call you and ask what is discussed during sessions?

Unfortunately, not without your child's consent. However, you will be contacted if an emergency arises. You can, discuss concerns through parent consultation with Social Worker. ***5.3.7 In clinical practice, College members have clients sign completed consent forms prior to the disclosure of information, where consent is required. A separate consent form is required to cover each authorization for disclosing client information. In urgent circumstances, a verbal consent by the client to the disclosure of information may constitute proper authorization. The member should document that this consent was obtained (CASW. 2005)***.

How can a student get access to their social work record that is not part of the OSR? Who else has access to the social work record?

Students can make a request with the Social Worker to gain access to their records (see client access via OSWSSW Code of Ethics for more information). Social Worker and student, are the only people who have access to the Social Work record unless a third-party consent form is signed by student to release their record.

Act of Psychotherapy

Psychotherapy is primarily talk-based therapy and is intended to help people improve and maintain mental health and well-being (OCSWSSW, 2017). Social Workers using psychotherapeutic technique, follow psychotherapy practice guidelines and understand the extent/ limits when utilizing psychotherapy in a school-based setting. When Social Workers provide psychotherapy services, the intent of the service is to provide treatment and is goal-oriented. The treatment would be addressing psycho-social needs, maladaptive coping strategies and other issues that affects the student's mental health and wellbeing. This treatment service differs from counselling, where the focus is to assist students in finding and providing solutions to their issues.

Psychotherapy Reference Steps:

1) Social Worker will review informed consent with student
2) Social Worker will conduct a comprehensive assessment during session
3) Social Worker generates case formulation based on the information given by the student
3) Social Worker and student will create goals based on their needs and which will be used to inform treatment planning
4) Treatment is implemented, adapted to student's evolving needs and will be revisited if adjustments need to be made

Frequently Asked Questions Regarding Psychotherapy

How long is therapy?
Social Worker and student will create goals together, the length of the therapeutic intervention is based on the progress of goal attainment.

What is the difference between psychotherapy and counselling?
Psychotherapy and Counselling have been used interchangeably. To clarify the difference, Psychotherapy is a controlled act and regulated profession that enables practitioners to assess for mental health disorders, create interventions and treat mental health conditions such as bi-polar, depression and other conditions (OCSWSSW, 2017). Psychotherapists use diverse treatment approaches, such as CBT, DBT, Somatic Therapy, and/or Motivational Interviewing to support clients to achieve their goals. Psychotherapists can address social issues and use a broader lens to help treat clients suffering from mental health disorders. Counsellors, on the other hand, tend to be focused on providing wellness techniques, advising clients and guiding them through their struggles.

What can psychotherapy help with?
Psychotherapy can help with treating mental health disorders, suicide ideation, trauma and other clinical conditions. Psychotherapy does not treat students with neurodevelopmental disorders like Tourette Syndrome, Down Syndrome, Motor Disorders, or Intellectual Disorders.

How do I know if treatment is working if the student is still academically struggling?
Psychotherapy focuses solely on the mental health of students. If the student is struggling academically, a student success meeting may need to be scheduled.

How can a staff member support students who are receiving Social Work services?
First, if a student is being identified with mental health concerns that are affecting their ability to function in the classroom, please refer student to Social Work Services.
Students who are receiving SW services all have different lived experiences and their individual needs are unique.

ALCDSB has collaborated with a trauma psychologist to incorporate trauma-informed practices into the classroom. Here are some tips how to provide support: be available to students, check in, use empathy and refrain from judging students who may be facing adversity. As well, connect with the Youth Worker to suggest implementation of regulation strategies in the classroom.

Mandatory Supervision & Professional Development

Clinical supervisors are experienced clinicians that provide insight to cases, evaluation of the intervention being utilized and guidance on how to move forward with the client. This also allows Social Workers to think critically, gain opportunities to self-reflect and learn new skills. OSWSSW mandates that all Social Workers should have access to ongoing clinical supervision. Supervision can either be individual or in small group. Social Workers who are new to the role should receive adequate supervision and meet frequently with the clinical supervisor. Failure to provide supervision where Social Workers are currently practicing, could result in a charge of professional misconduct under ***Professional Misconduct Regulation, O. Reg. 384/00 of the Social Work and Social Service Work Act, 1998, where it defines those who "fail to supervise adequately a person who is under the professional responsibility of the member and who is providing a social work service or a social service work service"(OCSWSSW, 2018).***

As part of OSWSSW competencies and to maintain in good standing with the college (**Reg. 383/00)**, Social Workers must engage in professional development. When providing services to students, Social Workers should be aware of their limitations and refer to another professional when needed, especially those who specialize in an area of expertise (i.e., psychiatry). Social Workers can familiarize themselves with the disorder, seek additional supervision and search for information that will help provide accurate treatment. Social Workers should be continuously provided with professional development opportunities.

Frequently used forms:

- Record of Social Work Services
- Social Work Service and Treatment Plan
- -Informed Consent-Virtual Platform
- Consent for in-person, text, email communications with clients
- Consent to release confidential information (third party)
- Confirmation of report form
- Secondary School Safety Plan
- Social Worker Referral Form
- Mental Health and Addictions Referral Form

References

Canadian Association of Social Workers (CASW) (2005). Guidelines for ethical practice. Ottawa, ON: CASW. Retrieved from https://www.casw-acts.ca/sites/default/files/attachements/casw_guidelines_for_ethical_practice.pdf

Ontario College of Social Workers and Social Service Workers (2017). Guidelines for Social Work and Social Service Work Members of the Ontario College of Social Workers and Social Service Workers. Retrieved from https://www.ocswssw.org/wp-content/uploads/PG_Performing_Controlled_Act_Psychotherapy_Feb2018.pdf

Ontario College of Social Workers and Social Service Workers (2018). Guide to the Personal Health Information Protection Act, 2004 (PHIPA). Retrieved from https://www.ocswssw.org/wp-content/uploads/OCSWSSW-PHIPA-Toolkit-ENG_FINAL-3.pdf

Appendices

- **Practice Guidelines for Performing the Controlled Act of Psychotherapy**
- **Privacy Toolkit for Social Workers and Social Service Workers**
- **Ontario College of Social Worker and Social Service Workers: Code of Ethics**

Ontario College of Social Workers and Social Service Workers

Ordre des travailleurs sociaux et des techniciens en travail social de l'Ontario

PROFESSIONAL • ETHICAL • QUALIFIED • ACCOUNTABLE

Code of Ethics and Standards of Practice Handbook

Second Edition – 2008

Includes amendments to the Standards of Practice, effective October 1, 2010, February 13, 2011, May 6, 2015, January 1, 2018 and September 7, 2018.

CODE OF ETHICS

The Ontario College of Social Workers and Social Service Workers regulates two professions, social workers and social service workers. The following sets out the Code of Ethics for members of the College:

1) A social worker or social service worker shall maintain the best interest of the client as the primary professional obligation;

2) A social worker or social service worker shall respect the intrinsic worth of the persons she or he serves in her or his professional relationships with them;

3) A social worker or social service worker shall carry out her or his professional duties and obligations with integrity and objectivity;

4) A social worker or social service worker shall have and maintain competence in the provision of a social work or social service work service to the client;

5) A social worker or social service worker shall not exploit the relationship with a client for personal benefit, gain or gratification;

6) A social worker or social service worker shall protect the confidentiality of all professionally acquired information. He or she shall disclose such information only when required or allowed by law to do so, or when clients have consented to disclosure;

7) A social worker or social service worker who engages in another profession, occupation, affiliation or calling shall not allow these outside interests to affect the social work or social service work relationship with the client;

8) A social worker or social service worker shall not provide social work or social service work services in a manner that discredits the profession of social work or social service work or diminishes the public's trust in either profession;

9) A social worker or social service worker shall advocate for workplace conditions and policies that are consistent with this Code of Ethics and the Standards of Practice of the Ontario College of Social Workers and Social Service Workers;

10) A social worker or a social service worker shall promote excellence in his or her respective profession;

11) A social worker or social service worker shall advocate change in the best interest of the client, and for the overall benefit of society, the environment and the global community.

The 1983 and the 1994 Canadian Association of Social Workers (CASW) Codes of Ethics have been used with the permission of CASW. The Social Work Code of Ethics (1994) adopted by the CASW Board of Directors is effective January 1, 1994 and replaces the CASW Code of Ethics (1983).

Table of Contents

EXPLANATORY NOTE

The purpose of the Standards of Practice is to provide assistance to members of the Ontario College of Social Workers and Social Service Workers and to promote excellence in their practice. The *Standards of Practice Handbook* sets out minimum standards of professional practice and conduct. This is in accordance with one of the objects of the College as stated in the *Social Work and Social Service Work Act, 1998* "to establish and enforce professional standards and ethical standards applicable to members of the College." For the purposes of the Act (Section 26), and the Professional Misconduct Regulation (Ontario Regulation 384/00), these standards have been approved in a by-law of the College as standards of practice for its members. The Standards of Practice are meant to be applied to members' practice in conjunction with any applicable legislation and with their professional judgement.

The *Standards of Practice Handbook* applies to the breadth and scope of social work practice and social service work practice. It is recognized that throughout the scope of practice for each profession, there are variations in approaches and that members vary their methods in response to the demands of a particular situation. The Principles and Interpretations contained within the *Standards of Practice Handbook* prescribe the basis on which professional practice is conducted in a sound and ethical manner.

Meaning of Client

Social workers and social service workers provide services to a wide spectrum of clients or client systems. In the broad sense, the term "client" refers to any person or body that is the recipient of social work or social service work services. In defining the client or client system a member could ask the question: "To whom do I have an obligation in respect to the services I am providing?" The term client refers to an individual, a family, group, community, organization or government. In research, the client may be a participant and in education, the client may include students.[1]

Types of Practice

Social workers and social service workers also provide a wide range of services that encompass direct and indirect practice and clinical and non-clinical interventions. Direct practice refers to professional activities on behalf of clients in which goals are reached through personal contact and immediate influence with those seeking services. Indirect practice refers to professional activities that do not involve immediate or personal contact with the client being served.[2] For social workers, clinical practice refers to the professional application of social work theory and methods to the treatment and prevention of psychosocial dysfunction, disability or impairment, including but not limited to emotional and mental disorders.[3] For social service workers, clinical practice refers to the professional application of social service work theory and methods to the treatment and prevention of social dysfunction, disability or impairment, including but not limited to emotional or mental disorders.

It is important to note that the contexts of practice may overlap. For example, a member may provide counselling (direct-clinical), information and referral (indirect-clinical) to the same client. A member may

provide social support to clients in a social-recreational group (direct-non-clinical) or may administer a human service program (indirect-non-clinical).

The *Standards of Practice Handbook* contains eight Principles. For each Principle, Interpretations are provided as standards that guide College members. All the standards apply to direct, indirect, clinical and non-clinical practice, unless otherwise stated in a particular standard. In the application of these Principles to their own practice situations, it is suggested that College members read and consider all eight Principles together as a whole. The Handbook is intended to expand upon the *Ontario College of Social Workers and Social Service Workers Code of Ethics* and provides standards to guide and assess the professional behaviour of College members and to adjudicate issues of professional practice.

This, the second edition of the *Standards of Practice Handbook*, reflects the ongoing nature of addressing not only complex issues, but the continuing evolution of social work and social service work practice. The College appreciates feedback from members with respect to the application of these standards. Comments may be brought to the attention of the Registrar of the College.

FOOTNOTES

[1]Adapted from the College of Nurses of Ontario glossary

[2] From the *Social Work Dictionary* 4th edition by Robert L. Barker, NASW Press

[3] From the *Social Work Dictionary* 4th edition by Robert L. Barker, NASW Press

ACKNOWLEDGEMENTS

This *Standards of Practice Handbook* is based on the *Professional Practice and Conduct Handbook* (3rd Edition,1998) published by the Ontario College of Certified Social Workers. The Ontario College of Social Workers and Social Service Workers (OCSWSSW) would like to thank the Ontario College of Certified Social Workers for granting its permission to use the *Professional Practice and Conduct Handbook* as the basis for this *Standards of Practice Handbook*. The OCSWSSW would also like to acknowledge the report by David Sernick entitled "Recommendations to the Transitional Council of the College of Social Workers and Social Service Workers (December 1999)" prepared on behalf of the Association of Social Service Work Educators of Ontario and funded by the Academic Vice Presidents of Colleges of Applied Arts and Technology in Ontario.

Beginning in 2002 the Standards of Practice Committee undertook a multi-phase consultation process to review the standards of practice. The OCSWSSW thanks the many members and stakeholders who took part in the various phases of the consultation, as well as Anne Westhues and David Sernick for their conceptualization of social work and social service work practice and their efforts to ensure the applicability of the standards of practice to the breadth of social work and social service work practice. Finally, the College thanks the members of the Standards of Practice Committee for their diligence and hard work.

Rachel Birnbaum Ph.D., RSW
President

This *Standards of Practice Handbook* applies to the profession of social work and the profession of social service work.

SCOPE OF PRACTICE FOR SOCIAL WORK

The scope of practice of the profession of social work means the assessment, diagnosis, treatment and evaluation of individual, interpersonal and societal problems through the use of social work knowledge, skills, interventions and strategies, to assist individuals, dyads, families, groups, organizations and communities to achieve optimum psychosocial and social functioning and includes, without limiting the generality of the foregoing, the following:

SW1 – The provision of assessment, diagnostic, treatment and evaluation services within a relationship between a social worker and a client;

SW2 – The provision of supervision and/or consultation to a social worker, social work student or other supervisee;

SW3 – The provision of social support to individuals and/or groups including relationship building, life skills instruction, employment support, tangible support including food and financial assistance, and information and referral services;

SW4 – The provision of educational services to social work and social service work students;

SW5 – The development, promotion, management, administration, delivery and evaluation of human service programs, including that done in collaboration with other professionals;

SW6 – The provision of services in organizing and/or mobilizing community members and/or other professionals in the promotion of social change;

SW7 – The provision of contractual consultation services to other social workers or professionals or organizations;

SW8 – The development, promotion, implementation and evaluation of social policies aimed at improving social conditions and equality;

SW9 – The conduct of research regarding the practice of social work, as defined in paragraphs (1) to (8) above; and

SW10 – Any other activities approved by the College.

SCOPE OF PRACTICE FOR SOCIAL SERVICE WORK

The scope of practice of the profession of social service work means the assessment, treatment, and evaluation of individual, interpersonal and societal problems through the use of social service work knowledge, skills, interventions and strategies, to assist individuals, dyads, families, groups, organizations and communities to achieve optimum social functioning and includes, without limiting the generality of the foregoing, the following:

SSW1 – The provision of assessment, treatment and evaluation services within a relationship between a social service worker and a client;

SSW2 – The provision of supervision and/or consultation to a social service worker or social service work student or other supervisee;

SSW3 – The provision of social support to individuals and/or groups including relationship-building, life skills instruction, employment support, tangible support including food and financial assistance, and information and referral services;

SSW4 – The provision of educational services to social service worker students;

SSW5 – The development, promotion, management, administration, delivery and evaluation of human service programs, including that done in collaboration with other professionals;

SSW6 – The provision of services in organizing and/or mobilizing community members and/or other professionals in the promotion of social change;

SSW7 – The provision of contractual consultation services to other social service workers, or professionals; or organizations;

SSW8 – The development, promotion, implementation and evaluation of social policies aimed at improving social conditions and equality;

SSW9 – The conduct of research regarding the practice of social service work, as defined in paragraphs (1) to (8) above; and

SSW10 – Any other activities approved by the College.

The Principles and Interpretations set out in the *Standards of Practice Handbook* are to be applied in the context of the scope of practice of each profession.

PRINCIPLE I:

RELATIONSHIP WITH CLIENTS

The social work relationship and the social service work relationship, as a component of professional service, are each a mutual endeavour between active participants in providing and using social work or social service work expertise, as the case may be. Clients and College members jointly address relevant social, organizational, and/or personal problems of concern to clients. The foundation of this professional orientation is the belief that clients have the right and capacity to determine and achieve their goals and objectives. The social work relationship and the social service work relationship are each grounded in and draw upon theories of the social sciences and social work or social service work practice, as the case may be.

Interpretation

Clients and client systems with whom College members are involved include individuals, couples, families, groups, communities, organizations and government. The following fundamental practice principles arise from basic professional values. College members adhere to these principles in their relationships with clients.

1.1 College members and clients participate together in setting and evaluating goals. A purpose for the relationship between College members and clients is identified.

1.1.1 Goals for relationships between College members and clients include the enhancement of a client's functioning and the strengthening of the capacity of clients to adapt and make changes.

1.2 College members observe, clarify and inquire about information presented to them by clients.

1.3 College members respect and facilitate self-determination in a number of ways including acting as resources for clients and encouraging them to decide which problems they want to address as well as how to address them.[1]

1.4 Although not compelled to accept clients' interpretation of problems, College members demonstrate acceptance of each client's uniqueness.

1.5 College members are aware of their values, attitudes and needs and how these impact on their professional relationships with clients.

1.6 College members distinguish their needs and interests from those of their clients to ensure that, within professional relationships, clients' needs and interests remain paramount.

1.7 College members employed by organizations maintain an awareness and consideration of the purpose, mandate and function of those organizations and how these impact on and limit professional relationships with clients.

FOOTNOTES

1. Limitations to self-determination may arise from the client's incapacity for positive and constructive decision-making, from law, from the order of any court of competent jurisdiction and from agency mandate and function.

PRINCIPLE II:

COMPETENCE AND INTEGRITY

College members maintain competence and integrity in their practice and adhere to the College standards in the *Ontario College of Social Workers and Social Service Workers Code of Ethics*, the *Standards of Practice Handbook* and the College's by-laws.

Interpretation

2.1 Competence

College members are committed to ongoing professional development and maintaining competence in their practice.

2.1.1 College members are responsible for being aware of the extent and parameters of their competence and their professional scope of practice and limit their practice accordingly.[1] When a client's needs fall outside the College member's usual area of practice, the member informs the client of the option to be referred to another professional. If, however, the client wishes to continue the professional relationship with the College member and have the member provide the service, the member may do so provided that:

(i) he or she ensures that the services he or she provides are competently provided by seeking additional supervision, consultation and/or education and
(ii) the services are not beyond the member's professional scope of practice.

Recommendations for particular services, referrals to other professionals or a continuation of the professional relationship are guided by the client's interests as well as the College member's judgement and knowledge.

2.1.2 College members remain current with emerging social work or social service work knowledge and practice relevant to their areas of professional practice. Members demonstrate their commitment to ongoing professional development by engaging in any continuing education and complying with continuing competence measures required by the College.

2.1.3 College members maintain current knowledge of policies, legislation, programs and issues related to the community, its institutions and services in their areas of practice.

2.1.4 College members ensure that any professional recommendations or opinions they provide are appropriately substantiated by evidence and supported by a credible body of

professional social work knowledge or a credible body of professional social service work knowledge. [2, 3]

2.1.5 As part of maintaining competence and acquiring skills in social work or social service work practice, College members engage in the process of self-review and evaluation of their practice and seek consultation when appropriate.

2.2 Integrity

College members are in a position of power and responsibility to all clients.[4] This necessitates that care be taken to ensure that these clients are protected from the abuse of such power during and after the provision of professional services.

College members establish and maintain clear and appropriate boundaries in professional relationships for the protection of clients. Boundary violations include sexual misconduct and other misuse and abuse of the member's power. Non-sexual boundary violations may include emotional, physical, social and financial violations. Members are responsible for ensuring that appropriate boundaries are maintained in all aspects of professional relationships.

2.2.1 College members do not engage in professional relationships that constitute a conflict of interest or in situations in which members ought reasonably to have known that the client would be at risk in any way. College members do not provide a professional service to the client while the member is in a conflict of interest.[5] College members achieve this by:

(i) evaluating professional relationships and other situations involving clients or former clients for potential conflicts of interest and seeking consultation to assist in identifying and dealing with such potential conflicts of interest;

(ii) avoiding conflicts of interest and/or dual relationships with clients or former clients, or with students, employees and supervisees, that could impair members' professional judgement or increase the risk of exploitation or harm to clients[6, 7]; and

(iii) if a conflict of interest situation does arise, declaring the conflict of interest and taking appropriate steps to address it and to eliminate the conflict.

2.2.2 College members do not have sexual relations with clients (See Principle VIII: Sexual Misconduct, especially Interpretations 8.6, 8.7 and 8.8 and footnote 1 thereto.) In other professional relationships, College members do not have sexual relations with any person where these relations, combined with the professional relationship, would create a conflict of interest. (See Interpretation 8.9 under Principle VIII: Sexual Misconduct)

2.2.3 College members do not use information obtained in the course of a professional relationship, and do not use their professional position of authority, to coerce, improperly

influence, harass, abuse or exploit a client, former client, student, trainee, employee, colleague or research subject.

2.2.4 College members do not solicit or use information from clients to acquire, either directly or indirectly, advantage or material benefits.

2.2.5 When a complaint investigation is underway or a matter has been referred to the Discipline Committee or the Fitness to Practise Committee for a hearing, College members co-operate fully with all policies and procedures of the Complaints, Discipline and Fitness to Practise Committees, and conduct themselves in a manner which demonstrates respect for both the complainant and the College.[8]

2.2.6 College members do not engage in the practice of social work or social service work,

i) while under the influence of any substance, or

ii) while suffering from illness or dysfunction,

which the member knows or ought reasonably to know impairs the member's ability to practise.

2.2.7 College members do not misrepresent professional qualifications, education, experience or affiliation. (See also Principle VI: Fees and Principle VII: Advertising)

2.2.8 In the practice of social work or social service work, College members avoid conduct which could reasonably be perceived as reflecting negatively on the professions of social work or social service work.

2.2.9 College members promote social justice and advocate for social change on behalf of their clients. College members are knowledgeable and sensitive to cultural and ethnic diversity and to forms of social injustice such as poverty, discrimination and imbalances of power that exist in the culture and that affect clients. College members strive to enhance the capacity of clients to address their own needs. College members assist clients to access necessary information, services and resources wherever possible. College members promote and facilitate client participation in decision making.[9]

2.2.10 If there is a conflict between College standards of practice and a College member's work environment, the College member's obligation is to the "Ontario College of Social Workers and Social Service Workers Code of Ethics" and the "Standards of Practice Handbook."[10]

FOOTNOTES

1. The scope of practice statements describe the professions' scope of practice, but do not exclusively limit the performance of the activities described therein to social workers and social service workers. Such statements provide three types of information – what the profession does, the methods the profession uses, and the purpose for which the profession does it. There is a scope of practice statement for social work and a scope of practice statement for social service work set out in the *Standards of Practice Handbook*. Note that the scope of practice differs from a job description, in which an employer defines the parameters of the various roles and duties to be performed by social workers and social service workers they hire. An employer is not obligated to allow a social worker or social service worker to perform all of the activities described in the scope of practice statement. Additionally, an employer may require a social worker or social service worker to perform activities that are not described in their scope of practice provided that the College member is permitted by law to perform those activities and the College member is competent to do so.

2. "Evidence" refers to information tending to establish facts. For College members, evidence can include, but is not limited to: direct observation; information collected in clinical sessions; information collected in professional meetings; collateral information; information from documents; and information gathered from the use of clinical tools (e.g. diagnostic assessment measures, rating scales).

3. Each of the phrases "body of professional social work knowledge" and "body of professional social service work knowledge" relates to both theoretical and practical understanding. A body of knowledge can be attained through education, professional experience, consultation and supervision, professional development and a review of relevant research and literature. Professional social work knowledge and professional social service work knowledge draw upon the knowledge base of other professions including sociology, psychology, anthropology, medicine, law and economics as well as their own respective distinct bodies of knowledge.

4. See the discussion of the term "client" in the Introductory Note to the Standards of Practice. While portions of Principle II refer separately to clients, students, employees and supervisees, the term "client" refers to any person or body that is the recipient of social work or social service work services, and may include students, employees and supervisees.

5. See, also, Principle VIII: Sexual Misconduct, Interpretation 8.5.

6. "Conflict of Interest" is defined as a situation in which a member has a personal, financial or other professional interest or obligation which gives rise to a reasonable apprehension that the interest or obligation may influence the member in the exercise of his or her professional responsibilities. Actual influence is not required in order for a conflict of interest situation to exist. It is sufficient if there is a reasonable apprehension that there may be such influence.

   One of the hallmarks of a conflict of interest situation is that a reasonable person, informed of all of the circumstances, would have a reasonable apprehension (in the sense of reasonable expectation or concern) that the interest might influence the member. The influence need not be actual but may simply be perceived. However, a mere possibility or suspicion of influence is not sufficient to give rise to a conflict of interest. The interest must be significant enough to give rise to a "reasonable apprehension" that the personal, financial or other professional interest may influence the member in the performance of his or her professional responsibilities.

7. "Dual Relationship" is defined as a situation in which a College member, in addition to his/her professional relationship, has one or more other relationships with the client, regardless of whether this occurs prior to,

during, or following the provision of professional services. A dual relationship does not necessarily constitute a conflict of interest; however, where dual relationships exist, there is a strong potential for conflict of interest and there may be an actual or perceived conflict of interest. Relationships beyond the professional one include, but are not limited to, those in which the College member receives a service from the client, the College member has a personal, familial or business relationship with the client, or the College member provides therapy to students, employees or supervisees. Members embark on an evaluation of whether a dual relationship might impair professional judgment or increase the risk of exploitation or harm to clients.

8. College members are cognizant of their influential position with respect to witnesses or complainants in complaint, discipline and fitness to practise proceedings.

9. Where the client is competent and able to give instruction, advocacy should be on direction of the client.

10. A social worker or social service worker shall advocate for workplace conditions and policies that are consistent with the *Code of Ethics and Standards of Practice of the Ontario College of Social Workers and Social Service Workers*. A social worker or social service worker will use professional judgement in determining how to advocate. Such advocacy may take the form of documenting concerns and discussing them with a supervisor or manager, or other key person in the organization.

PRINCIPLE III:

RESPONSIBILITY TO CLIENTS

College members ensure that professional services are provided responsibly to those persons, groups, communities or organizations seeking their assistance.

Interpretation

3.1 College members provide clients with accurate and complete information regarding the extent, nature, and limitations of any services available to them. (See also Principle VII: Advertising.)

3.2 College members deliver client services and respond to client queries, concerns, and/or complaints in a timely and reasonable manner.

3.3 College members do not solicit their employers' clients for private practice.[1,2]

3.4 College members do not discriminate against anyone based on race, ethnicity, language, religion, marital status, gender, sexual orientation, age, disability, economic status, political affiliation or national origin.[3]

3.5 College members assist potential clients to obtain other services if members are unable or unwilling, for appropriate reasons, to provide the requested professional help.[4,5]

3.6 College members inform clients of foreseeable risks as well as rights, opportunities, and obligations associated with the provision of professional services.

3.7 In a situation where a personal relationship does occur between the member and a client or former client, it is the member, not the client or former client, who assumes full responsibility for demonstrating that the client or former client has not been exploited, coerced or manipulated, intentionally or unintentionally.

3.8 College members may provide services and/or products so long as the provision of these services and/or products are relevant and conform to College standards. College members do not provide a service and/or product that the member knows or ought reasonably to know is not likely to benefit the client.

3.9 College members terminate professional services to clients when such services are no longer required or requested. It is professional misconduct to discontinue professional services that are needed unless:

i) the client requests the discontinuation,

ii) the client withdraws from the service,

iii) reasonable efforts are made to arrange alternative or replacement services,

iv) the client is given a reasonable opportunity to arrange alternative or replacement services, or

v) continuing to provide the services would place the member at serious risk of harm,

and in the circumstances described in subparagraph i, ii, iii, or iv, the member makes reasonable efforts to hold a termination session with the client.

3.10 College members who anticipate the termination or interruption of service to clients notify clients promptly and arrange the termination, transfer, referral, or continuation of service in accordance with clients' needs and preferences.

3.11 Where appropriate, College members advocate for and/or with clients and inform clients of any action taken and its outcome. Members adhere to Principle V: Confidentiality of this *Standards of Practice Handbook* when providing advocacy services.[6]

3.12 Members may provide appropriate services as a courtesy without remuneration, so long as these services adhere to College standards and do not constitute a conflict of interest.

FOOTNOTES

1. The term employer also includes a person or organization with whom the member has an independent service contract.

2. College members may accept referrals from their employers.

3. College members adhere to the Ontario *Human Rights Code* and the *Charter of Rights and Freedoms* in the provision of services.

4. Appropriate reasons for refusing to provide service include but are not limited to:

   i) complying with the potential client's request for service would require the member to violate ethical and legal requirements including, but not limited to: *the Ontario College of Social Workers and Social Service Workers Code of Ethics*; the *Standards of Practice Handbook*; the *Criminal Code of Canada*; the *Ontario Human Rights Code*, and the *Charter of Rights and Freedoms*;

   ii) complying with the potential client's request would violate the member's values, beliefs and traditions to the extent that the member would not be able to provide appropriate professional service;

   iii) the member is aware of extenuating circumstances (e.g. a planned absence from the office, serious health problems, relocation of practice, etc.) that would make compliance with the potential client's request for service impossible and/or not in the potential client's best interests;

iv) the potential client is unable or unwilling to reimburse the member or the member's employer for services rendered, wherever such reimbursement is both appropriate and required as a condition of providing service;

v) the potential client has repeatedly, and without adequate explanation, cancelled or changed the interview or meeting time to the extent that the member experiences or believes that financial hardship and/or service disruption will occur; and

vi) the potential client behaves in a threatening or abusive manner such that the member believes that the safety of the member or anyone with whom the member has a personal or professional relationship would be in jeopardy.

5 When a client is refused further service, the client should be provided with an explanation.

6. "Advocacy" is defined as, "The act of directly representing or defending others; in social work, championing the rights of individuals or communities through direct intervention or through empowerment. According to the *NASW Code of Ethics*, it is a basic obligation to the profession and its members." The *Social Work Dictionary* 2nd edition, Robert L. Barker, 1991. This definition applies equally to social service work.

PRINCIPLE IV:

THE SOCIAL WORK AND SOCIAL SERVICE WORK RECORD

The creation and maintenance of records by social workers and social service workers is an essential component of professional practice. The process of preparation and organization of material for the record provides a means to understanding the client and planning the social work and social service work intervention. The purpose of the social work and social service work record is to document services in a recognizable form in order to ensure the continuity and quality of service, to establish accountability for and evidence of the services rendered, to enable the evaluation of service quality, and to provide information to be used for research and education. College members ensure that records are current, accurate, contain relevant information about clients and are managed in a manner that protects client privacy and in accordance with any applicable privacy and other legislation. [1, 2]

Interpretation

4.1 Record Content and Format

4.1.1 Recorded information conforms with accepted service or intervention standards and protocols within the profession of social work and social service work, relevant to the services provided, and is in a format that facilitates the monitoring and evaluation of the effects of the service/intervention.[3]

4.1.2 College members do not make a statement in the record, or in reports based on the record, or issue or sign a certificate, report or other document in the course of practising either profession that the member knows or ought reasonably to know is false, misleading, inaccurate or otherwise improper.

4.1.3 College members keep systematic, dated, and legible records for each client or client system served.

4.1.4 The record reflects the service provided and the identity of the service provider. Members use the designation “RSW”, or one of the titles “Social Worker” or “Registered Social Worker”, in the case of a social worker, or the designation “RSSW”, or one of the titles “Social Service Worker” or “Registered Social Service Worker”, in the case of a social service worker, and comply with any requirements set out in any applicable legislation, in documentation used in connection with their practice of social work or social service work, as the case may be.[3.1]

4.1.5 College members document their own actions. College members do not sign records or reports authored by any other person, except in accordance with Interpretation 4.1.5.1 or 4.1.5.2.

4.1.5.1 A College member may sign a record or report authored by another person where the College member co-signs that record or report, together with the author,

(i) in the College member's capacity as a supervisor of the author of the record or report; or

(ii) in the College member's capacity as an authorized signing officer of a professional corporation, where the author of the record or report is an employee, shareholder, officer or director of that professional corporation; or

(iii) in College member's capacity as a member of a multi-disciplinary team that participated in providing the observations and recommendations contained in the record or report, where the author of the record or report is also a member of that multi-disciplinary team.

4.1.5.2 A College member may sign a record or report authored by another person where the author is unable to sign the record or report due to illness, disability, absence or other good cause, provided that:

(i) the content of the record or report is within the member's scope of practice;

(ii) the author expressly authorizes the member to sign the record or report on the author's behalf or, if such authorization is not reasonably available, the member takes steps to ensure the currency and accuracy of the information and recommendations contained in the record or report; [4] and

(iii) the member clearly indicates the capacity in which he or she is signing the record or report.[5]

4.1.6 Information is recorded when the event occurs or as soon as possible thereafter.

4.1.7 College members may use documentation by exception system provided that the system permits the total record to capture the minimum content as set out in Footnote 3.

4.2 Record Maintenance

4.2.1 College members comply with the requirements regarding record retention, storage, preservation and security set out in any applicable privacy and other legislation. College members employed by an organization acquire and maintain a thorough understanding of the organization's policies with regard to the retention, storage, preservation and security of records. Self-employed College members and College members who are responsible for complying with privacy legislation establish clear policies relating to record retention, storage, preservation and security.[6]

4.2.2 College members take necessary steps to protect the confidentiality and security of paper records, faxes, electronic records and other communications.[7]

4.2.3 College members ensure that each client record is stored and preserved in a secure location for at least seven years from the date of the last entry or, if the client was less than eighteen years of age at the date of the last entry, at least seven years from the day the client became or would have become eighteen. Different periods of storage time may be required by law. Longer periods of storage time may be defined by the policies of a member's employing organization or by the policies of a self-employed member or a member who is responsible for complying with privacy legislation.[8] Such policies should be developed with a view to the potential future need for the record.[9]

4.2.4 Self-employed College members, and College members who are responsible for complying with privacy legislation[10], who cease practice may (i) maintain their client records in accordance with Interpretation 4.2.3, or (ii) make arrangements to transfer the records to another College member or other regulated professional who first agrees in writing to comply with Principle IV and the Interpretations set out in Principle IV and make reasonable efforts to give notice to their clients of the future location of their records, unless they are required, under any applicable privacy or other legislation, to obtain their clients' consent to such transfer, in which case they obtain their clients' consent. College members comply with the requirements regarding transfer of records set out in any applicable privacy and other legislation. The College member to whom such records have been transferred complies with the principles regarding retention, storage, preservation and security with respect to the transferred records.

4.2.5 Client records may be destroyed following the time frames outlined in Interpretation 4.2.3. College members dispose of record contents in such a way that ensures that the confidentiality of the information is not compromised.

4.3 Access and Correction of a Record

4.3.1 College members comply with the requirements regarding access to and correction of client information including personal information in a record as set out in applicable privacy and other legislation.[11] College members employed by an organization acquire and maintain an understanding of the organization's policies regarding access to and correction of information in a record. Such policies pertain to access requests by the clients themselves. Self-employed College members and College members who are responsible for complying with privacy legislation[12] establish clear policies regarding access to and correction of information in a record.

4.3.2 College members inform clients of their policies regarding access to and correction of information in a record.

4.3.3 A College member provides the client or his or her authorized representative with access to the client's information contained in the record in accordance with any applicable privacy and other legislation, unless prohibited by law or the member is otherwise permitted to refuse access.[13] In the absence of any applicable legislation, a College member provides the client or his or her authorized representative with reasonable, supervised access to the client's record or such part or parts of the record as is reasonable in the circumstances. The client has the right to receive appropriate explanations by the College member of the information about the client in the record.

4.3.4 Where a member is prohibited by law from providing access to information in a record or is otherwise permitted to refuse access to information in a record, the College member complies with the requirements regarding a refusal to provide access set out in applicable privacy and other legislation. In the absence of any applicable legislation, the College member informs the client of the reason for refusal of access and of the recourse available to the client if he or she disagrees. When the record includes information that pertains to more than one client, and providing access to a record could therefore mean disclosing information about another person, a College member provides access to information that pertains only to the individual who has requested access unless the other person(s) has consented to the disclosure of information about the person.

4.3.5 College members preserve the integrity of client records. If a client disagrees with the accuracy or completeness of information in a record and wishes the record amended, the member shall comply with the requirements of any applicable privacy and other legislation with respect to the correction of the record. In the absence of any applicable legislation, if a client disagrees with the accuracy or completeness of a record and wishes the record amended, the member may incorporate into the record a signed statement by the client specifying the disagreement and the client's correction. The member shall not obliterate any incorrect information in the record.

4.4 Disclosure of Information from a Record

4.4.1 College members inform clients early in their relationship of any limits of client confidentiality including with respect to the client record. When clients or their authorized representatives consent in writing, College members disclose information from the record to third parties within a reasonable time. The consent must specify, (i) the information that is to be disclosed, for example a partial record, the entire record, or a summary of the member's contact with the client, (ii) the party or parties to whom the information is to be disclosed and (iii) the term of validity of the consent. If, in the member's professional judgement, disclosure of information from the record to a third party could result in harm to the client, College members make a reasonable effort to inform the client of the possible consequences and seek to clarify the client's consent to such disclosure. Members may disclose information from the record to third parties without the client's consent only if disclosure is required or allowed by law. (See also Interpretations 5.3.5 and 5.3.6)

4.4.2 When College members receive a request from a third party to disclose information from a record that pertains to more than one client, for example a couple, family, group, community agency, government department, or other organization/business, College members obtain consent to the disclosure of information from all of the clients before information from such record is disclosed to the third party. When College members receive a request from a client to disclose information from a record that pertains to more than one client, College members provide access to information that pertains only to the client who has requested access (see Interpretation 4.3.3) and, before disclosing information that pertains to any other client, obtain consent to the disclosure from each of them.

4.4.3 College members who are served with a formal notice or subpoena to produce client records before a court and who are of the opinion that disclosure would be detrimental to the client, should themselves, or through legal counsel, advocate for non-disclosure to the court.[14]

4.4.4 College members comply with the requirements regarding use or disclosure of information for research or educational purposes set out in any applicable privacy and other legislation. In the absence of any applicable legislation, College members may permit client records to be used for the purpose of research or education, provided that any identifying information has been removed and clients' anonymity is protected.[15] (See also Interpretation 5.6)

4.4.5 A College member or other regulated professional to whom another College member's client records have been transferred, complies with the aforementioned standards regarding access and disclosure with respect to the transferred records.[16]

FOOTNOTES

1. Social work and social service work records include any or all of the following: reports (handwritten, typed, or electronic); progress notes; checklists; correspondence; minutes; process logs; journals or appointment records; films and audio or video tapes. The tools or data used by the College member in developing a professional opinion may be or need not be included in the record. Such tools may be personal notes, memos or messages, test results, sociograms, genograms, etc. Once placed in the record, however, they become an integral part of that record. If they are kept separate from the record, the College member observes the same standards with respect to confidentiality, security and destruction as with the social work and social service work record.

2. An accurate record will:
   - (a) document the client's situation/problem exactly and contain only information that is appropriate and useful to the understanding of the situation and the management of the case;
   - (b) report impartially and objectively the factors relevant to the client's situation. The record clearly distinguishes the College member's observations and opinions from the information reported by the client;
   - (c) be easily understandable, avoiding vague, unclear or obscure language and symbols;
   - (d) identify corrections;
   - (e) be free of prejudice and discriminatory remarks;
   - (f) identify sources of data.

3. Information in the social work and social service work record with respect to each client includes the following:
   - (a) Identifying information regarding the recipient of services (individual, family, couple, group, agency, organization, community);
     Depending on the nature of the services provided, identifying information may include:
     - i) name, address, telephone number of each client(s);
     - ii) date of birth of each client(s);
     - iii) where indicated in risk situations, name, address, and telephone number of a person(s) to be contacted in case of emergency;
     - iv) name, address, telephone number(s) of the main contact person or position, if different from i); and
     - v) sponsors, funders, accountability.
   - (b) The date, initiator, purpose of the social work or social service work referral, where relevant, and, if significant, the setting of the first professional encounter with the client;
   - (c) Where applicable, the key elements of the contract or working agreement, namely: client, contracted services, provider of services, fee, reimbursement schedule, and time period for completion of services;
   - (d) The time period of involvement if not specified in (c);
   - (e) The date of completion/termination, where relevant, and if significantly different from (c), an explanation for the difference;
   - (f) Particulars of the social work or social service work process, as applicable:
     - i) the history obtained by the member;
     - ii) assessment, diagnosis, formulation and plan;
     - iii) treatment and other interventions, e.g. facilitation, advocacy, transfer of skills, development of action plans;
     - iv) outcome or results, mutual review and evaluation;
     - v) referrals made by the member;
     - vi) recommendations; and
     - vii) other services, e.g. verbal and/or written reports/briefs/analyses, research studies and/or their individual components, presentations/speeches/lectures, management related services, stakeholder consultations and professional opinions.
   - (g) Consents, releases or authorizations pertaining to the intervention or the communication of information about the client;
   - (h) Fees and charges administered, if any.

3.1 For example, the *Social Work and Social Service Work Act, 1998* sets out the conditions that must be met in order for a member of the College who holds an earned doctorate in social work, as defined in subsection 47.3(2) of the *Social Work and Social Service Work Act, 1998*, to use the title "doctor", a variation, abbreviation or an equivalent in another language (See also Footnotes 1 and 1.1 of Principle VII)

4. Where the member signs the record or report with the author's express authorization, the member shall sign the author's name (in quotation marks) to the record or report, followed by the member's name, and a statement indicating that the member is signing the record or report on behalf of the author, as follows:
["author's name"] by [member's name], on behalf of [author's name].
Where such express authorization is not reasonably available and the member has therefore taken steps to ensure the currency and accuracy of the information and recommendations contained in the record or report, the member shall sign his or her own name to the record or report.

5. See Footnote 4, above. By signing the report in his or her own name, the member is effectively endorsing the currency and accuracy of the information and recommendations in the record or report. In contrast, by signing the report in the author's name, with the author's express authorization, the member is not endorsing the currency and accuracy of the information and recommendations in the record or report, but is only signing on behalf of the author.

6. See Footnote 3 of Principle V for a discussion of "College members who are responsible for complying with privacy legislation".

7. Client records, whether they are paper files or electronic files such as computer diskettes, are kept in an area that is not accessible to persons who have no legitimate interest in the records, and where the privacy of the records may be secured by lock and key.

When sending faxes that contain client information, the College member ensures that the information is marked confidential and that the information has been received by the people for whom it was intended.

An electronic system containing social work and social service work records has the following security features:

(a) In the event of a shared system, the College member has a private access code or password that provides reasonable protection against unauthorized access;
(b) The system maintains an audit trail that:
  i) records the date and time of each entry of information for each client;
  ii) indicates any changes in the recorded information; and
  iii) preserves the original content of the recorded information when changed or updated;
(c) The system allows for the recovery of files, or otherwise provides reasonable protection against loss of, damage to, and inaccessibility of information;
(d) The system provides for a paper printout of the record.

8. See Footnote 3 of Principle V for a discussion of "College members who are responsible for complying with privacy legislation".

9. Examples of situations in which records may be retained for longer periods include cases such as sexual abuse, accidents involving minors and situations where litigation may be ongoing or may arise in the future.

10. See Footnote 3 of Principle V for a discussion of "College members who are responsible for complying with privacy legislation".

11. Privacy legislation, such as the federal *Personal Information Protection and Electronic Documents Act* and the *Ontario Personal Health Information Protection Act, 2004*, sets out rules respecting the collection, use and disclosure of personal information or personal health information and an individual's right of access to personal information or personal health information about the individual.

12. See Footnote 3 of Principle V for a discussion of "College members who are responsible for complying with privacy legislation".

13. Determining whether a person is a client's authorized representative may depend on the governing legislation and the particular circumstances. For example, under the *Personal Health Information Protection Act, 2004* ("PHIPA") determining whether a person is authorized to exercise powers on someone else's behalf depends on the circumstances: whether the individual is capable and at least sixteen, whether the individual is deceased, whether the individual is mentally incapable of making decisions, whether the individual is a child under the age of sixteen, or whether an Act (provincial or federal) authorizes a person to act on behalf of another person. PHIPA provides rules on who is authorized to exercise powers on someone else's behalf in each of these circumstances.

14. College members comply with any specific requirements for disclosure of a record or other information pursuant to a summons, order, direction or similar requirement that are set out in legislation, such as the *Mental Health Act*, *Long-Term Care Act*, *Child, Youth and Family Services Act* and the *Criminal Code*.

15. 'Identifying information' means information that identifies an individual or for which it is reasonably foreseeable in the circumstances that it could be utilized, either alone or with other information, to identify an individual.

16. Before a College member is permitted to transfer his or her client records to another regulated professional, the regulated professional must first agree in writing to comply with Principle IV and the Interpretations set out in Principle IV. See Interpretation 4.2.4

PRINCIPLE V:

CONFIDENTIALITY

College members respect the privacy of clients by holding in strict confidence all information about clients and by complying with any applicable privacy and other legislation. College members disclose such information only when required or allowed by law to do so or when clients have consented to disclosure.

Interpretation

5.1 College members comply with any applicable privacy and other legislation.[1] College members obtain consent to the collection, use or disclosure of client information including personal information,[2] unless otherwise permitted or required by law.

5.2 College members employed by an organization acquire and maintain a thorough understanding of the organization policies and practices relating to the management of client information, including:

(a) when, how and the purposes for which the organization routinely collects, uses, modifies, discloses, retains or disposes of information;

(b) the administrative, technical and physical safeguards and practices that the organization maintains with respect to the information;

(c) how an individual may obtain access to or request correction of a record of information about the individual; and

(d) how to make a complaint about the organization's compliance with its policies and practices. Self-employed College members and College members who are responsible for complying with privacy legislation[3] establish clear policies and practices relating to the management of client information, including the matters identified in (a), (b), (c) and (d) above, and make information about these policies and practices readily available in accordance with any applicable privacy and other legislation.

5.3 College members shall not disclose information concerning or received from clients, subject to any exceptions contained in the following interpretation.

5.3.1 When College members are employed by an agency or organization, College standards of confidentiality may conflict with the organization's policies and procedures concerning confidentiality. Where there is a conflict, College standards take precedence.[4]

5.3.2 When in a review, investigation or proceeding under the Act in which the professional conduct, competency or capacity of a College member is in issue, the member and, where the member is practising on behalf of a professional corporation, the professional

corporation may disclose such information concerning or received from a client as is reasonably required by the member or the College or, where applicable, the professional corporation, for the purposes of the review, investigation or proceeding, without the client's consent. College members and professional corporations do not divulge more information than is reasonably required.

5.3.3 When disclosure is required or allowed by law or by order of a court, College members do not divulge more information than is required or allowed.

5.3.4 College members wishing to use collection agencies or legal proceedings to collect unpaid fees may disclose, in the context of legal proceedings, only the client's name, the contract for service, statements of accounts and any records related to billing. College members do not divulge more information than is reasonably required. (See also Interpretation 6.1.3.)

5.3.5 When consent to the disclosure of information is required, College members make reasonable efforts to inform clients of the parameters of information to be disclosed and to advise clients of the possible consequences of such disclosure. [5]

5.3.6 College members do not disclose the identity of and/or information about a person who has consulted or retained them unless the person consents. Disclosure without consent is justified if the disclosure is required or allowed by law.[6] (See also Interpretation 4.4.1.)

5.3.7 In clinical practice, College members have clients sign completed consent forms prior to the disclosure of information, where consent is required. A separate consent form is required to cover each authorization for disclosing client information. In urgent circumstances, a verbal consent by the client to the disclosure of information may constitute proper authorization. The member should document that this consent was obtained.

5.3.8 College members make reasonable efforts to ensure that the information disclosed is pertinent and relevant to the professional service for which clients have contracted and take reasonable steps to ensure that the information is accurate, complete and up-to-date as is necessary for the purposes of the disclosure or clearly set out the limitations, if any, on the accuracy, completeness or up-to-date character of the information.

5.4 College members inform clients early in their relationship of the limits of confidentiality of information. In clinical practice, for example, when social work service or social service work service is delivered in the context of supervision or multi-disciplinary professional teams, College members explain to clients the need for sharing pertinent information with supervisors, allied professionals and paraprofessionals, administrative co-workers, social work or social service work students, volunteers and appropriate accreditation bodies. College members respect their clients' right to withhold or withdraw consent to, or place

conditions on, the disclosure of their information.[7] (See also Principle IV: The Social Work and Social Service Work Record.)

5.5 College members in indirect non-clinical practice distinguish between public and private information related to their clients. Public information, as defined below, may be disclosed in the appropriate circumstances.

5.5.1 'Public information' is any information about clients and/or their activities that is readily available to the general public and the disclosure of which could not harm the client. 'Public Information' does not include personal information about an individual. When in doubt, the College member obtains consent from the client or a duly authorized representative before using or disclosing such information.[8]

5.5.2 When working with community groups, government agencies and other organizations, the College member keeps confidential any information about the personal lives, personalities, and personal behaviour of the individuals involved.

5.5.3 The College member also keeps confidential any other sensitive information about such clients, including human resources, financial, managerial, strategic and/or politically sensitive material, the disclosure of which could harm the client.

5.6 College members obtain clients' consent before photographing, audio or video taping or permitting third party observation of clients' activities. [9] College members comply with the requirements regarding use or disclosure of information for research or educational purposes set out in any applicable privacy and other legislation. In the absence of any applicable legislation, where case scenarios are presented for research, educational or publication purposes, client confidentiality is ensured through the alteration and disguise of identifying information. (See also Interpretation 4.4.4.)

5.7 College members may use public information and/or non-identifying information for research, educational and publication purposes.

5.8 College members are aware of the distinction between consultation and supervision as it pertains to sharing client information. In consultation, clients are not identified.

FOOTNOTES

1. Privacy legislation includes the federal *Personal Information Protection and Electronic Documents Act*, the federal *Privacy Act*, the *Personal Health Information Protection Act, 2004*, the *Freedom of Information and Protection of Privacy Act* and the *Municipal Freedom of Information and Protection of Privacy Act*.

2. 'Personal information' means information about an identifiable individual and includes personal health information.

3. College members who are responsible for complying with privacy legislation include College members who are "health care practitioners" (within the meaning of the *Personal Health Information Protection Act, 2004*) and are employed or retained by persons who are not "health information custodians" (within the meaning of *the Personal Health Information Protection Act, 2004*). Examples include social workers or social service workers who provide health care as part of their duties and are employed by children's aid societies, social workers or social service workers who provide health care as part of their duties and are employed by a supportive housing provider and social workers or social service workers who provide health care as part of their duties and are employed by government bodies to provide services in correctional facilities or youth justice facilities.

4. See "Ontario College of Social Workers and Social Service Workers Code of Ethics", "A social worker or social service worker shall maintain the best interest of the client as the primary professional obligation."

5. In clinical practice the College member makes reasonable efforts to inform the client of at least the following:

    a) who wants the information (name, title, employer and address);

    b) why the information is desired;

    c) how the receiving party plans to use the information;

    d) if the receiving party may pass the information on to yet a third party without the client's consent;

    e) exactly what information is to be disclosed;

    f) the repercussions of giving consent or refusing permission for the disclosure;

    g) the expiration date of the consent;

    h) how to revoke the consent.

    For further information, see Steven Shardlow, "The Boundaries of Client-Worker Relationship" in Richard Hugman and David Smith, eds., Ethical Issues in Social Work, (London and New York: Routledge, 1995) p.66.

6. For example, *the Personal Health Information Protection Act, 2004* ("PHIPA") provides a number of circumstances where it is permitted for a person who is a "health information custodian" (within the meaning of PHIPA) to disclose personal health information without consent. These circumstances include disclosure to the College for the purpose of the administration or enforcement of the *Social Work and Social Service Work Act, 1998* and disclosure to the Public Guardian and Trustee or a children's aid society so that they can carry out their statutory functions.

7. College members anticipate circumstances which may limit confidentiality. Clear discussion of these limits and contracting for confidentiality with the team, group or community should be undertaken. Individual clients should be aware, however, that, if their confidentiality is violated by another group member, there may not be legal recourse.

8. For example, in indirect non-clinical practice College members should obtain the client's consent before:

a) publishing reports about their work with the client;

b) referring to their work with the client in their advertising;

c) speaking with media, funders, potential funders and other individuals/groups about the organization, agency or community; and

d) bringing guests, observers, or media to meetings involving the client.

9. Exceptions may be allowed under law, for example, in child abuse investigations.

PRINCIPLE VI:

FEES

When setting or administering fee schedules for services performed, College members inform clients fully about fees, charges and collection procedures.

Interpretation

6.1 College members do not charge or accept any fee which is not fully disclosed.

6.1.1 College members explain in advance or at the commencement of a service the basis of all charges, giving a reasonable estimate of projected fees and disbursements, pointing out any uncertainties involved, so that clients may make informed decisions with regard to using a member's services.[1]

6.1.2 College members discuss and renegotiate the service contract with clients when changes in the fee schedule are anticipated.

6.1.3 College members ensure that fee schedules clearly describe billing procedures, reasonable penalties for missed and cancelled appointments or late payment of fees, the use of collection agencies or legal proceedings to collect unpaid fees and third party fee payments.[2] (See also Interpretation 5.3.4)

6.1.4 College members may reduce, waive or delay collecting fees in situations where there is financial hardship to clients, or they may refer clients to appropriate alternative agencies so that clients are not deprived of professional social work or social service work services.[3,4]

6.1.5 College members do not charge fees on the basis of material or financial benefits accruing to clients as a result of services rendered or fees which are excessive in relation to the service performed.

6.1.6 College members do not accept or give commissions, rebates, fees, other benefits or anything of value for receiving or making a referral of a client to or from another person.

6.1.7 College members seek an agreement, preferably in writing, dealing with the provisions of Interpretations 6.1.1 to 6.1.5 inclusive, at the time of contracting for service with a client.

FOOTNOTES

1. These charges may be based on such factors as the amount of time and effort required and spent, the complexity of the matter and whether a special skill, expertise or service has been required and provided.

2. Interest on late payments should be expressed as an annualized rate.

3. College members who accept barter payments are aware of the potential conflict of interest and taxation issues that this style of payment may create. College members avoid this method of payment if it constitutes a conflict of interest.

4. College members are not expected to reduce their fees unless required to do so by the policy of the agency by whom they are employed. College members may request that the client notify the member immediately if any circumstances arise that may interfere with the normal payment of fees.

PRINCIPLE VII:
ADVERTISING

Advertising is intended to inform and educate the public about available social work and social service work services. College members ensure that advertisements are compatible with the standards and ethics of the social work and social service work professions.

Interpretation

7.1 College members may advertise their services through public statements, announcements, advertising media and promotional activities provided that these:

7.1.1 are not false or misleading, and that any factual information is verifiable;

7.1.2 do not bring the professions or College into disrepute;

7.1.3 do not compare services with other College members;

7.1.4 do not include any endorsements or testimonials;

7.1.5 do not display any affiliation with an organization or association in a manner that falsely implies that organization's sponsorship or certification;

7.1.6 do not claim uniqueness or special advantage unsupported by professional or scientific evidence; and

7.1.7 are in keeping with standards of good taste and discretion.

7.2 College members may advertise fees charged for their services provided that advertised fees clearly relate to proposed services and include disclosure of possible limits, uncertainties or circumstances whereby additional fees may be charged. (See also Principle VI: Fees.)

7.3 College members' education, training, and experience, as well as areas of competence, professional affiliations and services are described in an honest and accurate manner.[1,1.1,1.2,2]

7.3.1 College members may represent themselves as specialists in certain areas of practice only if they can provide evidence of specialized training, extensive experience or education;

7.3.2 College members do not make false, misleading or exaggerated claims of efficacy regarding past or anticipated achievements with respect to clients, scholarly pursuits or contributions to society.

7.3.3 College members correct, whenever possible, false, misleading or inaccurate information and representations made by others concerning College members' qualifications or services.

7.4 College members do not solicit prospective clients in ways that are misleading, that disadvantage fellow members or that discredit the professions of social work or social service work.

FOOTNOTES

1. The following alternatives are acceptable forms for individual vocational designation on business cards, letterhead stationery, forms, business telephone listings, directories, signs and identification of business premises, etc.:

a) College members who are social workers identify themselves by using the designation "RSW", or one of the titles "Social Worker" or "Registered Social Worker", following their names. College members who are social service workers identify themselves by using the designation "RSSW", or one of the titles "Social Service Worker" or "Registered Social Service Worker", following their names. College members may add an optional one line description of the College member's area of limited practice or specialty; or

b) "RSW", "Social Worker" or "Registered Social Worker", in the case of a social worker, or "RSSW", "Social Service Worker" or "Registered Social Service Worker", in the case of a social service worker, following the highest academic degree or diploma;

b.1) where a College member is a member who holds an inactive certificate of registration under the Registration Regulation (Ontario Regulation 383/00), the member must use "inactive" in English or "inactif" in French immediately following "RSW", "Social Worker" or "Registered Social Worker", in the case of a social worker, or "RSSW", "Social Service Worker" or "Registered Social Service Worker", in the case of a social service worker, and the member must not engage in the practice of social work or social service work, as the case may be, in Ontario;

b.2) where a College member is a member who holds a retired certificate of registration under the Registration Regulation (Ontario Regulation 383/00), the member must use "retired" in English or "retraité" in French immediately following "RSW", "Social Worker" or "Registered Social Worker", in the case of a social worker, or "RSSW", "Social Service Worker" or "Registered Social Service Worker", in the case of a social service worker, and the member must not engage in the practice of social work or social service work, as the case may be, in Ontario;

b.3) a College member who is authorized to perform the controlled act of psychotherapy may use the title "psychotherapist", provided that the member must set out his or her full name, immediately followed by at least one of the following, followed in turn by "psychotherapist":

i) Ontario College of Social Workers and Social Service Workers together with RSW, in the case of a social worker, or RSSW, in the case of a social service worker; or

ii) social worker or registered social worker; or

iii) social service worker or registered social service worker.

c) where a College member holds an earned doctorate in social work, as defined in subsection 47.3(2) of the *Social Work and Social Service Work Act, 1998,* the member may use either, but not both, of i) or ii) as follows:

i) the degree in addition to the designation or title in either of clauses a) or b); or

ii) the title "Doctor" or "Dr.", as a prefix, provided that it is followed by the

member's full name, and immediately followed by one of (A), (B) or (C), as follows:

(A) Ontario College of Social Workers and Social Service Workers together with RSW, in the case of a social worker, or RSSW, in the case of a social service worker,
(B) social worker or registered social worker, or
(C) social service worker or registered social service worker; or

c.1) where a College member does not hold an earned doctorate in social work, as defined in subsection 47.3(2) of the *Social Work and Social Service Work Act, 1998,* but does hold a doctoral degree, the member may use either, but not both, of i) or ii) as follows:

i) the degree, in addition to the designation or title in either of clauses a) or b); or
ii) the title "Doctor" or "Dr.", as a prefix, in addition to the designation or title in either of clauses a) or b), provided that the member may not use the title "Doctor", a variation or abbreviation or an equivalent in another language in the course of providing or offering to provide, in Ontario, health care to individuals; or d) where the College member is a consultant or advisor in the public or private sector, the phrase "Consultant in . . ." or "Advisor in . . ." , when contained in professional materials, is used only in connection with such position and as an addition to the designation in either clauses a) or b); and e) where the College member is an employee in the public or private sector, such affiliation with an accurate and appropriate indication of rank, title or nature of function may be displayed on a professional card and used only in connection with such employment in addition to the designation in clauses a) or b).

1.1 A College member who is authorized to perform the controlled act of psychotherapy may use the title "psychotherapist" if the member complies with the conditions set out in section 47.2 of the *Social Work and Social Service Work Act, 1998*.

Members are referred to the College's "Practice Guidelines for Performing the Controlled Act of Psychotherapy". These practice guidelines are intended to, among other things, assist members in identifying what factors they should consider in order to determine if they are competent to perform the controlled act of psychotherapy.

1.2 "Earned doctorate" means a doctoral degree in social work that is,

(a) granted by a post-secondary educational institution authorized in Ontario to grant the degree under an Act of the Assembly, including a person that is authorized to grant the degree pursuant to the consent of the Minister of Training, Colleges and Universities under the *Post-secondary Education Choice and Excellence Act, 2000,*
(b) granted by a post-secondary educational institution in a Canadian province or territory other than Ontario and that is considered by the College to be equivalent to a doctoral degree described in clause (a), or
(c) granted by a post-secondary educational institution located in a country other than Canada that is considered by the College to be equivalent to a doctoral degree described in clause (a). (Subsection 47.3(2) of the *Social Work and Social Service Work Act, 1998*).

Members are referred to the College's "Policy respecting Earned Doctorates in Social Work under subsection 47.3(2) of the *Social Work and Social Service Work Act, 1998".* This Policy describes the criteria that the College uses to determine whether a member holds an earned doctorate in social work, as defined in subsection 47.3(2) of the *Social Work and Social Service Work Act, 1998*.

2. College members practising the profession of social work or social service work through a business, partnership or professional corporation may use one of the following acceptable alternatives as applicable:

   a) a list of the names of the partners, with College members designated as in Footnote 1;
   b) a partnership title containing:
      i) he surnames or full names of two or more actual partners; or
      ii) where there are three or more actual partners, the surnames or full names may be used with the term “and Associate” or “and Associates” as appropriate;
   c) a partnership title as above with an individual listing of the College members' names and acceptable vocational designations (see Footnote 1);”
   d) where an unincorporated business, the business name with an individual listing of the College members’ names and acceptable vocational designations (see Footnote 1);
   e) where a professional corporation, the corporate name of the professional corporation;
   f) where a professional corporation, the corporate name of the professional corporation with an individual listing of the names of the College members who are shareholders and acceptable vocational designations (see Footnote 1);
   g) where a professional corporation has a practice name other than its corporate name, the practice name together with the corporate name of the professional corporation; and
   h) where a professional corporation has a practice name other than its corporate name, the practice name together with the corporate name of the professional corporation and an individual listing of the names of the College members who are shareholders and acceptable vocational designations (see Footnote 1).

PRINCIPLE VIII:
SEXUAL MISCONDUCT

The influence of the professional relationship upon clients is pervasive and may endure long after the relationship has terminated. College members are aware of the potential for conflict of interest and abusive treatment of clients within the professional relationship. Behaviour of a sexual nature by a College member toward a client represents an abuse of power in the professional relationship. College members do not engage in behaviour of a sexual nature with clients.

Interpretation

8.1 College members are solely responsible for ensuring that sexual misconduct does not occur.

8.2 College members do not engage in the following actions with clients:

8.2.1 Sexual intercourse or another form of physical sexual relations between the member and the client;[1]

8.2.2 Touching, of a sexual nature, of the client by the member;[2] and

8.2.3 Behaviour or remarks of a sexual nature by the member towards the client, other than behaviour or remarks of a clinical nature appropriate to the service provided.[3]

8.3 If a College member develops sexual feelings toward a client that could, in the member's judgement, put the client at risk, the member seeks consultation/supervision and develops an appropriate plan.[4]

8.4 If a client initiates behaviour of a sexual nature, the member states clearly that this behaviour is inappropriate by virtue of the professional relationship.

8.4.1 If overtures or provocative sexual behaviour by a client toward a College member become intrusive to the provision of professional services, the College member may choose to terminate the relationship and may offer to assist the client to seek alternate services.

8.5 College members do not provide clinical services to individuals with whom they have had a prior relationship of a sexual nature.

8.6 Sexual relations between College members and clients at the time of referral, assessment, counselling, psychotherapy (including psychotherapy services and/or the controlled act of psychotherapy), or other professional services are prohibited. In other professional relationships,

College members do not have sexual relations with any person where those relations, combined with the professional relationship, would create a conflict of interest.[5]

8.7 Sexual relations between College members and clients to whom the members have provided psychotherapy and/or counselling services, or with respect to whom the members have performed the controlled act of psychotherapy, are prohibited at any time following termination of the professional relationship.[6, 7]

8.8 Sexual relations between College members and clients to whom the members have provided social work or social service work services, other than psychotherapy or counselling services and/or the performance of the controlled act of psychotherapy, are prohibited for a period of one (1) year following termination of the professional relationship.[6, 7, 8]

8.9 College members do not engage in sexual activities with clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to the client or when such activities would compromise the appropriate professional boundaries between the member and the client.

FOOTNOTES

1. Physical sexual relations whether or not initiated by the client, include, but are not limited to, kissing of a sexual nature, touching of breasts or genitals, genital contact and sexual intercourse.

2. Touching is defined as physical contact of a sexual nature. It includes hugging, holding, patting, stroking, rubbing and any form of contact which is unnecessary to the helping process.

3. Behaviour or remarks of a sexual nature include but are not limited to amorous, romantic, seductive and sexual behaviours or remarks. These may include: expressing amorous and/or romantic feelings, e.g. being "in love"; requests to date; inappropriate gift giving; unnecessarily arranging sessions in off-site locations,
e.g. in restaurants or the client's or the member's home, or beyond normal business hours; unnecessary comments about the client's body or clothing; requesting details of sexual history or sexual preferences not pertinent to the service that is being provided; initiation by the College member of conversations regarding the College member's sexual problems, preferences or fantasies; the wearing of sexually suggestive clothing or adornment; displaying pornographic or other offensive material and jokes or remarks that are sexually provocative or sexually demeaning.

   Behaviour or remarks of a sexual nature do not include behaviour or remarks of a clinical nature appropriate to the service being provided.

4. In such cases it may be appropriate for the College member to seek alternative services for the client and terminate the relationship as soon as possible, in keeping with the client's interests.

5. See Principle II, Interpretation 2.2.

6. "Psychotherapy Services" are defined as any form of treatment for psycho-social or emotional difficulties, behavioural maladaptations and/or other problems that are assumed to be of an emotional nature, in which a College member establishes a professional relationship with a client for the purposes of promoting positive personal growth and development. The controlled act of psychotherapy, which may fall within or overlap with "psychotherapy services", is defined in the *Regulated Health Professions Act, 1991* (the "*RHPA*") as "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."

7. "Counselling services" are defined as services provided within the context of a professional relationship with the goal of assisting clients in addressing issues in their lives by such activities as helping clients to find solutions and make choices through exploration of options, identification of strengths and needs, locating information and providing resources, and promoting a variety of coping strategies, but do not include psychotherapy services or the controlled act of psychotherapy.

8. Members should note that in addition to Principle VIII, other provisions of the College's Standards of Practice also apply to sexual relations between College members and clients or former clients. For example, even after the expiry of the one-year period referred to in Interpretation 8.8 (regarding sexual relations with former clients to whom the member provided social work or social service work services, other than psychotherapy or counselling services, and/or performance of the controlled act of psychotherapy), sexual relations between a member and a former client will give rise to a dual relationship and create the potential for a conflict of interest (see: Principle II, Interpretations 2.2 and 2.2.1 to 2.2.4). Prior to engaging in sexual relations with a former client, a member must evaluate not only whether such relations are permitted under Principle VIII and Interpretation 8.8, but also whether they give rise to a dual relationship and/or conflict of interest, or may contravene any other Standard of Practice of the College.

GLOSSARY

Advocacy 1. The act of directly representing or defending others. 2. Championing the rights of individuals, groups or communities through direct intervention or through empowerment. It is a basic obligation of the professions and its members.**†

Assessment The process of determining the nature, cause, progression and prognosis of a problem and the personalities and situations involved therein; the function of acquiring an understanding of a problem, what causes it, and what can be changed to minimize or resolve it.**† The identification of strengths and capacities and redefinition of problems as needs. *****

Barter When a client pays for a service by providing goods and/or services to a member instead of paying them money. ***†

Body of knowledge Each of the phrases "Body of professional social work knowledge" and "body of professional social service work knowledge" relates to both theoretical and practical understanding. A body of knowledge can be attained through education, clinical experience, consultation and supervision, professional development and a review of relevant research and literature. Professional social work knowledge and professional social service work knowledge draw upon the knowledge base of other professions including sociology, psychology, anthropology, medicine, law and economics as well as their own respective distinct bodies of knowledge.

Client "Client", in relation to a member of the College, refers to any person or body that is the recipient of, or has contracted to receive, social work or social service work services from the member, including an individual, couple, group, family, organization, government agency or community that receives (or contracts to receive) direct or indirect social work or social service work services, (as described in the scopes of practice). In social work or social service work research, the client may include a participant in that research. In social work or social service work education, the client may include a student or supervisee. Clients of members employed by an organization are considered clients of both the member and the organization. **†

Competence 1. For social workers and social service workers it means: The ability to fulfill the requirements of professional practice. Competence includes possession of all relevant educational and experiential requirements, and the ability to carry out professional duties and achieve goals while adhering to the values and code of ethics of the professions. 2. Competence for social workers and social service workers also includes, but is not limited to, having the capacity to understand and act reasonably. ** †

Complaints Committee A statutory committee of the College, the mandate of which is to consider and investigate written complaints regarding the conduct or actions of members of the College and to determine the appropriate action to be taken in respect of such complaints, in accordance with the *Social Work and Social Service Work Act*, including but not limited to issuing a caution or referral of the matter to the Discipline Committee or Fitness to Practise Committee †

Confidentiality A principle of ethics according to which the member may not disclose information about a client without the client's consent. This information includes, but is not limited to, the identity of the client, the content of overt verbalizations or other communications with the client, professional opinions about the client, and material from records relating to or supplied by the client.**

Conflict of Interest is defined as a situation in which a member has a personal, financial or other professional interest or obligation which gives rise to a reasonable apprehension that the interest or

obligation may influence the member in the exercise of his or her professional responsibilities. Actual influence is not required in order for a conflict of interest situation to exist. It is sufficient if there is a reasonable apprehension that there may be such influence.

One of the hallmarks of a conflict of interest situation is that a reasonable person, informed of all of the circumstances, would have a reasonable apprehension (in the sense of reasonable expectation or concern) that the interest might influence the member. The influence need not be actual but may simply be perceived. However, a mere possibility or suspicion of influence is not sufficient to give rise to a conflict of interest. The interest must be significant enough to give rise to a "reasonable apprehension" that the personal, financial or other professional interest may influence the member in the performance of his or her professional responsibilities.

Counselling services Counselling services are defined as services provided within the context of a professional relationship with the goal of assisting clients in addressing issues in their lives by such activities as helping clients to find solutions and make choices through exploration of options, identification of strengths and needs, locating information and providing resources, and promoting a variety of coping strategies, but do not include psychotherapy services or the controlled act of psychotherapy.

Diagnosis A social work diagnosis defines that series of judgments made by a social worker based on social work knowledge and skills in regard to individuals, couples, families and groups. These judgements:

a) serve as the basis of actions to be taken or not taken in a case for which the social worker has assumed professional responsibility and
b) are based on the Social Work Code of Ethics and Standards of Practice.

Such judgments and the procedures and actions leading from them are matters for which the social worker expects to be accountable.

Disbursements Money paid out by or on behalf of a client for charges or expenses (other than the member's professional fees) relating to professional services provided by a member to the client. Disbursements may include, but are not limited to, charges for facsimile transmissions, photocopies, long distance telephone calls, etc.*

Documentation by exception Recording only those behaviours which do not occur routinely. The member records situations or behaviours that are out of keeping with the client's usual behaviour or circumstance.****

Dual relationship Dual relationship is defined as a situation in which a College member, in addition to his/her professional relationship, has one or more other relationships with the client, regardless of whether this occurs prior to, during, or following the provision of professional services. A dual relationship does not necessarily constitute a conflict of interest; however, where dual relationships exist, there is a strong potential for conflict of interest and there may be an actual or perceived conflict of interest. Relationships beyond the professional one include, but are not limited to, those in which the College member receives a service from the client, the College member has a personal, familial or business relationship with the client, or the College member provides therapy to students, employees or supervisees.

Dysfunction A disorder or condition, either physical or intellectual, which could impair or call into question the ability of a social worker or social service worker to provide objective professional assessments and interventions in the course of their practice.

Efficacy The capacity to help the client achieve, in a reasonable time period, the goals of a given intervention.**†

Evidence Refers to information tending to establish facts. For College members, evidence can include, but is not limited to: direct observation; information collected in clinical sessions; collateral information; information from documents and information gathered from the use of clinical tools

(e.g. diagnostic assessment measures, rating scales).

Fitness to Practise Committee A statutory committee of the College, the mandate of which is to hold hearings which are generally closed to the public and to determine allegations of incapacity referred to it by the Complaints Committee, the Executive Committee or Council, in accordance with the legislation; to hold hearings to determine applications for reinstatement or to vary terms, conditions or limitations imposed as a result of a Fitness to Practise hearing.

Formal notice A written statement concerning a fact that is communicated to the affected person, giving that person an awareness of the fact.*

Genogram A diagram used to depict family relationships extended over three generations. The diagram uses circles to represent women and squares for men, with horizontal lines indicating marriages.

Vertical lines are drawn from the marriage lines to other circles and squares to depict the children. The diagram may contain other symbols or written explanations to indicate critical events, such as death, divorce, and remarriage, and to reveal recurrent patterns of behaviour.**†

Intervention 1. Coming between groups of people, events, planning activities, or an individual's internal conflicts. 2. In social work, the term is analogous to the physician's term "treatment". Many social workers prefer using "intervention" because it includes "treatment" and also encompasses the other activities social work members use to solve or prevent problems or achieve goals for social betterment. These could include psychotherapy (including psychotherapy services and/or the controlled act of psychotherapy), advocacy, mediation, social planning, community organization, finding and developing resources.**†

Paraprofessional An individual with specialized knowledge and technical training who works closely with and is supervised by a professional.** †

Physical sexual relations Physical sexual relations whether or not initiated by the client, include, but are not limited to, kissing of a sexual nature, touching of breasts or genitals, genital contact and sexual intercourse.

Professional corporation In relation to the practice of social work or social service work by one or more College members, "professional corporation" means a body corporate with share capital incorporated or continued under the *Business Corporations Act*, RSO 1990, c. B.16 for the purpose of practising social work or social service work, that holds a valid certificate of authorization issued under the *Social Work and Social Service Work Act*, S.O. 1998, c. 31.

Psychosocial Of or involving the influence of social factors or human interactive behaviour, it recognizes the complex interdependence of individual psychology, cultural and social/interpersonal context.

Psychotherapy services Psychotherapy services are defined as any form of treatment for psycho-social or emotional difficulties, behavioural maladaptations and/or other problems that are assumed to be of an emotional nature, in which a College member establishes a professional relationship with a client for the purposes of promoting positive personal growth and development.

Psychotherapy, The Controlled Act The controlled act of psychotherapy is defined in the *Regulated Health Professions Act, 1991* (the "*RHPA*") as "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." It should be noted that the definition of the controlled act of psychotherapy is different from the definition of psychotherapy services. While it is possible that not all psychotherapy would be found to fall under the definition of the controlled act, this cannot yet be determined with certainty, given that there is currently no guidance on that point from the courts or College Discipline Committees.

RSSW Registered Social Service Worker. A member of the College who holds a certificate of

registration for social service work.

RSW Registered Social Worker. A member of the College who holds a certificate of registration for social work.

Self-determination An ethical principle that recognizes the rights and needs of clients to be free to make their own choices and decisions. Inherent in the principle is the requirement for the member to help the client know what the resources and choices are and what the potential consequences of selecting any one of them may be. **†

Sociogram A diagram or graphic presentation used by group workers and other professionals to display how members of the group feel about one another and how they tend to align themselves with some and against other members of the group or organization.

Subpoena A legal document requiring a person to attend before a court or a tribunal, or at an out-of-court examination, to be examined as a witness in a legal proceeding.*

Touching Touching, as included in Principle VIII: Sexual Misconduct, is defined as physical contact of a sexual nature. It includes hugging, holding, patting, stroking, rubbing and any form of contact which is unnecessary to the helping process.

Sources

* Black's Law Dictionary, Fifth Edition, Henry Campbell Black et al, 1979

** The Social Work Dictionary, 4th Edition, Robert L. Barker, 1999

*** Client Rights in Psychotherapy and Counselling, A Handbook of Client Rights and Therapist Responsibility, Susan Beamish, Michelle Melanson and Marilyn Oladimeji, 1998

**** Ontario Association of Social Workers, Guidelines for Social Work Record-Keeping, 1999

***** The Strengths Perspective in Social Work, Dennis Saleebey, 1992

† Definition has been adapted by the Standards of Practice Committee

STANDARD OF PRACTICE FOR SOCIAL WORKERS COMMUNICATING POST EVALUATION, A FINDING OF INCAPACITY WITH RESPECT TO ADMISSION TO CARE FACILITIES OR PERSONAL ASSISTANCE SERVICES

Preamble

The following standard of practice for communicating a finding of incapacity with respect to admission to a care facility or personal assistance service has been prepared in the context of the development of standards of professional practice and conduct for the Ontario College of Social Workers and Social Service Workers. This standard of practice is intended to be specific to the social work profession in the province of Ontario.

Registered social workers who evaluate a person and communicate a finding of incapacity with respect to admission to a care facility or personal assistance service are governed by the standards of practice of the social work profession prescribed by the College.

It is recognized that there are variations in the approaches of individual social workers to the evaluation of client capacity to consent to admission to a care facility or a personal assistance service. Also, social workers will vary their methods in response to the demands of each particular situation. Members of the College who hold a certificate of registration for social work will adhere to this standard of practice of the social work profession prescribed by the College.

Communication of a finding of incapacity

1.01 The College member who makes the determination of incapacity will:

(a) Inform the client that a substitute decision-maker will be asked to assist the client and to make final decisions on his or her behalf. The client's right to receive this information should be respected whether or not it is believed he or she is capable of comprehending it. In informing the client regarding the substitute decision-maker, the member will exercise professional judgment and have regard to the particular needs of the client.

(b) If the client disagrees with the need for a substitute decision-maker or disagrees with the involvement of the present substitute, advise the client of his or her options. The member will assist the client if he or she expresses the wish to exercise the options. These options

include applying to the Consent and Capacity Board for review of the finding of incapacity and/or finding another substitute of the same or more senior rank.

(c) Help the incapable client participate as far as possible with the substitute decision-maker in planning for himself or herself.

1.02 The member who conducted the evaluation must complete documentation of the finding of incapacity.

MAY 2000

The following excerpts from the *Health Care Consent Act, 1996* are current to August 28, 2012. The following regulation (O.Reg. 104/96) is current to August 28, 2012. They are provided for the purpose of background information for members of the Ontario College of Social Workers and Social Service Workers. For current and comprehensive information, please refer to the official statute and regulations for the authoritative text.

HEALTH CARE CONSENT ACT, 1996

Section 2. (1)
"In this Act, ….

"Board" means the Consent and Capacity Board;"

"care facility" means,

(a) a long-term care home as defined in the *Long-Term Care Homes Act, 2007*, or
(b) a facility prescribed by the regulations as a care facility;"

"evaluator" means, in the circumstances prescribed by the regulations,

(a) a member of the College of Audiologists and Speech-Language Pathologists of Ontario,
(b) a member of the College of Dietitians of Ontario,
(c) a member of the College of Nurses of Ontario,
(d) a member of the College of Occupational Therapists of Ontario,
(e) a member of the College of Physicians and Surgeons of Ontario,
(f) a member of the College of Physiotherapists of Ontario,
(g) a member of the College of Psychologists of Ontario, or
(h) a member of a category of persons prescribed by the regulations as evaluators;"

"incapable" means mentally incapable, and "incapacity" has a corresponding meaning;"

"personal assistance service" means assistance with or supervision of hygiene, washing, dressing, grooming, eating, drinking, elimination, ambulation, positioning or any other routine activity of living, and

includes a group of personal assistance services or a plan setting out personal assistance services to be provided to a person, but does not include anything prescribed by the regulations as not constituting a personal assistance service;"

"recipient" means a person who is to be provided with one or more personal assistance services,

(a) in a long-term care home as defined in the *Long-Term Care Homes Act, 2007*,
(b) in a place prescribed by the regulations in the circumstances prescribed by the regulations,
(c) under a program prescribed by the regulations in the circumstances prescribed by the regulations, or
(d) by a provider prescribed by the regulations in the circumstances prescribed by the regulations;"

Section 4. (1)
"A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision."

Section 4. (2)
"A person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services."

Section 4. (3)
"A person is entitled to rely on the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment, the admission or the personal assistance service, as the case may be."

Section 40.(1)
"If a person's consent to his or her admission to a care facility is required by law and the person is found by an evaluator to be incapable with respect to the admission, consent may be given or refused on the person's behalf by his or her substitute decision-maker in accordance with this Act."

Section 43. (1)
"Before giving or refusing consent on an incapable person's behalf to his or her admission to a care facility, a substitute decision-maker is entitled to receive all the information required in order to make the decision."

Section 43. (2)
"Subsection (1) prevails despite anything to the contrary in the *Personal Health Information Protection Act, 2004*."

Section 50. (1)
"A person may apply to the Board for a review of an evaluator's finding that he or she is incapable with respect to his or her admission to a care facility."

Section 57.(1)
"If a recipient is found by an evaluator to be incapable with respect to a personal assistance service, a decision concerning the service may be made on the recipient's behalf by his or her substitute decision- maker in accordance with this Act."

Section 60. (1)
"Before making a decision on an incapable recipient's behalf concerning a personal assistance service, a substitute decision-maker is entitled to receive all the information required in order to make the decision."

Section 60. (2)
"Subsection (1) prevails despite anything to the contrary in the *Personal Health Information Protection Act, 2004*."

Section 65.(1)
"A recipient may apply to the Board for a review of an evaluator's finding that he or she is incapable with respect to a personal assistance service."

ONTARIO REGULATION 104/96

made under the

Health Care Consent Act,

1996 Amended to O. Reg.

517/10

EVALUATORS

1. (1) Social workers are evaluators for the purposes of subsection 2 (1) of the Act. O. Reg. 517/10, s. 1.

(2) In this section,

"social worker" means a member of the Ontario College of Social Workers and Social Service Workers who holds a certificate of registration for social work. O. Reg. 517/10, s. 1.

2. Social workers and persons described in clauses (a) to (g) of the definition of "evaluator" in subsection 2 (1) of the Act may act as evaluators in the following circumstances:

1. For the purpose of determining whether a person is capable with respect to his or her admission to a care facility.

2. For the purpose of determining whether a person is capable with respect to a personal assistance service. O. Reg. 517/10, s. 1.

Ontario College of
Social Workers and
Social Service Workers

Ordre des travailleurs
sociaux et des techniciens
en travail social de l'Ontario

Privacy Toolkit for Social Workers and Social Service Workers

Guide to the *Personal Health Information Protection Act, 2004* (PHIPA)

Warning and Disclaimer

- This Toolkit is provided for general information purposes only. The Toolkit is not intended, and should not be construed, as legal advice or professional advice and opinion.
- The description of the *Personal Health Information Protection Act, 2004* in this Toolkit is based on current information and may change as experience with the legislation and its enforcement develops.
- The Toolkit refers to information available from other organizations and their websites. Any such reference does not imply that the College endorses the information.
- The Toolkit should not be relied upon as a substitute for the *Personal Health Information Protection Act, 2004* or its regulations. Provisions of the legislation have been simplified for the purpose of identifying issues for consideration.
- The *Personal Health Information Protection Act, 2004* may not be the only legislation applicable, depending on the particular circumstances.
- Social workers and social service workers concerned about the applicability of privacy legislation to their activities or the interpretation of the legislation are advised to seek legal or professional advice based on their particular circumstances.

Foreword

The first edition of this Toolkit was prepared by Anzen Consulting Ltd. in collaboration with staff of the Ontario College of Social Workers and Social Service Workers and was reviewed by WeirFoulds LLP. The second edition was prepared by staff at the College and reviewed by WeirFoulds LLP. The Toolkit is designed as a general guide to assist social workers and social service workers in understanding the *Personal Health Information Protection Act, 2004* ("the Act") and the changing privacy expectations of clients and the public. The Toolkit is organized into five chapters.

Chapter 1 of the Toolkit provides important background information on the Act's purposes, its definition of "personal health information", how social workers and social service workers should determine if and how the Act may apply to them, rules for recipients of personal health information, rules for collecting, using and disclosing a health number and describes when social workers and social service workers may wish to seek legal or professional advice.

Chapter 2 outlines the responsibilities for health information custodians and their agents. Responsibilities for health information custodians are summarized in six general rules with examples to illustrate what these rules mean and how they might be followed in the practices of social work and social service work. Rules for agents in their handling of personal health information are also presented in this chapter with examples to illustrate their meaning.

Chapter 3 outlines the rules for consent and for specific information handling practices. The chapter also describes the "circle of care" and "lockbox" concepts and outlines the rules for the disclosures of personal health information to the Ontario College of Social Workers and Social Service Workers as well as the rules for providing access and correcting records of personal health information.

Chapter 4 identifies the rules for substitute decision-makers and also comments on the relationship between these rules and those contained in other legislation.

Chapter 5 outlines the mandatory reporting obligations of health information custodians.

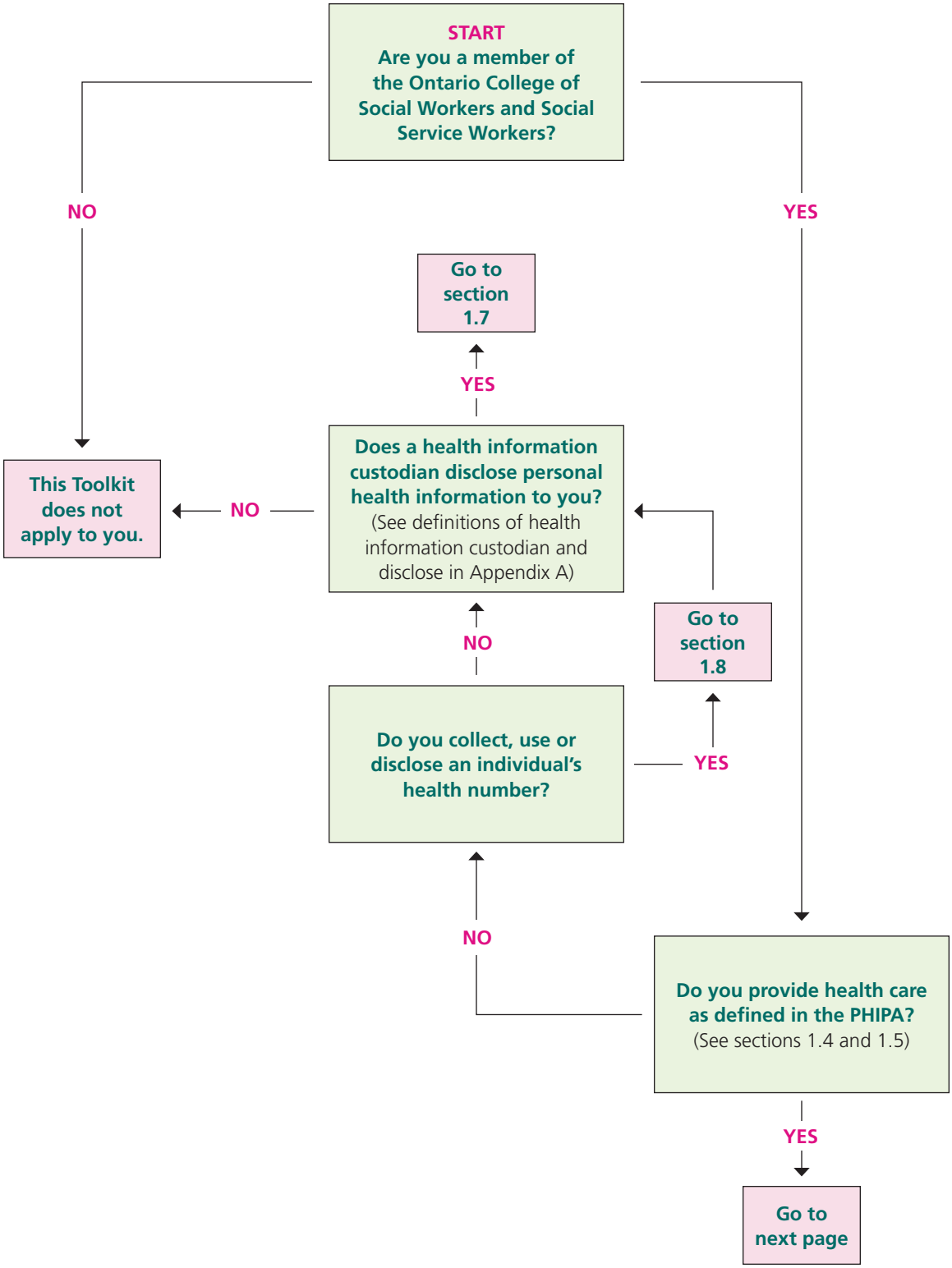
Finally, **Chapter 6** discusses the role of the Office of the Information and Privacy Commissioner/Ontario ("the Commissioner"), who oversees compliance with the Act, and orders made by the Commissioner.

Each chapter begins with a **summary of key questions** that the chapter addresses, with references to the appropriate section number of the chapter. The Toolkit also contains four appendices intended to provide readers with additional information. These include an appendix with select excerpts from the *Personal Health Information Protection Act, 2004* and the regulation made under the Act for readers who want additional information about relevant sections of the Act and the regulation (Appendix A), a list of policy resources for readers who need to make publicly available a written statement relating to their policies and procedures relating to the collection, use and disclosure of personal health information under section 16(1) of the Act (Appendix B), and a brochure for clients

on their privacy rights under the Act produced by the Commissioner (Appendix C). Several health information custodians have placed copies of this brochure in their waiting rooms or offices as a means of supporting their own written public statements. Finally, Appendix D contains a list of web sites with resources on the Act.

Each chapter in the Toolkit is designed to "stand-alone", meaning that a reader who has already considered his or her role under the Act (this is outlined in Chapter 1) could easily flip to other chapters or sections of the Toolkit for information about specific topics. At the same time, however, the College also recognizes that some members may be unsure of the applicability of the *Personal Health Information Protection Act, 2004* to their day-to-day information handling activities or how to understand some of the Act's provisions. For this reason, the Toolkit can also be read cover-to-cover as a "complete whole". The College encourages readers to approach the Toolkit in whichever manner best meets their needs.

Decision Tree for Using this Toolkit



Decision Tree for Using this Toolkit

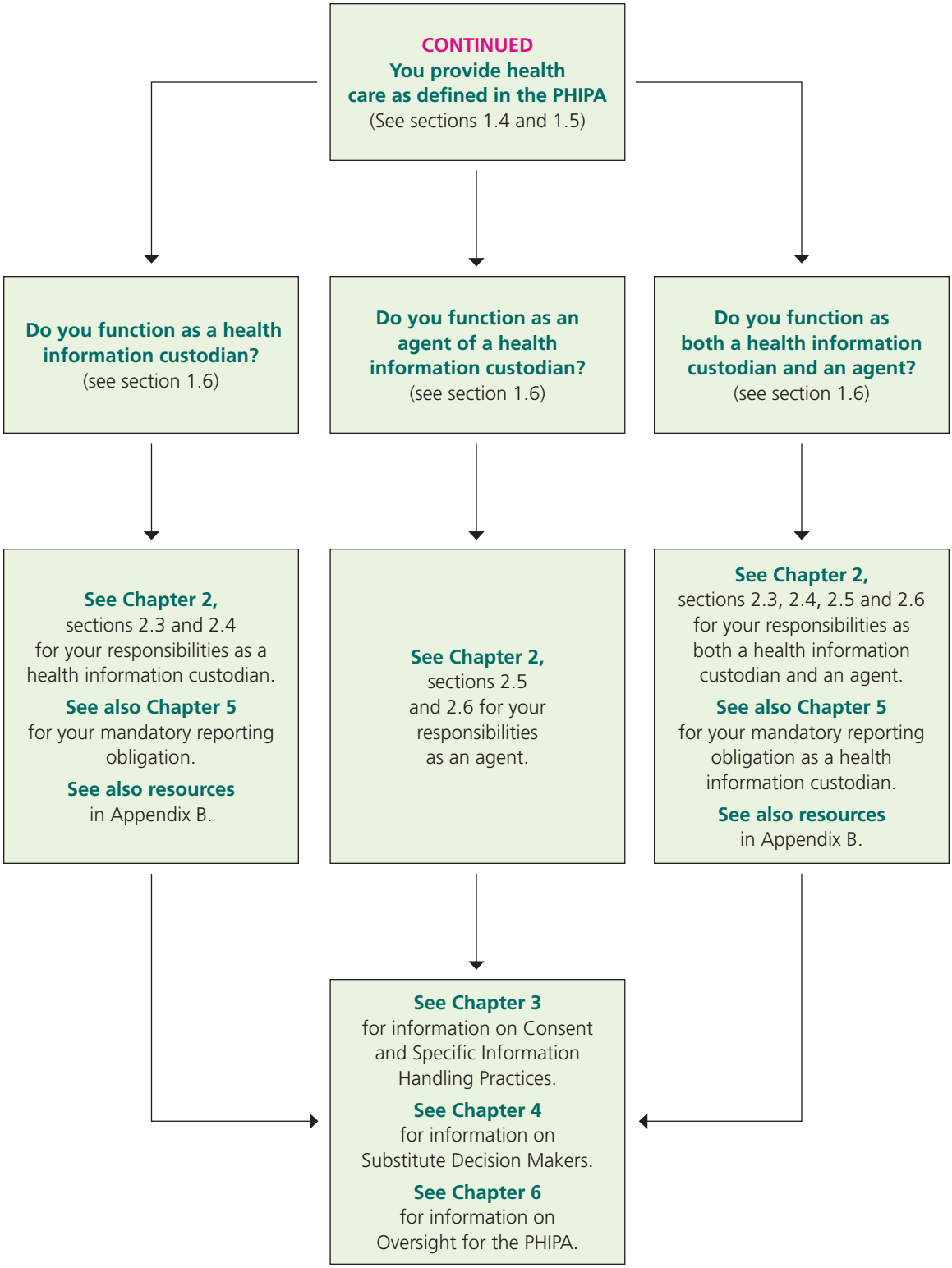


Table of Contents

Introduction and Overview

1.1 SUMMARY OF KEY QUESTIONS COVERED IN THIS CHAPTER

- What is the *Personal Health Information Protection Act, 2004* ("the Act")? (See section 1.2).
- What is "personal health information"? (See section 1.3).
- To whom does the Act apply? (See section 1.4).
- What is "health care" and "health-related purposes" under the Act? (See section 1.5).
- How do I know if the Act applies to me? (See section 1.6).
- What is a "recipient of personal health information" and what are the rules for recipients? (See section 1.7).
- What are the rules for collecting, using and disclosing a **health number**? (See section 1.8).
- What are some tips for knowing when to seek legal or professional advice? (See section 1.9).

1.2 WHAT IS THE *PERSONAL HEALTH INFORMATION PROTECTION ACT, 2004*?

On November 1, 2004, the Ontario government brought into force the *Personal Health Information Protection Act, 2004* – a provincial law that helps keep the personal health information of individuals who interact with the Ontario health care system private, confidential and secure by imposing rules relating to its collection, use and disclosure. This privacy law has been amended a number of times since November 1, 2004.

The Act has a number of purposes, including the establishment of specific rules for the collection, use and disclosure of personal health information while facilitating the provision of health care, providing individuals with a right to access and request corrections to their personal health information (with limited exceptions outlined in the Act), and providing effective remedies for violations of the Act.

The Act also allows for the independent review and resolution of complaints regarding the handling of personal health information and designates the Office of the Information and Privacy Commissioner/Ontario as the body responsible for overseeing compliance with the Act's provisions. Additional information about each of these topics is found in later chapters of the Toolkit.

1.3 WHAT IS PERSONAL HEALTH INFORMATION?

The Act concerns the handling of **"personal health information"** by "health information custodians" and their "agents". It also concerns the handling of **"personal health information"** by a person who has received personal health information from a "health information custodian" and the handling of the health number by any person. Under the Act, "personal health information" is defined as certain information about an individual, whether living or deceased and whether in oral or recorded form. Personal health information is information that can identify an individual and relates to matters such as the individual's physical or mental health, the providing of health care to the individual, the identity of a health care provider or a substitute decision-maker for the individual, payments or eligibility for health care or eligibility for coverage under an insurance arrangement for health care in respect of the individual, the donation by the individual of a body part or bodily substance, and the individual's health number. The Act does not apply to recorded information about an individual if the record was created more than 120 years ago or if 50 years or more have passed since the death of the individual. The Act also does not apply to information in anonymous or de-identified form. For social workers and social service workers, records of personal health information may contain references to more than one individual. For example, in their goal to achieve optimum social functioning for their clients, social workers and social service workers may be given personal health information about a client's family members, such as a history of physical or mental illness, past uses of prescription medications or past histories of physical or emotional abuse, etc. Clause (a) of section 4(1) defines personal health information about an individual as including the "health history of the individual's family." For information about access to records of personal health information containing references to more than one individual or client, see section 3.15.

1.4 TO WHOM DOES THE *PERSONAL HEALTH INFORMATION PROTECTION ACT, 2004* APPLY?

The Act applies directly to "health care practitioners". Under section 2 of the Act, a "health care practitioner" is defined to include "a person who is a member of the Ontario College of Social Workers and Social Service Workers **and who provides health care**" (emphasis added). See section 1.5 to learn more about whether the services you provide to clients may be defined as "health care".

The types of legal obligations you have under the *Personal Health Information Protection Act, 2004* will depend on whether you are classified as: (1) a "health information custodian"; (2) an "agent" of a health information custodian; or (3) both a "health information custodian" and an "agent" of a health information custodian. See section 1.6 for more information. The Act also may apply to you if you are not a "health information custodian" or an "agent" but receive personal health information from a custodian or if you collect, use or disclose the health card number. See sections 1.7 and 1.8 for more information.

1.5 SCOPE OF "HEALTH CARE" AND "HEALTH-RELATED PURPOSES" UNDER THE *PERSONAL HEALTH INFORMATION PROTECTION ACT, 2004*

Unlike physicians, nurses and many other health care professionals, the breadth and scope of social work practice and social service work practice may include roles and duties that are not related to the provision of health care. For example, if you work for an income support program, depending on the nature of your duties or practice, you may not provide health care within the meaning of the *Personal Health Information Protection Act, 2004*. (You will, however, obviously still collect private and potentially sensitive information about your clients whose confidentiality you will need to protect, but the information in this Toolkit may not apply to you).

Section 2 of the *Personal Health Information Protection Act, 2004* defines **"health care"** as "any observation, examination, assessment, care, service or procedure that is done for a health-related purpose and that:

(a) is carried out or provided to diagnose, treat or maintain an individual's physical or mental condition,

(b) is carried out or provided to prevent disease or injury or to promote health, or

(c) is carried out or provided as part of palliative care,

and includes,

(d) the compounding, dispensing or selling of a drug, a device, equipment or any other item to an individual, or for use of an individual, pursuant to a prescription, and

(e) a community service that is described in subsection 2(3) of the *Home Care and Community Services Act, 1994* and provided by a service provider within the meaning of that Act."

The above definition suggests that you need to consider whether the services you provide are performed for a "health-related purpose". For example, a social service worker could be seen as providing health care in accordance with the above definition in circumstances where he or she is providing services to a client in crisis. This is because the social service worker might apply skills (e.g. "care" or "service") that re establish immediate coping and give support (e.g. "treat an individual's mental condition"), and reduce lethality (e.g. "prevent disease or injury") and is done for a health-related purpose. If a social worker were involved in this case, he or she may also be seen as providing health care in accordance with the above definition since he or she might attempt to deal with a situation resulting from a past trauma, such as post-traumatic stress, which requires a higher level of knowledge and skill (e.g. carrying out an assessment to "diagnose" and/or "treat" an "individual's physical or mental condition") and is done for a health-related purpose.

Note that you may provide health care to a client without actually being an employee of or under contract with a health care organization – for example, if you volunteer your services to a hospital, long-term care centre or other health care facility. These are known as health information custodians and are described in section 1.6. Also note that whether or not you provide health care to a client can change over time, depending on the client's circumstances.

EXAMPLE OF A SOCIAL WORKER OR SOCIAL SERVICE WORKER WHO IS *NOT* PROVIDING HEALTH CARE:

"All children in the primary school years will receive education about the health benefits of eating a minimum of 4-5 servings of fruits and vegetables per day. The school sees this educational program as an important health promotion effort. John Doe will take this information home in a family nutrition kit, which also includes online information. I [the social worker or social service worker] will visit the school next week to give a short presentation and to answer questions from John Doe's class."

EXAMPLE OF SOCIAL WORKER OR SOCIAL SERVICE WORKER WHO IS PROVIDING HEALTH CARE:

"All children in the primary school years will receive education about the health benefits of eating a minimum of 4-5 servings of fruits and vegetables per day. John Doe will take this information home in a family nutrition kit, which also includes online information. He has told a former professional athlete who visited the school today for 'Nutrition Month' that he is bothered by his peers' comments about his weight and that his parents want him to improve his physical fitness level and confidence in social situations. His family and teacher have asked me [the social worker or social service worker] to work with him on these issues."

As seen in the second example above, a child that once received general information on the benefits of healthy food choices is now receiving health care from his social worker or social service worker since the social worker or social service worker is now making "observations" and "assessments" about a specific child for a "health-related purpose" that is "carried out to diagnose[1], treat or maintain the child's physical or mental condition".

[1] Only social workers may provide a social work diagnosis. Diagnosis is not included in the scope of practice of social service work as set out in the Standards of Practice published by the Ontario College of Social Workers and Social Service Workers.

1.6 DECIDING HOW THE ACT MAY APPLY TO YOU

Under the *Personal Health Information Protection Act, 2004*, you may function as:

1. A **health information custodian (HIC)**;
2. An **agent** of a health information custodian; or
3. A **health information custodian** *and* an **agent** of a health information custodian.

Health information custodians and their agents share some of the same privacy responsibilities under the Act, but they also have some privacy responsibilities that are unique. Read this section to determine if you are: (1) a health information custodian; (2) an agent of a health information custodian; or (3) both a health information custodian and an agent. Responsibilities for health information custodians and their agents are described in Chapter 2.

You are a HIC if...

- You provide health care AND:
  - You are a social worker or social service worker in independent practice; or
  - You operate a group practice of social workers or social service workers or other health care practitioners who provide health care; or
  - You are a social worker or social service worker that provides health care as part of your duties for an organization that is not a health information custodian; or
  - You are an evaluator under the *Health Care Consent Act, 1996* or an assessor under the *Substitute Decisions Act, 1992* and do not provide these services as an agent of a health information custodian.

EXAMPLE:

You are a HIC if you run your own independent social work or social service work practice and provide health care. You may specialize in a particular area such as individual, couple, family or group therapy. You may rent or own a small office space that you use for your business activities (e.g. for client meetings). In business terms, you are probably the sole proprietor of your practice.

You are also a HIC if you operate a *group practice*[2] of social workers, social service workers or other health care practitioners (such as psychologists or occupational therapists) that provide health care. You have likely rented or own office space out of which you operate your group practice. Your group practice may specialize in a particular area, such as individual, couple, family or group therapy. You may employ other individuals such as a receptionist. The individuals who provide health care on behalf of your group practice are agents and are described below.

Finally, you are also a HIC if you provide health care as part of your duties for an organization that is not a HIC, such as an Employee Assistance Program, a school board or a Children's Aid Society. For a list of organizations that are health information custodians, see the information in Appendix A.

[2] A "group practice" is different from a "professional corporation". In a group practice, members do not have to be part of the same profession.

You are an agent of a HIC if ...

- You are employed by or perform services or activities *for or on behalf* of a HIC, and not for your own purposes. You may be an employee of a health information custodian, such as a hospital or nursing home, but you do not have to be employed by or remunerated by the custodian to still be classified as an agent of a health information custodian. For example, you may perform services on a volunteer basis to a hospital.

EXAMPLE:

You are an agent of a HIC if you are employed by or perform services or activities for or on behalf of that HIC. Examples of HICs include: hospitals, psychiatric facilities, walk in clinics or medical centres that offer other health care services (e.g. family physicians, nurses or nurse practitioners, physiotherapists), nursing homes, long-term care centres, local health integration networks or community health or mental health centres, programs or services.

You should also know that there are other types of HICs under the Act, but social workers and social service workers are less likely to be employed by or perform services or activities for or on their behalf. These include pharmacies, laboratories and ambulance services. Appendix A contains the full list of individuals and organizations that are classified as a HIC under the *Personal Health Information Protection Act, 2004* and O. Reg. 329/04.

Finally, you are both a HIC and an agent of a HIC if, for example...

- You are a social worker or social service worker in independent practice who provides health care

  AND

- You also perform services or activities for or on behalf of a health information custodian.

EXAMPLE:

You run an independent practice that provides health care on a part-time basis (you are a HIC) and you are also employed by a local health integration network to provide health care to its clients on a part-time basis (you are an agent of a HIC).

You work full time at a hospital during which time you provide services to hospital patients (you are an agent of a HIC) and you also provide health care to your own clients in independent practice (you are a HIC). In this situation, you may rent office space from the hospital, you may fund the purchase or leasing of office equipment at the hospital from your independent practice, and you may also store client records from your independent practice separately from the records of your hospital patients.

1.7 RECIPIENT OF PERSONAL HEALTH INFORMATION FROM A HEALTH INFORMATION CUSTODIAN

Section 49(1) of the *Personal Health Information Protection Act, 2004* places restrictions on a person who is not a health information custodian and to whom a health information custodian discloses personal health information (referred to here as a "recipient"; see section 1.3 for the definition of "personal health information"). This rule provides that, subject to certain exceptions, a recipient shall not use or disclose the information for any purpose other than:

- the purpose for which the health information custodian was authorized to disclose the information under the Act, or
- the purpose of carrying out a statutory or legal duty.

There is also a general rule under section 49(2) which states that, subject to prescribed exceptions, a recipient shall not use or disclose more of the information than is reasonably necessary to meet the purpose of the use or disclosure unless the use or disclosure is required by law.

1.8 COLLECTION, USE OR DISCLOSURE OF A HEALTH NUMBER

The health number means the number, the version code or both of them assigned to an insured person within the meaning of the *Health Insurance Act* by the General Manager within the meaning of that Act. Under the *Personal Health Information Protection Act, 2004*, "personal health information" includes an individual's health number. If you are a health information custodian (HIC) or an agent of a HIC, the rules for collection, use or disclosure of personal health information apply to the health number. However, the *Personal Health Information Protection Act, 2004* imposes specific restrictions with respect to the collection, use or disclosure of a health number by a person who is not a HIC.

Under the Act, a person who is not a HIC shall not collect or use another person's health number except:

- For purposes related to the provision of provincially funded health resources to that person;
- For the purposes for which a HIC has disclosed the number to the person;
- If the person is the governing body of health care practitioners who provide provincially funded health resources and is collecting or using health numbers for purposes related to its duties or powers; or
- If the person is prescribed and is collecting or using the health number, as the case may be, for purposes related to health administration, health planning, health research, or epidemiological studies. (Note that "prescribed" means a regulation has been made under the Act for that purpose.)

Under the Act, a person who is not a HIC may not disclose a health number except as required by law or except as prescribed in the regulations.

These restrictions do not apply to an agent of a HIC who is using or disclosing the health number on behalf of the custodian in accordance with the Act.

1.9 WHEN TO SEEK LEGAL OR PROFESSIONAL ADVICE

Depending on how the Act applies to you, circumstances under which you may wish to seek legal or professional advice include:

- If you are concerned about the applicability of the *Personal Health Information Protection Act, 2004* to your activities or the meaning of any provisions of the Act;
- If you receive a question or complaint about the handling of personal health information under the Act and you are not sure how to respond; or
- Some organizations may not be aware that they are a health information custodian. The Act states that a centre, program or service for community health or mental health whose primary purpose is the provision of health care is a health information custodian (see Appendix A). If you provide health care as part of your duties for an organization and you are unsure whether the organization may be a health information custodian, then you are advised to encourage the organization to seek legal or professional advice.
- Note that if you are an agent of a health information custodian, you may also contact the custodian's privacy contact person for assistance.

Responsibilities of Health Information Custodians and their Agents

2.1 SUMMARY OF KEY QUESTIONS COVERED IN THIS CHAPTER

- Are responsibilities for handling personal health information the same for a HIC as for its agents? (See section 2.2).
- What must I **know** about my responsibilities for handling personal health information if I am a **HIC**? (See section 2.3).
- What must I do to handle personal health information in accordance with the Act if I am a **HIC**? (See section 2.4).
- Where can I find **resources for written public statements and information practices** required under the Act? (See section 2.4).
- Where can I find **resources for clients** about the Act? (See section 2.4).
- What must I **know** about my responsibilities for handling personal health information if I am an **agent of a HIC**? (See section 2.5).
- What must I **do** to handle personal health information in accordance with the Act if I am **an agent of a HIC**? (See section 2.6).

2.2 RESPONSIBILITIES OF A HIC VERSUS RESPONSIBILITIES OF AGENTS OF A HIC

If you have determined from section 1.6 of the Toolkit that you are a health information custodian (HIC), then you have several obligations with respect to personal health information. These are summarized below in **six rules** in section 2.3. The information in section 2.4 describes these rules in more detail and shows how health information custodians might fulfill these responsibilities using examples from the practices of social work and social service work.

If you are an *agent* of a HIC, your obligations under the Act are different from those of a HIC, although you still have a responsibility to protect the privacy and security of any personal health information you handle for or on behalf of a HIC. The information in sections 2.5 and 2.6 describes responsibilities for agents of a HIC and provides examples of how you might fulfill these responsibilities as a social worker or social service worker.

2.3 WHAT YOU MUST KNOW IF YOU ARE A HIC

You must know the following six rules if you are a HIC:

1. You are responsible for any personal health information in your custody or control;
2. You must have in place **policies and procedures** with respect to your **collection, use, modification, disclosure, retention and disposal of personal health information**;

3. You must have in place **policies and procedures** with respect to the **administrative, technical and physical safeguards** that you have implemented to protect personal health information (the policies and procedures referred to in rules 2 and 3 are defined as "information practices" under the Act);

4. You must take reasonable steps to ensure that your clients' personal health information is as **accurate**, complete and up-to-date as needed for its use or disclosure;

5. You must **take reasonable steps to ensure that personal health information is not collected without authority and to protect personal health information against theft, loss, and unauthorized use or disclosure. If personal health information about an individual is stolen, lost or used or disclosed without authority, you must notify the individual at the first reasonable opportunity and include in the notice a statement that the individual is entitled to make a complaint to the Ontario Information and Privacy Commissioner. In the prescribed circumstances, you must notify the Ontario Information and Privacy Commissioner, as well** (For a description of these circumstances, see Rule #5 under section 2.4); and

6. You must make available to the public a **written statement that describes your policies and procedures** with respect to the handling of personal health information, how to contact the custodian's privacy contact person, how an individual can obtain access or request a correction to a record of his or her personal health information, and how to make a complaint concerning your handling of personal health information to the Office of the Information and Privacy Commissioner/Ontario.

The ways in which you meet the responsibilities outlined above will depend on your circumstances. **For example, in connection with your obligation for making a written statement available to the public (that is, rule #6), section 16(1) of the Act requires that a HIC must do so in a manner that is "practical in the circumstances"**. If you are a social worker or social service worker in independent practice, it may be sufficient for your written public statement to be available only in hard copy. This is because it may not be practical for you to post your written public statement on a web site (e.g. since you may not have a web site for your practice) and it may also not be practical for you to incur costs to professionally produce client brochures that contain your written public statement.

On the other hand, if you run a group practice, it may be practical for you to pay to have brochures professionally produced that contain your written public statement and, if you have a web site for your practice, for you to post your written public statement there.

Another example relates to your responsibility to protect personal health information against theft, loss and unauthorized use or disclosure (that is, rule #5). **Section 12(1) of the Act requires that you "take steps that are reasonable in the circumstances" to protect personal health information.** One would expect that the steps that are reasonable in the circumstances will vary.

2.4 WHAT YOU MUST DO IF YOU ARE A HIC

Rule #1 – You are responsible for any personal health information in your custody or control.

What the Rule Means:

- Personal health information in your "custody or control" means personal health information that you control or manage, regardless of where it is stored.
- You may have personal health information in your custody that includes information you collect directly from clients as well as information you may collect or receive indirectly about your clients.
- You may permit your agents to collect, use, disclose, retain or dispose of personal health information on your behalf, but only if certain conditions are met. (See section 17(1) of the Act in Appendix A).
- You must take reasonable steps to ensure that your agents comply with the conditions imposed on their permission to collect, use, disclose, retain or dispose of personal health information. (See section 17(3) of the Act in Appendix A.)

EXAMPLE:

You are a social worker that provides health care and you are employed by an agency that provides employee assistance services. You collect personal health information directly from your client with her consent about her possible anxiety attacks and sleep problems. You are responsible for handling this information in accordance with the rules outlined in the *Personal Health Information Protection Act, 2004*.

Rule #2 – You must have in place policies and procedures with respect to your collection, use, modification, disclosure, retention and disposal of personal health information.

What the Rule Means:

- This rule relates to the actions you take with respect to personal health information.
- **"Collect"** means to gather, acquire, receive or obtain personal health information by any means from any source.
- **"Use"** means to view, handle or otherwise deal with personal health information that is in your custody or control as a HIC, but does not mean to disclose personal health information. The providing of personal health information between a HIC and an agent of a HIC is a use by the HIC and not a disclosure by the person providing the information or a collection by the person to whom the information is provided.
- **"Disclose"** means to make personal health information available or to release it to another HIC, person or organization; it does not mean to use personal health information.

- In your policies and procedures, you must explain when, how and the purposes for which you routinely **collect, use, modify, disclose, retain and dispose of personal health information**.
- Your policies and procedures should be written in terms that are understandable to your clients. If you use professional terms or acronyms, you should define these, or provide your clients with a user-friendly glossary. You may also want to consider developing answers to a list of frequently asked questions about your policies and procedures for your clients.

EXAMPLE:

You operate a group practice of social workers, social service workers or other health care practitioners and in order to deliver health care to a client, you need to share personal health information about a client's health history with another member of the practice; this would be considered a use of personal health information (and not a disclosure of it). In your policies and procedures, you must identify the purposes for which you use personal health information. Also see Chapter 3 regarding consent.

You are a social worker or social service worker in independent practice and you have been requested to share personal health information about your client's tension, headaches and feelings of hopelessness with the client's family physician or a hospital; this would be considered a disclosure of personal health information. In your policies and procedures, you must identify the purposes for which you disclose personal health information. Also see Chapter 3 regarding consent.

Rule #3: You must have in place policies and procedures with respect to the administrative, technical and physical safeguards that you have implemented to protect personal health information.

What the Rule Means:

- **Administrative** safeguards mean the rules you have in place to protect personal health information.
- **Technical** safeguards mean the things or processes related to technology you have in place to protect personal health information.
- **Physical** safeguards mean the observable aspects or features of your environment you have in place to protect personal health information.

EXAMPLE:

Examples of *administrative* safeguards include mandatory confidentiality agreements, privacy training for any of your agents, and policies which give access only to people who "need to know" the personal health information in question to perform their work.

Technical safeguards do not have to be "high-tech"; they can be everything from shredders to dispose of personal health information securely, to individual user names and passwords for information systems (e.g. no generic accounts), to anti-viral software and encryption programs for your software.

Examples of *physical* safeguards include locked doors and filing cabinets.

Rule #4 – You must take reasonable steps to ensure that your clients' personal health information is as accurate, complete and up-to-date as needed for its use or disclosure.

What the Rule Means:

- The "reasonable steps" that are necessary may vary, depending on the circumstances.

EXAMPLE:

It is reasonable for you to contact an individual or organization from which you have received personal health information and ask any questions you have regarding the accuracy of the information you have received (e.g. you want to confirm a client's address, substitute decision-maker or diagnosis). It may not be reasonable, however, for you to routinely call all organizations and individuals from which you receive personal health information to verify the accuracy of the information they are disclosing to you.

It is reasonable for you to ask a client to confirm certain information on a regular basis, especially information which may change regularly depending on your client's circumstances. This could include your client's address, your client's medications, or your client's feelings about his health or the health care he is receiving. It is probably not reasonable to ask your clients to verify the accuracy of their personal health information each time you meet.

Rule #5 – You must take reasonable steps to ensure that personal health information is not collected without authority and to protect personal health information against theft, loss and unauthorized access or disclosure. If personal health information about an individual is stolen, lost or used or disclosed without authority, you must notify the individual at the first reasonable opportunity and include in the notice a statement that the individual is entitled to make a complaint to the Ontario Information and Privacy Commissioner. In the prescribed circumstances, you must notify the Ontario Information and Privacy Commissioner, as well. These circumstances include where:

- **you believe that the personal health information was stolen;**
- **you believe that the personal health information was intentionally used or disclosed without authority;**
- **you are required to give notice to a health regulatory College or the College of a loss or unauthorized use or disclosure of personal health information (see Chapter 5 related to mandatory reporting obligation to a College); and**
- **you determine that the loss or unauthorized use or disclosure was significant, after considering all relevant circumstances.**

(For the complete list of circumstances where you must notify the Ontario Information and Privacy Commissioner, see section 6.3 of O. Reg. 329/04 in Appendix A.)

What the Rule Means:

- You will probably use the administrative, technical and physical safeguards described under Rule #3 to help you meet this obligation.
- This rule also requires a HIC to inform clients at the first reasonable opportunity when a privacy breach concerning their personal health information has occurred (that is, a "duty to notify").
- The duty to notify includes notifying the individual that he or she is entitled to make a complaint to the Information and Privacy Commissioner of Ontario and, in many circumstances, notifying the Commissioner of the privacy breach.

EXAMPLE:

As a HIC, you must decide in accordance with the Act who is permitted to access personal health information under what circumstances. For example, if you operate a group practice, you might decide that it is appropriate for all social workers, social service workers or other health care practitioners in the practice to access personal health information on clients of the group practice for purposes of providing health care to clients, but you probably wouldn't allow your receptionist to access personal health information, other than information needed for billing purposes or to book client appointments.

You may notify individuals whose personal health information has been stolen, lost or used or disclosed without authority in a variety of ways (e.g. by letter, telephone or in person at the client's next appointment). You might also choose to inform the police in this situation (e.g. if your practice is broken into). How you notify individuals will depend on the nature and sensitivity of the personal health information and the number of people involved. For example, if you are a HIC whose stolen laptop contains hundreds or thousands of client records, it may not be practical for you to meet in person or phone every client affected by the theft. Consideration should also be given to the timing of notification; that is, when is the first reasonable opportunity. The Office of the Information and Privacy Commissioner/Ontario has provided guidance to organizations about the timing and manner of notification. Remember you must include in your notification a statement that the individual is entitled to make a complaint to the Ontario Information and Privacy Commissioner and, in many circumstances, you must notify the Ontario Information and Privacy Commissioner.[3]

Rule #6 – You must make available to the public a written statement that describes your policies and procedures, how to contact the custodian's privacy contact person, how an individual can obtain access or request a correction to a record of his or her personal health information, and how to make a complaint concerning your handling of personal health information to the Office of the Information and Privacy Commissioner/Ontario.

What the Rule Means:

- The Act requires a HIC to follow this rule in order to foster openness and accountability for its information handling practices.
- Most social workers, social service workers and other health care practitioners are comfortable with the idea that a client should know the purposes for which a HIC will collect, use and disclose personal health information and the idea that a client might want to access or request changes to a record of his or her personal health information. However, the idea that a client or another individual may complain about how you protect

[3] O. Reg. 329/04 describes the circumstances under which you must also notify the Ontario Information and Privacy Commissioner of the theft, or loss, or the unauthorized use or disclosure.

the privacy of his or her personal health information to an external oversight body (that is, the Commissioner) is a concept that social workers, social service workers and other health care practitioners should also understand. See Chapter 5 for more information on the role of the Commissioner.

- To see samples of the written public statement that health information custodians are required to have under section 16(1) of the *Personal Health Information Protection Act, 2004*, consult the resources found in Appendix B.

EXAMPLE:

If you are a HIC that is an individual person, you must make available a written public statement that describes your policies and procedures, but you do *not* need to designate a privacy **contact person** as listed under section 15(3) of the Act. However, you then assume the responsibilities of the contact person yourself. Therefore, you must inform your agents of their duties under the Act, respond to inquiries from the public about your policies and procedures, respond to requests from your clients or other individuals to access or request corrections to their records of personal health information, and receive complaints from the public about any alleged contraventions of the Act.

If you operate a group practice, you must comply with the above requirements and you must designate a privacy contact person who performs the functions described above and who also facilitates your compliance with the Act as a HIC. This person will be an agent of your practice. You may choose a manager for your group practice or a specific social worker, social service worker or other health care practitioner to serve as your contact person. You may also designate a receptionist who has regular contact with the public to serve as your privacy contact person.

If you are a HIC and the organization which employs you is a non-HIC, you must meet all of the obligations of a HIC, including the obligations outlined in this rule. In order to meet the obligations outlined in this rule, you may wish to co-operate with the non-HIC in this regard.

For example, the non-HIC may have already made available to the public a written statement about its policies and procedures, including the process an individual must follow if he or she wishes to access information in his or her record. These documents might be appropriate for you to use, provided that they comply with the requirements of the *Personal Health Information Protection Act, 2004*. If not, then you will need to write your own statement for the public or work with the non-HIC to amend its documents to comply with the *Personal Health Information Protection Act, 2004*.

If you wish to provide your clients with additional information about their rights under the Act, the Commissioner has published a free brochure for the public, which can assist you in this regard. See Appendix C for a copy of the brochure; extra copies of this brochure are available through the Commissioner at www.ipc.on.ca. Although this brochure does not directly refer to social workers or social service workers, it may still be a useful resource for members of the College.

2.5 WHAT YOU MUST KNOW IF YOU ARE AN AGENT OF A HIC

If you are an agent of a HIC (see section 1.6 of the Toolkit), section 17(1) of the *Personal Health Information Protection Act, 2004* gives a HIC the right to permit you to collect, use, disclose, retain or dispose of personal health information on the HIC's behalf under certain conditions. These include:

- The HIC must be permitted or required to collect, use, disclose, retain or dispose of the personal health information, as the case may be;
- The collection, use, disclosure, retention or disposition of the personal health information, as the case may be, is necessary in the course of your duties as an agent and is not contrary to the *Personal Health Information Protection Act, 2004* or another law; and
- You and the HIC must meet any prescribed requirements.

A HIC may impose conditions or restrictions on the permission granted to you.

Except if there is an exception prescribed in a regulation made under the Act, section 17(2) of the Act permits you to collect, use, disclose, retain or dispose of personal health information under certain conditions. These include:

- The collection, use, disclosure, retention or disposition of the personal health information, as the case may be, is permitted by the HIC, is necessary in order for you to carry out your duties as an agent, is not contrary to the *Personal Health Information Protection Act, 2004* or another law, and complies with any conditions or restrictions imposed by the HIC.

In accordance with an exception prescribed in the regulation made under the Act, if you are an agent of a HIC, you are permitted to disclose personal health information about a client without the HIC's permission under the following circumstances:

- If you believe on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or a group of persons.
- To the Ontario College of Social Workers and Social Service Workers for the purpose of the administration or enforcement of the *Social Work and Social Service Work Act, 1998*.
- To the Public Guardian and Trustee or a Children's Aid Society so that they can carry out their statutory functions.
- To a College within the meaning of the *Regulated Health Professions Act, 1991* for the purpose of the administration or enforcement of the *Regulated Health Professions Act, 1991* or a health profession Act listed in that Act.

2.6 WHAT YOU MUST DO IF YOU ARE AN AGENT OF A HIC

- You probably assume that the HIC who employs you or for whom you perform services or activities is permitted or required to collect, use, disclose, retain or dispose of any personal health information to which you have access and which the HIC asks you to handle on its behalf. If you have any questions about the authority of the HIC, you should contact the HIC immediately and/or seek legal or professional advice.
- You will want to ensure that the collection, use, disclosure, retention or disposition of personal health information, as the case may be, is necessary in the course of your duties and not contrary to the *Personal Health Information Protection Act, 2004* or another law.
- As an agent, you may only collect, use, disclose, retain or dispose of personal health information for or on behalf of a HIC with the authorization of the HIC and the collection, use, disclosure, retention or disposal complies with the conditions described in section 2.5, unless an exception has been prescribed under a regulation made under the Act.
- You are permitted to disclose personal health information you handle for or on behalf of a HIC without the HIC's permission under the circumstances described in section 2.5.
- **You are required to notify *the HIC* at the first reasonable opportunity if personal health information you handle on behalf of the HIC is stolen, lost or used or disclosed without authority.** This means, for example, that if you store client records containing personal health information in a laptop or a briefcase which is stolen from your office, then you need to notify the HIC at the first reasonable opportunity about the incident. The HIC is then obligated to inform the individuals whose personal health information was stolen at the first reasonable opportunity (e.g. the clients whose records were stolen).
- You are responsible for complying with the policies and procedures of the HIC in order to protect the privacy and security of any personal health information you handle for or on behalf of a HIC, and for complying with any conditions or restrictions imposed by the HIC on your collection, use, disclosure, retention or disposal of personal health information.
- As an agent, you are not required to make available to the public a written statement as required under section 16(1) of the Act. This responsibility should be handled directly by the HIC who employs you or for whom you perform services or activities. However, it may make "good business sense" to have copies of the HIC's public statement readily available to your clients (e.g. in your office or waiting room).
- If you function as both an agent of a HIC and a HIC (e.g. a social worker or social service worker in independent practice who provides health care to your "own" clients as well as to patients of a HIC – see section 1.6 for more information), then you are obligated to make a written statement available under section 16(1) of the Act as a HIC and comply with the other obligations of a HIC. With respect to the services or activities you perform as an agent of a HIC, you must comply with the obligations of an agent with respect to those functions.

Consent and Specific Information Handling Practices

3.1 SUMMARY OF KEY QUESTIONS COVERED IN THIS CHAPTER

- What is **informational consent**? (See section 3.2).
- What is the difference between **implied** and **express consent**? (See section 3.2).
- What are the conditions for a **valid consent**? (See section 3.3).
- How do I know if a client is **capable** of giving consent? (See section 3.4).
- When can I rely on **implied consent**? (See section 3.5).
- When must I obtain **express consent**? (See section 3.6).
- What are some examples of situations when I do **not need consent** from clients? (See section 3.7).
- What if a client wants to **withdraw consent**? (See section 3.8).
- What is the **"circle of care"**? (See section 3.9).
- What is the **"lockbox"**? (See section 3.10).
- What are the rules for **psychiatric facilities**? (See section 3.11).
- What are the rules for **consent and children and youth**? (See section 3.12).
- What are the rules when a **client is deceased**? (See section 3.13).
- What are the rules for disclosing personal health information to the **College**? (See section 3.14).
- What are the rules for providing **access to records of personal health information**? (See section 3.15).
- What are the rules for **correcting records of personal health information**? (See section 3.16).

3.2 WHAT YOU MUST KNOW ABOUT CONSENT

In this Toolkit, consent refers to the permission an individual gives for the collection, use or disclosure of his or her personal health information. This is known as **informational consent**. It is different from **consent to treatment**. The *Personal Health Information Protection Act, 2004* has *not* changed the rules for consent to treatment; these rules are found in the *Health Care Consent Act, 1996*. There may, however, be circumstances where the relationship between the *Personal Health Information Protection Act, 2004* and the *Health Care Consent Act, 1996* needs to be considered. For more information on substitute decision-makers, the *Personal Health Information Protection Act, 2004* and the *Health Care Consent Act, 1996*, see Chapter 4.

In this chapter, the term "you" is generally used to refer to a health information custodian (HIC). If you are an agent of a HIC, you should also understand the obligations of a HIC described in this chapter because, as an agent, you are generally only permitted to collect, use, disclose, retain or dispose of personal health information on behalf of a HIC if the HIC is permitted or required by law to do so. (For information on the obligations of an agent, see sections 2.5 and 2.6.)

Under the *Personal Health Information Protection Act, 2004*, there are some situations when you do not need consent to collect, use or disclose personal health information. These are described in section 3.7. If these circumstances are not applicable or any other provincial law that specifically prevails over the Act requires consent, you will need either **express** or **implied consent** before you may collect, use or disclose personal health information:

- **Implied consent** is generally understood as being a consent that, from an individual's action or inaction in particular circumstances, one concludes has been given.
- For example, if you ask a client for personal health information in order to open a record on that client and the client answers your questions, you can infer consent to the collection of his or her personal health information since you can conclude that the client understands the purpose of the collection.
- There are certain circumstances under which you can rely on implied consent to collect, use or disclose personal health information.
- These are described in section 3.5.
- **Express consent** is generally understood as a consent that has been explicitly provided by the individual.
- For example, if you want to disclose personal health information to a client's insurer or employer, you must obtain the client's express permission first. Express consent may be given orally or in writing.
- The circumstances under which you must obtain express consent are described in section 3.6.
- There are also other specific circumstances when you may collect, use or disclose personal health information **without consent**. These are described in section 3.7.
- The *Mental Health Act* has specific rules on permitted collection, use or disclosure of personal health information without consent that are applicable to psychiatric facilities and other matters governed by the *Mental Health Act*. These are described in section 3.11.
- Finally, the *Personal Health Information Protection Act, 2004* has rules that deal with the consent of children and youth and consent when an individual is deceased. These are described in sections 3.12 and 3.13.

3.3 MAKING SURE CONSENT IS VALID

Whether it is an implied or express consent, the consent must meet certain conditions in order for it to be valid. These conditions are:

- The person giving consent must have the **capacity** to do so (see section 3.4);
- You must obtain consent directly from your client or from someone who has the legal authority to consent for the client (that is, a **substitute decision-maker** – see section 3.12, section 3.13 and Chapter 4 for information on substitute decision-makers);
- The consent must not be obtained through deception or coercion;
- The consent must be related to the personal health information in question; and
- The consent must be knowledgeable, meaning it must be reasonable to believe that your client understands:
  - why you are collecting, using or disclosing the information; and
  - that the client has the right to withhold or withdraw his or her consent.

A health information custodian who has obtained an individual's consent to a collection, use or disclosure of personal health information about an individual or who has received a copy of a document purporting to record the individual's consent is entitled to assume that the consent fulfils the requirements of the Act unless it is not reasonable to assume so.

Finally, two general principles need to be considered in connection with the rules for consent in the *Personal Health Information Protection Act, 2004*. These principles are:

1. You are required not to collect, use or disclose personal health information if other information will serve the purpose, and
2. You are required not to collect, use or disclose more personal health information than is reasonably necessary to meet the purpose of the collection, use or disclosure.

3.4 CONSENT AND CAPACITY

Unless you have reasonable grounds to believe otherwise, you may assume that your client is **capable** of consenting to the collection, use or disclosure of his or her personal health information. Under the Act, an individual is capable of consenting to the collection, use or disclosure of personal health information if:

- The individual is able to understand the information that is relevant to deciding whether to consent to the collection, use or disclosure; and
- The individual is able to appreciate the reasonably foreseeable consequences of giving, withholding or withdrawing consent.

If you determine that a client does not have the capacity to consent and the client has not applied for a review by the Consent and Capacity Board, you must get consent from the client's **substitute decision-maker** instead. Substitute decision-makers are discussed in Chapter 4.

3.5 WHEN CAN YOU RELY ON IMPLIED CONSENT?

- **If you are a health information custodian (HIC), you may generally rely on implied consent when you collect or use a client's personal health information (some exceptions apply) or when you disclose a client's personal health information to another HIC *to provide health care*.** If you are a HIC and wish to disclose a client's personal health information to a person that is not a HIC or to another HIC for a purpose other than the provision of health care, you must generally obtain express consent (see section 3.6 below).

- If you are a HIC whose core functions are the provision of health care (as described in paragraph 1, 2 or 4 of the definition of "health information custodian" or as prescribed by regulation[4]) and you receive a client's personal health information from the client, a substitute decision-maker, or another HIC for the purpose of providing or assisting in providing health care to the client, then you may **assume** that you have the client's implied consent to collect, use or disclose the information for the purpose of providing or assisting in providing health care, unless you are aware that the client has expressly withheld or withdrawn consent. (See section 3.10 on the **lockbox** for more information on a client's right to expressly withhold or withdraw consent for the use or disclosure of his or her personal health information).

- If you wish to rely on implied consent, **you need to make sure your clients have the information they need in order to understand why you are collecting their personal health information and how you may use or disclose it. You also need to make sure that your clients are informed that they may withhold or withdraw their consent and that they have information on how they can do so.**

- You may do this by posting notices or placing brochures in your office or waiting room or in other areas where clients are likely to see them or by providing your individual clients with such notices or brochures. If you are a HIC, you are responsible for developing these notices or brochures; if you are an agent of a HIC, the HIC is responsible for developing the notices or brochures.

- Remember that consent may never be implied if a client specifically states that you may not collect, use or disclose his or her personal health information.

- Lastly, there may be situations where, based on your professional opinion or experience, you may want to obtain an individual's express consent to collect, use and/or disclose his or her personal health information. Nothing in the Act prevents you from doing so.

[4] See Appendix A for the definition of "health information custodian".

EXAMPLE OF A PERMITTED "COLLECTION" OF PERSONAL HEALTH INFORMATION WITH IMPLIED CONSENT:

You are a social worker or social service worker who works for a home support agency for seniors and collects personal health information for the purpose of providing health care to seniors (e.g. you are a HIC working for a non-HIC). You may assume that you have the individual's implied consent to collect personal health information about your client directly from your client or his or her substitute decision-maker in order to provide health care to your client, unless the client or his or her substitute decision-maker has expressly withheld or withdrawn consent.

EXAMPLE OF A PERMITTED "USE" OF PERSONAL HEALTH INFORMATION WITH IMPLIED CONSENT:

You are a social worker or a social service worker who provides counselling to women with HIV/AIDS for the purpose of providing health care at a hospital (e.g. you are an agent of a HIC). You want to share some of the personal health information you have collected from a client with one of the hospital's physiotherapists who you believe may be able to help the client improve her mobility and relieve some of her joint and muscular aches (e.g. you want to share personal health information with another agent of the same HIC for the purpose of providing health care to that client). You may assume that you have the individual's implied consent when you share this information, unless the client expressly instructs you not to share her personal health information with others.

EXAMPLE OF A PERMITTED "DISCLOSURE" OF PERSONAL HEALTH INFORMATION WITH IMPLIED CONSENT:

You are a social worker or social service worker in independent practice. Your client has advised you about his feelings of hopelessness and addiction to prescription pain killers and you are providing counselling services to your client for the purpose of providing health care (e.g. you are a HIC). You have previously discussed the limits of confidentiality with your client, and your client is aware that you may disclose information to his family doctor if you feel it is necessary to provide health care. You have serious concerns about the potential adverse effects of your client's feelings of hopelessness and addiction on his mental and physical health and you have told your client that he needs to discuss these issues with his family doctor. You may assume that you have the individual's implied consent to share the client's personal health information with his family doctor, unless the client expressly instructs you not to share this information with his doctor.

3.6 WHEN MUST YOU OBTAIN EXPRESS CONSENT?

- You must obtain a client's express consent **if you want to disclose any of his or her personal health information to someone other than a health information custodian** (HIC), unless the Act permits the disclosure without consent.
- You must obtain a client's express consent **if you want to disclose any of his or her personal health information to another HIC if the purpose of the disclosure is *not* for providing health care or assisting in providing health care**, unless the Act permits the disclosure without consent. (See section 3.7 for information on when consent is not required.)

EXAMPLE OF A "DISCLOSURE" REQUIRING EXPRESS CONSENT:

You are a social worker or social service worker who provides counselling to troubled youth for a school board (e.g. you are a HIC working for a non-HIC). You want to disclose personal health information about one of your clients to a local community club (e.g. a non-HIC) that is offering a free guest lecture series on youth motivation and team-building. You must obtain express consent from the client (see section 3.12 for information on children, youth and consent).

3.7 WHEN IS CONSENT NOT REQUIRED?

There are situations when you do not need consent from your client to collect, use or disclose his or her personal health information. Only some of these are described below. For a comprehensive list of these situations, you must refer to the Act.

Unless you are required to do so by the Act or another law, then you are permitted - rather than required - to disclose personal health information in the situations described below. There may be situations where, based on your professional opinion, you may nonetheless wish to obtain consent for the disclosure. Nothing in the Act prevents you from doing so.

Collection:

If you are a health information custodian (HIC), you do not need a client's consent to **collect** his or her personal health information directly from the client (even if the client is incapable of consenting) (e.g. **"direct collection"**) if:

- You need the information to provide health care to the client; and
- There is no time for you to obtain consent.

You do not need a client's consent to **collect** personal health information about a client from someone *other* than the client or his or her substitute decision-maker (e.g. **"indirect collection"**) if:

- the personal health information is necessary for providing health care or assisting in providing health care to the individual and
  - it is not possible to collect information from the individual that can be relied on as accurate, or
  - it is not possible to collect information from the individual in a timely manner.
- The Information and Privacy Commissioner/Ontario ("the Commissioner") specifically authorizes the collection;
- You collect the information from a person who is permitted or required by law to disclose it to you; or
- You are permitted or required by law to collect the information indirectly.

Use:

If you are a HIC, you do not need a client's consent to **use** his or her personal health information for:

- Complying with a legal requirement or participating in legal or administrative proceedings or contemplated proceedings in which you are involved or are expected to be involved;

> **EXAMPLE:**
> You need to review client charts in preparation for a legal or administrative proceeding in which the information in the chart is relevant to the proceeding.

- Planning, delivering or monitoring health-related programs or services you provide;

> **EXAMPLE:**
> You do not need a client's consent to use information from client satisfaction surveys to plan a future health-related program for your clients.

- Educating agents to provide health care to your clients;

> **EXAMPLE:**
> You do not need a client's consent to have social work or social service work students sit in on client interviews or meetings for educational purposes.

- Managing risks or errors or improving or maintaining the quality of care or the quality of any related programs or services you provide;

> **EXAMPLE:**
> You do not need a client's consent to use information he or she has provided on a communicable illness to disinfect a client meeting room, thereby managing risks associated with the spread of infectious diseases.

- Disposing or altering information to ensure that others cannot link the information to a specific individual;

> **EXAMPLE:**
> You do not need a client's consent to shred records or to remove personal identifiers from the record so that the client cannot be identified.

- Seeking consent for additional collections, uses, and disclosures when only the client's name and contact information is used; or

> **EXAMPLE:**
> You do not need a client's consent to call him or her to ask if you may use the client's name and contact information to send the client a monthly newsletter from your practice.

- Collecting payments for health care services you have provided.

> **EXAMPLE:**
> You do not need a client's consent to collect payments for counselling sessions you provided to the client for a health-related purpose or hiring a debt collector as an agent to do so on your behalf.

If you are a HIC, you may also use personal health information without consent for research provided that certain conditions and restrictions are met. For more information, see Appendix A.

Disclosure:

If you are a HIC, you do not need a client's consent to **disclose** his or her personal health information provided that:

- **The information is reasonably necessary to provide health care;**
- **You cannot obtain consent in a timely manner; and**
- **The client has not expressly instructed you not to disclose the information;**

AND the disclosure is to:

- Another health care practitioner or person who operates a group practice of health care practitioners;
- A service provider as defined in the *Home Care and Community Services Act, 1994* who provides a community service;
- A public or private hospital[5];
- A psychiatric facility;
- An independent health facility[6];
- A long-term care home;
- A retirement home;
- A pharmacy;
- A laboratory;
- An ambulance service;
- A home for special care;
- A centre, program or service for community or mental health whose primary purpose is providing health care;
- A medical officer of health of a board of health;
- Ontario Agency for Health Protection and Promotion;
- Ontario Air Ambulance Services Corporation; or
- A local health integration network.

[5] Subparagraph 4i of the definition of "health information custodian" currently includes a private hospital. It is expected that the reference to private hospital will be repealed in the future.

[6] Subparagraph 4i of the definition of "health information custodian" currently includes an independent health facility. It is expected that the reference to independent health facility will be replaced by "community health facility" in the future.

If you are a HIC, you also do not need a client's consent to **disclose** his or her personal health information to the following people or organizations or for the following purposes:

- For the purpose of determining, assessing or confirming capacity under the *Health Care Consent Act, 1996*, the *Substitute Decisions Act, 1992* or the Act;
- The Ontario College of Social Workers and Social Service Workers for the purpose of the administration or enforcement of the *Social Work and Social Service Work Act, 1998*.
- A regulated health profession College for the purpose of the administration or enforcement of the *Drug and Pharmacies Regulation Act*, the *Regulated Health Professions Act, 1991* or an Act named in Schedule 1 to that Act;
- The Public Guardian and Trustee, the Children's Lawyer, a Children's Aid Society, a Residential Placement Advisory Committee established under the *Child, Youth and Family Services Act, 2017*, or a custodian appointed under the *Child, Youth and Family Services Act, 2017* so they can carry out their statutory functions;
- A person carrying out an inspection, investigation or similar procedure that is authorized by a warrant or by or under the Act or any other Act of Ontario or an Act of Canada for the purpose of complying with the warrant or for the purpose of facilitating the inspection, investigation or similar procedure;
- A researcher provided that certain conditions and restrictions are met. For more information, see Appendix A;
- The Chief Medical Officer of Health or a medical officer of health for purposes set out in the *Health Protection and Promotion Act*;
- The Ontario Agency for Health Protection and Promotion for the purpose of the *Ontario Agency for Health Protection and Promotion Act, 2007*; and
- The head of a penal (or similar) institution or the officer in charge of a psychiatric facility within the meaning of the *Mental Health Act*, where the client is being lawfully detained in order to assist the institution or facility in making a decision concerning arrangements for the provision of health care or regarding where the client should be placed.

Finally, if you are a HIC, you also do not need a client's consent to disclose personal health information if:

- You are permitted or required by law to disclose the information;

> **EXAMPLE:**
> You do not need a client's consent to disclose information in order to report a child in need of protection to a Children's Aid Society.

- You need to contact a relative, friend or potential substitute decision-maker of a client who is injured, incapacitated, or ill and unable to give consent personally;

> **EXAMPLE:**
> You do not need a client's consent to contact your client's spouse or partner if your client is unconscious.

- The information is needed to determine or verify eligibility for health care or related goods, services or benefits provided under legislation and funded by the government, a local health integration network or a municipality;

> **EXAMPLE:**
> You do not need a client's consent to disclose information to the Ontario Health Insurance Plan in order to determine whether the client qualifies for coverage.

- You believe on reasonable grounds the information is needed to eliminate or reduce a significant risk of serious bodily harm to the client, another individual or a group of persons;

> **EXAMPLE:**
> You are aware that your client has recently been diagnosed as HIV positive, your client refuses to disclose the risk of HIV infection to his/her sexual partner(s), and is continuing to have unprotected sexual intercourse. You do not need the client's consent to disclose this information.

- You disclose personal health information to a potential purchaser of your practice to assess and evaluate your operations, provided that the potential purchaser agrees in writing to keep the information confidential and secure and to keep the information no longer than necessary to reach a conclusion;

> **EXAMPLE:**
> You are a social worker or social service worker in independent practice who is considering selling your practice. You do not need consent from your clients to disclose information the potential purchaser requires to assess and evaluate your operations provided that he or she agrees in writing to keep your client information confidential and secure and to keep the information no longer than is necessary for the purchaser to reach a conclusion about buying your practice.

- You disclose personal health information for the purpose of a proceeding or a contemplated proceeding in which you, your agent or a former agent is a party or a witness, if the information is relevant to the proceeding.

> **EXAMPLE:**
> A former client has commenced a legal action in which he or she is claiming he or she has suffered damages as a result of your professional negligence. You do not need your client's permission to disclose information about the client that is relevant to the proceeding.

3.8 WITHDRAWAL OF CONSENT

Where express or implied consent is required, clients may withdraw their consent for the collection, use or disclosure of their personal health information at any time. A client who wants to withdraw his or her consent must notify you that he or she no longer consents to your collection, use and disclosure of personal health information. **If a client withdraws his or her consent, it has no effect on information you have already collected, used or disclosed before the client withdrew consent, but it has effect from the time you receive it.** A client's substitute decision-maker who consented on a client's behalf may also withdraw consent at any time by notifying you if the substitute decision-maker still has authority to act for the client; for example, the client is still not capable.

If the withdrawal of consent will compromise the care you deliver to a client, you should discuss the effect of the client's withdrawal with the client and document the withdrawal and these discussions in the client's record.

3.9 THE IMPLICATIONS OF THE "CIRCLE OF CARE"

The "circle of care" is actually not defined in the *Personal Health Information Protection Act, 2004* or its regulations, although it is discussed by the Office of the Information and Privacy Commissioner/Ontario in its frequently asked questions about the law (www.ipc.on.ca).

The circle of care commonly refers to the individuals who are involved in the provision of health care to a specific individual. For example, a social worker or social service worker who provides health care to a patient at a hospital would be in that patient's circle of care, but not all social workers or social service workers employed at the hospital would be in the patient's circle of care unless they were all providing health care, or assisting in providing health care, to that patient.

Because the *Personal Health Information Protection Act, 2004* generally allows those health information custodians whose core functions are the provision of health care (as described in paragraph 1, 2 or 4 of the definition of "health information custodian" or as prescribed by regulation[7]) to collect, use or disclose an individual's personal health information to provide health care on the assumption of having the client's implied consent, the concept of the circle of care is very important to health care practitioners. As a social worker or social service worker who provides health care, **you must be providing, or assisting in providing, health care to an individual to be part of that individual's circle of care.**

[7] See Appendix A for the definition of "health information custodian".

EXAMPLE:

You may be part of an individual's circle of care if you are asked for your professional opinion on the delivery of health care to a particular patient or client, even though you may not actually deliver health care directly to that patient or client. This may happen during rounds at a hospital or you may be part of a group practice of social workers, social service workers or other health care practitioners and are asked for your professional opinion on the delivery of health care to a particular patient or client.

Note from the above example that whether you are part of an individual's circle of care is determined on a case-by-case basis by the *needs of the individual patient or client* (e.g. whether or not you are providing, or assisting in providing, health care to that patient or client). Whether or not you are part of the circle of care and can rely on the assumption of having the client's implied consent is NOT determined by the fact that your *role is a health care practitioner* (as defined under the Act) or an agent of a health information custodian. As such, social workers or social service workers should not assume that they are "automatically" part of – or not part of – the circle of care at their facility, just as physicians or other health care practitioners should not assume that they are "automatically" part of – or not part of – the circle of care at their facility. Being part of the circle of care will depend on whether you provide or assist in providing health care to that patient or client.

As a social worker or social service worker, you may still be permitted to collect, use or disclose personal health information even if you are *not* in an individual's circle of care if you have the client's consent (implied or express) or the collection, use or disclosure is permitted without consent. See section 3.5 for information on permitted collections, uses and disclosures of personal health information on the basis of implied consent or section 3.7 for information on permitted collections, uses and disclosures of personal health information without consent.

3.10 THE LOCKBOX PROVISION

Individuals are permitted to make express instructions concerning allowable uses and disclosures of their personal health information under sections 19, 37(1)(a), 38(1)(a), and 50(1)(e) of the *Personal Health Information Protection Act, 2004*. This means that **your clients may request that you not use or disclose their personal health information for the purposes described in sections 37(1)(a), 38(1)(a) or 50(1)(e) of the Act.** These sections generally relate to the provision of health care.

For example, a client may request that none of the other social workers, social service workers or other health care practitioners in your group practice be able to access his or her personal health information; this would be a restriction on the use of the client's personal health information. Or a client could request that you not share his or her personal health information with his or her family doctor or with individuals or organizations outside of the group practice; this would be a restriction on the disclosure of the client's personal health information. Note that an individual can impose restrictions on all of his or her personal health information, or just components of his or her information, such as a particular prescription drug the individual is taking or a specific diagnosis.

The right of an individual to restrict the use or disclosure of his or her personal health information under the Act is known as a "lockbox", although this term – like the "circle of care" – is actually not used in the Act. Personal health information for which a client has restricted uses or disclosures may be considered "locked". You may "unlock" personal health information if you obtain the consent of the client to "unlock" the information.

There are also circumstances where the client's express instructions not to use or disclose personal health information may be overridden by other provisions of the Act. For example, you may disclose "locked" personal health information where another law requires you to disclose the information or you believe on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons – see section 40(1) of the *Personal Health Information Protection Act, 2004* in Appendix A.

A client can only "lock" information that requires his or her consent for you to collect, use or disclose in the first place or that is subject to the express instruction ("lockbox") provisions (sections 37(1)(a), 38(1)(a) or 50(1)(e)) of the Act. For example, a client may instruct you to "lock" personal health information about abusive behaviour towards a child from disclosure to a Children's Aid Society, but you would not be able to comply with a lockbox request in this circumstance because you are required to disclose such information to the Children's Aid Society under the *Child, Youth and Family Services Act, 2017*. A client's request to "lock" personal health information also cannot stop you from recording personal health information as required by law or established standards of professional practice or institutional practice.

Finally, as a disclosing custodian, you have a duty to notify the receiving custodian that you have not disclosed all of the personal health information if you consider that information reasonably necessary for the provision of health care. Section 20(3) of the *Personal Health Information Protection Act, 2004* states that "if the disclosing custodian does not have the consent of the individual to disclose all the personal health information about the individual that it considers reasonably necessary for that purpose" [that is, for providing health care to the individual], you must notify the receiving custodian of that fact. Section 38(2) of the Act states that "if an instruction of the individual made under that clause [38(1)(a)] prevents the custodian from disclosing all the personal health information that the custodian considers reasonably necessary to disclose for the provision of health care or assisting in the provision of health care to the individual, the custodian shall notify the person to whom it makes the disclosure of that fact".

There is thus a legal requirement for health information custodians disclosing an individual's personal health information in cases where they believe information in the lockbox is relevant to providing health care to inform the receiving custodian that the individual has not consented to the disclosure of all of his or her relevant personal health information.

3.11 PSYCHIATRIC FACILITIES AND THE *PERSONAL HEALTH INFORMATION PROTECTION ACT, 2004*

The *Mental Health Act*, which applies to psychiatric facilities, has certain special rules related to the collection, use and disclosure of personal health information. These rules govern where there is a conflict between that Act and the *Personal Health Information Protection Act, 2004*. The following describes some of the special rules.

Under the *Mental Health Act*, the officer in charge of a psychiatric facility is permitted to collect, use or disclose personal health information with or without consent to:

- Assess, observe, examine or detain a client in accordance with the *Mental Health Act*; or
- Comply with Part XX.1 (Mental Disorder) of the Criminal Code (Canada) or an order or disposition under that Part.

If you are a social worker or social service worker named in a community treatment order as participating in the treatment or care and supervision of a person subject to the order, you may share personal health information with any other person named in the community treatment plan to treat, care for and supervise the person in accordance with the plan. Disclosure is also permitted for consultation between a physician and regulated health care professionals, social workers or others where a physician is considering issuing or renewing a community treatment order.

However, with respect to the use of Form 14 as a consent to the disclosure of personal health information, Form 14 no longer exists as a form approved by the Minister of Health and Long-Term Care under the *Mental Health Act*. Therefore, Form 14 should no longer be used by health information custodians after November 1, 2004 to obtain the express consent of an individual to the collection, use or disclosure of his or her personal health information. You should now obtain consent from a client as outlined in the *Personal Health Information Protection Act, 2004*, unless there is a lawful basis not to obtain consent (for example, your client's case falls under one of the *Mental Health Act* exceptions). Where express consent is required for the disclosure of personal health information under the *Personal Health Information Protection Act, 2004* or the *Mental Health Act* and no exception to obtaining the required consent applies, you may look to the sample consent form that the Ministry of Health and Long-Term Care has developed; the sample consent form is available at: http://www.health.gov.on.ca/english/providers/project/priv_legislation/sample_consent.html#download. If you wish to rely on a consent that was obtained prior to the *Personal Health Information Protection Act, 2004* coming into force, you must ensure that the previously obtained consent meets the consent requirements in the Act.

3.12 CHILDREN, YOUTH AND CONSENT

Many social workers and social service workers have clients who are children and/or youth. Where a child is capable, the child may consent to the collection, use or disclosure of the child's personal health information. (See section 3.4 to determine whether an individual is capable. The *Personal Health Information Protection Act, 2004* does not set out an age which would determine whether or not a child is capable of consenting.) You are entitled to rely on a presumption that an individual, including a child, is capable unless it is unreasonable to do so.

EXAMPLE:

You have a client who is a toddler and is not yet speaking. It would be unreasonable to presume the child has the capacity to consent in these circumstances.

For children under sixteen years of age, a parent (but not a parent who has only a right of access to the child) or a Children's Aid Society or other person who is lawfully entitled to give or refuse consent in the place of the parent, may also consent to the collection, use or disclosure of a child's personal health information even if the child has the capacity to consent, unless the information relates to:

- Treatment within the meaning of the *Health Care Consent Act, 1996* about which the child has made his or her own treatment decision; or
- Counselling in which the child has participated on his or her own under the *Child, Youth and Family Services Act, 2017*.

In the event of a conflict between a decision of a child under sixteen who is capable of consenting and a decision of a person who is entitled to consent on behalf of the child, the capable child's decision prevails.

EXAMPLE:

You are a social worker or social service worker who provides health care to a youth under the age of sixteen. The youth has just informed you that she has obtained a prescription for the birth control pill from a local family planning clinic (e.g. she has made a decision on her own about treatment within the meaning of the *Health Care Consent Act, 1996*). Unless it is not reasonable in the circumstances, you may presume that your client has the capacity to consent to the collection, use and disclosure of any personal health information associated with this treatment decision. In addition, so long as the client is capable, the youth's consent would be needed in order to disclose the personal health information related to her treatment, even to her parent(s) or other lawful custodian.

3.13 CLIENT WHO IS DECEASED

In cases where a client is deceased, the deceased estate's trustee or the person who has assumed responsibility for the administration of the deceased's estate, if the estate does not have an estate trustee, may give consent for the collection, use or disclosure of personal health information.

3.14 THE DISCLOSURE OF PERSONAL HEALTH INFORMATION TO THE ONTARIO COLLEGE OF SOCIAL WORKERS AND SOCIAL SERVICE WORKERS

Section 43 of the *Personal Health Information Protection Act, 2004* allows health information custodians (HICs) to disclose personal health information without consent to the Ontario College of Social Workers and Social Service Workers for the purpose of the administration or enforcement of the *Social Work and Social Service Work Act, 1998*. An agent of a HIC is also permitted to disclose personal health information without consent to the Ontario College of Social Workers and Social Service Workers for the same purpose. (See section 7 of O. Reg. 329/04.) The Act provides that nothing in the Act shall be construed to interfere with the regulatory activities of the Ontario College of Social Workers and Social Service Workers. (See section 9(2)(e) of the Act.)

3.15 ACCESS TO RECORDS OF PERSONAL HEALTH INFORMATION

Under the *Personal Health Information Protection Act, 2004*, an individual has a right of access to a record of personal health information about himself or herself that is in the custody or control of a health information custodian (HIC) unless one of the exceptions or exclusions in the Act applies. Examples of a record, or part of a record, to which a requestor does not have a right of access include a record containing information that is subject to a legal privilege, such as solicitor-client privilege, or information that is prohibited by law from being disclosed to the requestor, or where granting access could reasonably be expected to result in a risk of serious harm to the treatment or recovery of the individual or a risk of serious bodily harm to the individual or another person. See sections 51(1) and 52(1) of the Act for more information on exceptions and exclusions to an individual's right of access to a record of personal health information about the individual.

As a social worker or social service worker, if you are a HIC, then you must comply with the Act's access provisions:

- An access request can be made by an individual or his or her substitute decision-maker under the Act.
- As a HIC, you must take "reasonable steps" to satisfy yourself of the requestor's identity before providing access to a record of personal health information, such as asking the requestor for photo identification.
- You may charge a fee for making the record available, or for providing a copy to the requestor, but you must first give the requestor a fee estimate. The amount of the fee cannot exceed the amount prescribed in regulation or, if no amount is prescribed, the amount of "reasonable cost recovery."[8] As a HIC, you may also waive the fee if, in your

[8] As of June 1, 2018, there were no fees prescribed in the regulations.

opinion, it is "fair and equitable" to do so. For example, several hospitals have chosen to waive access fees for the homeless, for patients on social assistance and for assault victims.

- You must respond to an access request within 30 days of receiving the request, but you can extend the time limit for up to a maximum of an additional 30 days, as long as it is done within the initial 30 day limit. In such cases, you must give the requestor written notice of the extension and set out its length (not to exceed 30 days) and the reason for the extension. Extensions are possible only if meeting the time limit would "unreasonably interfere" with your operations as a HIC because the records are numerous or a lengthy search is required to locate them or consultations are necessary which make the 30 day time limit not "reasonably practical".
- If you fail to respond to an access request within the 30 day limit, or before an extension expires, you are deemed to have refused the request.
- If you refuse or are deemed to have refused the request, the requestor is entitled to make a complaint about the refusal to the Ontario Information and Privacy Commissioner.
- The Act sets out requirements for how to reply to an access request, depending on whether you are granting or refusing the request. (For more information on how to reply to an access request, you may wish to refer to the resources referred to in Appendix D.)

Individuals can also request a shorter response time. As a HIC, you are required to comply with a request for a shortened response time if the requestor provides you with "satisfactory evidence" that the requestor needs the record on an "urgent basis" within the shorter time period and you are "reasonably able" to provide the response within the shortened time period.

If you are a HIC and the organization which employs you is a non-HIC and is covered by public sector privacy legislation, the access rules under the Act do not apply.

- Where a record is held by a HIC in the course of acting as an agent/employee of an institution under the *Freedom of Information and Protection of Privacy Act* (FIPPA) or the *Municipal Freedom of Information and Protection of Privacy Act* (MFIPPA), **where the institution itself is not a** HIC (e.g. a social worker or social service worker who provides health care as part of your duties for a school board, community college or provincial correctional facility), the *Personal Health Information Protection Act, 2004* does not apply to access to a record of personal health information in the HIC's custody or control. Access to the record is instead provided by the institution in accordance with the applicable public sector privacy act (that is, either FIPPA or MFIPPA).

If you are an agent of a HIC, the HIC (that is, the organization which employs you or for or on whose behalf you perform services or activities) is responsible to handle requests for access. More specifically, one of the duties of a HIC's privacy contact person is to respond to requests of an individual for access to a record of personal health information. If you are an agent of a HIC, you are responsible for complying with the HIC's policies and procedures for handling access requests. For example, if you are a social worker or social service worker

who is employed by a hospital, the hospital may have established specific access policies and procedures under the Act which might require requestors to file access requests through the hospital's Health Records Department. You should follow the HIC's policies and procedures respecting access requests.

Finally, social workers and social service workers may deal with records of personal health information which contain information about more than one individual. If you are a HIC, consideration will need to be given to various factors before you respond to an access request for a record of personal health information that contain references to more than one individual.

These factors include whether the record is a record of personal health information about the individual requesting access, whether the record is dedicated primarily to the personal health information about the individual requesting access, whether any part of the information should be severed from the record before providing access and whether any of the exceptions or exclusions under the Act apply.

For example, you are a social worker or social service worker in independent practice who provides individual counselling for a health-related purpose to a woman and she provides information to you about her spouse's health problems. The client requests access to her client record which may contain personal health information about her spouse. The Ministry of Health and Long-Term Care notes that where the record in question is "a record dedicated primarily to personal health information about the individual requesting access", such as a patient chart, the individual has a right of access to the entire record, subject to the exceptions and exclusions listed in the Act, including personal health information about third persons. (See page 26 of the *Personal Health Information Protection Act, 2004: Overview for Health Information Custodians, August 2004*[9]).

This same example could give rise to a request for access to the record of personal health information by the client's spouse. The regulation made under the Act (O. Reg. 329/04) provides that a person does not have a right of access to information about the person that is contained in a record that is dedicated primarily to the personal health information of another person. The Ministry of Health and Long-Term Care notes that a person does not have a right of access to personal health information that is contained in the record of another individual (apart from the substitute-decision making provisions, where applicable) even if that person is referred to in that record, for example, as part of the client's family medical history or in counselling notes (see page 27 of the *Personal Health Information Protection Act, 2004: Overview for Health Information Custodians, August 2004*[10]).

If you are a social worker or social service worker in independent practice with records that contain personal health information about more than one client to whom you are providing health care (e.g. couples counselling or family counselling), the clients to whom you are providing health care may each have a right of access to the record of personal health information, or part of it, about him or her, subject to the exceptions and exclusions outlined in the Act. Consideration should be given to section 52(3) of the Act that provides that, if a record is not a record dedicated primarily to personal health information about

[9] http://www.health.gov.on.ca/english/providers/project/priv_legislation/info_custodians.pdf

[10] http://www.health.gov.on.ca/english/providers/project/priv_legislation/info_custodians.pdf

the individual requesting access, the individual has a right of access only to the portion of personal health information about the individual in the record that can reasonably be severed from the record for the purpose of providing access.

If you are a HIC and you receive an access request(s) for a record of personal health information where the record contains information on more than one individual, you should consult the Act and regulation before responding to the access request and, where appropriate, seek legal or professional advice.

3.16 CORRECTIONS TO RECORDS OF PERSONAL HEALTH INFORMATION

Under the *Personal Health Information Protection Act, 2004*, an individual has the right to request that a health information custodian (HIC) correct a record of an individual's personal health information if the individual believes the record is "inaccurate or incomplete for the purposes" for which the HIC collected or used the information. The right of correction applies only to records of personal health information to which an individual has been granted a right of access. As with access requests, a HIC has 30 days, or the expiry of an extended time limit, for responding to individuals who have filed a correction request. Failure to respond in time is considered a "deemed refusal".

If you are a HIC, you are not required to correct a record if you did not originally create the record and if you do not have sufficient "knowledge, expertise or authority" to correct the record. You are also not required to correct a record if the information requested to be corrected is a "professional opinion or observation" that you have made in good faith about the individual, or if you believe on reasonable grounds that a correction request is frivolous, vexatious or made in bad faith. Apart from these exceptions, however, you are obligated to correct a record if the individual demonstrates to you that the record is "inaccurate or incomplete for the purposes" for which you use it.

EXAMPLE:

You observe that your client is not coping well after his wife has died, that he needs emotional support from other family members and friends, and that he would benefit from grief counselling. You are not obligated to correct this observation if your client disagrees with it, provided you have made a professional observation in good faith.

If you are a HIC and you grant a request for correction, the Act sets out your duties with respect to making the correction including how the requested correction is to be made.

If you are a HIC and you refuse to correct a record, you must provide a notice to the requestor explaining your reasons for refusing the correction request. Further information on requirements for refusing correction, such as the obligation to attach a statement of disagreement if requested to do so, is outlined in the Act. (For more information on how to reply to a request for correction, you may wish to refer to the resources referred to in Appendix D.)

If you are an agent of a HIC, the HIC (that is, the organization which employs you or for or on whose behalf you perform services or activities), is responsible for responding to correction requests. For example, if you are a social worker or social service worker who is employed by a hospital, you should follow the custodian's policies and procedures for responding to correction requests.

Substitute Decision-Makers

4.1 SUMMARY OF KEY QUESTIONS COVERED IN THIS CHAPTER

- What is a **substitute decision-maker** under the *Personal Health Information Protection Act, 2004*? (See section 4.2).
- **Who can be a substitute decision-maker**? (See section 4.3).
- What is the **role of a substitute decision-maker** under the *Health Care Consent Act, 1996*? (See section 4.4).
- What are the **responsibilities of substitute decision-makers**? (See section 4.5).
- What is the **relationship between consent under the *Personal Health Information Protection Act, 2004* and consent under the *Health Care Consent Act, 1996***? (See section 4.6).

4.2 WHAT IS A SUBSTITUTE DECISION-MAKER UNDER THE *PERSONAL HEALTH INFORMATION PROTECTION ACT, 2004*?

Under the *Personal Health Information Protection Act, 2004*, a **substitute decision-maker** is a person who is authorized under the Act to consent on behalf of the individual to the collection, use or disclosure of personal health information about the individual. The Act sets out rules for when a substitute decision-maker can act on behalf of a capable individual, a deceased individual and an incapable individual. This chapter focuses on a substitute decision-maker when the client is incapable. (Also see section 3.12 for information on children, youth and consent and section 3.13 for information on a client who is deceased.)

Many social workers and social service workers deal with clients who are incapable of consenting to the collection, use of disclosure of their personal health information. In such cases, a substitute decision-maker may give consent for the collection, use or disclosure of personal health information about the individual. The **substitute decision-maker** may also withhold or withdraw consent for the collection, use or disclosure of personal health information about the individual or take a step under the Act, such as expressing an instruction or making an access request.

A client's need for a substitute decision-maker may change over time, depending on his or her circumstances. For example, your client may be capable of consenting to the collection, use or disclosure of some parts of his or her personal health information, but incapable of consenting with respect to other parts. Or your client may be capable of consenting to the collection, use or disclosure of personal health information at one time, but incapable of consenting at another time.

Unless you have reasonable grounds to believe otherwise, you may presume that your client is capable of consenting to the collection, use or disclosure of his or her personal health information.

EXAMPLE:

You are a social worker or social service worker who provides health care to a client that has a specific mental health condition. The client is capable of consenting to the collection, use or disclosure of his or her personal health information some of the time, but not others.

You are a social worker or social service worker who provides health care to a client that is "in and out of consciousness" at a hospital and who may not be capable of consenting to the collection, use or disclosure of his or her personal health information at all times.

In these circumstances, you would consider your client's capacity every time you seek consent.

4.3 WHO CAN BE A SUBSTITUTE DECISION-MAKER?

When a client is not capable of providing consent for the collection, use or disclosure of his or her personal health information, you may obtain consent from the following individuals, ranked in the order in which they are listed:

- The client's guardian of the person or guardian of property, if the guardian has the authority to make a decision on behalf of the client;
- The client's attorney for personal care or attorney for property, if the attorney has the authority to make such decisions;
- A representative appointed by the Consent and Capacity Board constituted under the *Health Care Consent Act, 1996*, if the representative has the authority to give consent;
- The client's spouse or partner;
- The client's child, parent (excluding a parent who only has a right of access), or a Children's Aid Society or other person legally entitled to give or withhold consent in place of a parent;
- The client's parent who only has access rights;
- The client's brother or sister; or
- Any other relative of the client (related by blood, marriage or adoption).

Note that a child's parent cannot consent on behalf of a child in situations where there is a Children's Aid Society or other person that is legally entitled to give or withhold consent in place of a parent.

A person listed above may only serve as a substitute decision-maker if he or she:

- Is capable of consenting to the collection, use or disclosure of personal health information by a health information custodian;
- Is at least 16 years of age or is the parent of the individual to whom the personal health information relates;

- Is not prohibited by court order or separation agreement from having access to the individual to whom the personal health information relates or from giving or refusing consent on the individual's behalf;
- Is available to give consent on behalf of the individual; and
- Is willing to assume the responsibility of making a decision about whether or not to consent.

If you cannot find anyone who meets these requirements and is willing to take on the role of a substitute decision-maker, the Public Guardian and Trustee can give consent on behalf of your client. The Public Guardian and Trustee can also give consent if two or more equally ranked substitute decision-makers disagree about whether to consent – e.g. the Public Guardian and Trustee would break the "deadlock" between the disputing parties.

4.4 WHAT IS THE ROLE OF A SUBSTITUTE DECISION-MAKER UNDER THE *HEALTH CARE CONSENT ACT, 1996*?

If a person functions as a substitute decision-maker for your client under the *Health Care Consent Act, 1996*, then he or she will also function as the client's substitute decision-maker with respect to informational consent issues under the *Personal Health Information Protection Act, 2004* if the purpose of the collection, use or disclosure of personal health information is related to a decision under the *Health Care Consent Act, 1996*. **This means that if a person is serving as an authorized substitute decision-maker for your client with respect to a decision about the client's treatment, personal assistance service, or admission to a long-term care facility under the *Health Care Consent Act, 1996*, then that same person will also function as the substitute decision-maker for the collection, use and disclosure of your client's personal health information in connection with the decision to be made under that Act. In these circumstances, a substitute decision-maker under the *Health Care Consent Act, 1996* has priority over a substitute decision-maker from the list referred to above.**

4.5 RESPONSIBILITIES OF SUBSTITUTE DECISION-MAKERS

All substitute decision-makers are responsible for considering specific factors when making decisions about the collection, use or disclosure of personal health information on behalf of an incapable client or making decisions about the withholding or withdrawal of consent for the collection, use or disclosure of personal health information or about providing an express instruction on behalf of an incapable client.

For example, substitute decision-makers must consider:

- The wishes, values and beliefs of the incapable individual that the person knows the individual held when capable and that he or she would have wanted reflected in decisions concerning his or her personal health information;
- Whether the benefits expected from the collection, use or disclosure of personal health information outweigh the risks of negative consequences occurring as a result of the collection, use or disclosure;

- Whether the purpose for the collection, use or disclosure sought can be accomplished without the collection, use or disclosure; and
- Whether the collection, use or disclosure is necessary to satisfy any legal obligation.

If your client requires a substitute decision-maker, you should always make sure that the substitute decision-maker understands and is willing to assume consent responsibilities by discussing these responsibilities with him or her.

If you do not believe that a substitute decision-maker has properly considered the above factors with respect to your client, you may apply to the Consent and Capacity Board to determine whether the substitute decision-maker has met the requirements.

4.6 RELATIONSHIP BETWEEN CONSENT UNDER THE *PERSONAL HEALTH INFORMATION PROTECTION ACT, 2004* AND CONSENT UNDER THE *HEALTH CARE CONSENT ACT, 1996*

The *Personal Health Information Protection Act, 2004* has not changed the rules for consent to treatment; these rules are found in the *Health Care Consent Act, 1996*. However, there are some differences between the requirements for "consent to treatment" and the requirements for "informational consent". You will remember from Chapter 3 (section 3.3) that "informational consent" must be **"knowledgeable"**, meaning that it must be reasonable for you to believe that your client understands:

- why you are collecting, using or disclosing the information; and
- that the client has the right to withhold or withdraw his or her consent.

By contrast, "consent to treatment" must be **"informed"**. Section 11(2) of the *Health Care Consent Act, 1996* states that a consent to treatment is informed if, before giving it:

(a) The person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and

(b) The person received responses to his or her requests for additional information about those matters.

Section 11(3) of the *Health Care Consent Act, 1996* provides that the matters referred to subsection (2) are:

1. The nature of the treatment;
2. The expected benefit of the treatment;
3. The material risks of the treatment;
4. The material side effects of the treatment;
5. Alternative courses of action; and
6. The likely consequences of not having the treatment.

In addition to being "informed", the following are also required for consent to treatment under section 11(1) of the *Health Care Consent Act, 1996*:

1. The consent must relate to the treatment;
2. The consent must be given voluntarily; and
3. The consent must not be obtained through misrepresentation or fraud.

These three requirements are similar to the requirements under the *Personal Health Information Protection Act, 2004* for "informational consent". (See section 3.3.)

Finally, **consent to treatment may be express or implied** under section 11(4) of the *Health Care Consent Act, 1996*. By contrast, as the Toolkit outlined in Chapter 3, there are certain circumstances when informational consent may be implied or not required, as well as circumstances when you must obtain express consent from the client or his or her substitute decision-maker.

Mandatory Reporting by Health Information Custodians

5.1 SUMMARY OF KEY QUESTIONS COVERED IN THIS CHAPTER

- To whom does the mandatory reporting obligation apply? (See section 5.2).
- What are the circumstances that trigger a mandatory report? (See section 5.3).
- To whom must a mandatory report be filed? (See section 5.4).
- What is the relationship between the mandatory reporting obligations under the *Personal Health Information Protection Act, 2004* and the mandatory reporting obligations under the *Social Work and Social Service Work Act, 1998*? (See section 5.5).

5.2 MANDATORY REPORTING OBLIGATIONS UNDER THE *PERSONAL HEALTH INFORMATION PROTECTION ACT, 2004*

In 2006, the *Personal Health Information Protection Act, 2004*, was amended and, among other things, imposed mandatory reporting obligations on a health information custodian (HIC). A HIC that employs, or extends privileges to, a health care practitioner who is a member of the College or a health regulatory College must give written notice to the appropriate College within 30 days of certain events occurring. (See section 5.3). Similarly, a HIC must give written notice to the appropriate College within 30 days of certain events occurring in connection with an agent of the HIC. (See section 5.3). See section 1.4 for a definition of health care practitioner.

5.3 WHAT ARE THE EVENTS THAT TRIGGER A MANDATORY REPORT?

A HIC that employs a health care practitioner who is a member of the College or a health regulatory College must provide the College or a health regulatory College with written notice if one of the events set out below occurs. A HIC that employs an agent must also provide the appropriate College with written notice if one of the events set out below occurs.

1. The employee, or agent's employment, is terminated, suspended or subject to disciplinary action as a result of the unauthorized collection, use, disclosure, retention or disposal of personal health information by the employee;
2. The employee, or agent, resigns from their employment and the HIC believes that the resignation is related to an investigation or other action by the HIC with respect to an unauthorized collection, use, disclosure, retention or disposal of personal health information by the employee.

Similar events trigger a mandatory report where a HIC extends privileges to a health care practitioner who is a member of the College or a health regulatory College. See section 1.4 for a definition of health care practitioner.

5.4 TO WHOM MUST A MANDATORY REPORT BE FILED?

The HIC must give written notice of any of the above events to the College or a health regulatory College within 30 days of the event occurring. The notice should include the name of the person filing the report, the name of the member who is the subject of the report, the reasons for filing the report and an explanation of the alleged health privacy breach. In the future, there may be regulations made under the *Personal Health Information Protection Act, 2004* setting out the requirements for such notice.

5.5 WHAT IS THE RELATIONSHIP BETWEEN THE MANDATORY REPORTING OBLIGATIONS UNDER THE *PERSONAL HEALTH INFORMATION PROTECTION ACT, 2004* AND THE MANDATORY REPORTING OBLIGATIONS UNDER THE *SOCIAL WORK AND SOCIAL SERVICE WORK ACT, 1998*?

The mandatory reporting obligations under the *Personal Health Information Protection Act, 2004* are in addition to the mandatory reporting obligations under the *Social Work and Social Service Work Act, 1998* including those imposed on employers of social workers and social service workers to file a written report with the College where the employer terminates, or intends to terminate, the employment of a social worker or social service worker for reasons of professional misconduct, incompetence or incapacity.

Oversight

6.1 SUMMARY OF KEY QUESTIONS COVERED IN THIS CHAPTER

- **What is the role of the Ontario Information and Privacy Commissioner**? (See section 6.2).
- **What other proceedings may result from a privacy breach under the *Personal Health Information Protection Act, 2004*?** (See section 6.3).

6.2 THE ROLE OF THE ONTARIO INFORMATION AND PRIVACY COMMISSIONER

The *Personal Health Information Protection Act, 2004* allows for the independent review and resolution of complaints regarding the handling of personal health information and designates the Office of the Information and Privacy Commissioner/Ontario ("the Commissioner") as the body responsible for overseeing compliance with the provisions of the Act and regulations.

The Commissioner may **investigate** where:

- A complaint has been received; or
- The Commissioner has reasonable grounds to believe that a person has contravened or is about to contravene the Act.

The Commissioner has the power to enter and inspect premises, require access to personal health information and compel testimony.

Prior to investigating a complaint, the Commissioner may:

- Inquire as to what means, other than the complaint, the complainant is using or has used to resolve the complaint;
- Require the complainant to explore a settlement; or
- Authorize a mediator to review the complaint and try and settle the complaint.

The Commissioner may also decide **not to investigate** a complaint where:

- An adequate response has been provided to the complainant;
- The complaint has been or could be dealt with through another procedure;
- The complainant does not have sufficient personal interest in the issue; or
- The complaint is frivolous, vexatious or made in bad faith.

After conducting an investigation, the Commissioner may issue an order. The orders that the Commissioner has authority to issue include:

- To provide access to, or correction of, a record of personal health information;
- To cease collecting, using or disclosing personal health information in contravention of the Act;
- To dispose of records collected in contravention of the Act (but only if the disposal is not reasonably expected to adversely affect the provision of health care to an individual); or
- To change, cease or implement an information practice.

The Commissioner has issued a number of orders that relate to contraventions of the *Personal Health Information Protection Act, 2004*. The breaches described in these orders include:

- a patient's personal health information held by a hospital was accessed by a diagnostic imaging technologist who was not providing care to the patient;
- a hospital reported two separate breaches of patient privacy involving allegations that hospital employees used and/or disclosed the personal health information of mothers for the purposes of selling or marketing RESPs;
- a USB memory stick containing personal health information was lost by a public health nurse on her way to a flu immunization clinic;
- theft of a laptop computer containing the personal health information of approximately 2,900 patients;
- a patient's personal health information was accessed by a nurse who was not providing care to the patient. The nurse disclosed the patient's personal health information to the patient's estranged husband.

The orders related to unauthorized access to personal health information have included:

- findings that the health care practitioners used and disclosed personal health information in contravention of the *Personal Health Information Protection Act, 2004*;
- findings that the health information custodian did not take steps that were reasonable in the circumstances to safeguard the information;
- findings that the health information custodian did not have information practices that comply with the *Personal Health Information Protection Act, 2004*;
- requirements to take a number of remedial actions in order to prevent or reduce the risk of similar privacy breaches in the future.

6.3 WHAT OTHER PROCEEDINGS MAY RESULT FROM A PRIVACY BREACH UNDER THE *PERSONAL HEALTH INFORMATION PROTECTION ACT, 2004*?[11]

A person is guilty of an offence if, among other things, the person wilfully collects, uses or discloses personal health information in contravention of the Act or its regulations. Therefore, a contravention of the Act or its regulations can also result in a prosecution under the *Provincial Offences Act*. If convicted of an offence, an individual is liable to a fine of up to $100,000, and an organization is liable to a fine of up to $500,000.[12]

An individual affected by an order of the Commissioner, or by conduct that gave rise to an offence, may bring an action for damages for actual harm suffered as a result of a contravention of the Act or its regulations, or as a result of the conduct, as the case may be. In addition, where the harm suffered was caused by a contravention or an offence that a person engaged in wilfully or recklessly, the damages award may include an award not exceeding $10,000 for mental anguish.[13]

It can be expected that the College will receive mandatory reports made by health information custodians where there is an alleged privacy breach, as required by the *Personal Health Information Protection Act, 2004* (see section 5). The College will conduct an investigation and the appropriate Committee will determine whether the allegations should be referred to the Discipline Committee for a hearing.

For more information on the role of the Commissioner and orders made under the Act, see www.ipc.on.ca.

[11] This Toolkit does not address lawsuits, class action lawsuits, or criminal or regulatory proceedings that have resulted or may result from a privacy breach.

[12] In one example of a prosecution under the *Provincial Offences Act*, a Masters of Social Work student was found guilty of a health privacy breach and ordered to pay a $20,000 fine and a $5,000 victim surcharge.

[13] The *Personal Health Information Protection Act, 2004* provides that no action for damages may be instituted against a health information custodian or any other person for:

- anything done in good faith and that was reasonable in the circumstances, in the exercise or intended exercise of any powers or duties under the Act, or
- any alleged neglect or default that was reasonable in the circumstances in the exercise in good faith of any powers or duties under the Act.

Appendix A

SELECT EXCERPTS FROM THE *PERSONAL HEALTH INFORMATION PROTECTION ACT, 2004* AND O. REG. 329/04

Relevant excerpts from the Act for Chapter 1 of the Toolkit (current as of June 1, 2018):

Note: references are listed in the order in which they appear in the Act.

Agent – Section 2

"agent", in relation to a health information custodian, means a person that, with the authorization of the custodian, acts for or on behalf of the custodian in respect of personal health information for the purposes of the custodian, and not the agent's own purposes, whether or not the agent has the authority to bind the custodian, whether or not the agent is employed by the custodian and whether or not the agent is being remunerated;

Collect – Section 2

"collect", in relation to personal health information, means to gather, acquire, receive or obtain the information by any means from any source, and "collection" has a corresponding meaning;

Disclose – Section 2

"disclose", in relation to personal health information in the custody or under the control of a health information custodian or a person, means to make the information available or to release it to another health information custodian or to another person, but does not include to use the information, and "disclosure" has a corresponding meaning;[1]

Use – Section 2

"use", in relation to personal health information in the custody or under the control of a health information custodian or a person, means to view, handle or otherwise deal with the information, subject to subsection 6(1), but does not include to disclose the information, and "use", as a noun, has a corresponding meaning.

Health information custodian – Section 3(1)

In this Act,

"health information custodian", subject to subsections (3) to (11), means a person or organization described in one of the following paragraphs who has custody or control of personal health information as a result of or in connection with performing the person's or organization's powers or duties or the work described in the paragraph, if any:

1. A health care practitioner or a person who operates a group practice of health care practitioners.
2. A service provider within the meaning of the *Home Care and Community Services Act, 1994* who provides a community service to which that Act applies.

[1] See also definition of disclose under O. Reg. 329/04.

3. Repealed.

4. A person who operates one of the following facilities, programs or services:

    i. A hospital within the meaning of the *Public Hospitals Act*, a private hospital within the meaning of the *Private Hospitals Act*, a psychiatric facility within the meaning of the *Mental Health Act* or an independent health facility within the meaning of the *Independent Health Facilities Act*.

Note: On a day to be named by proclamation of the Lieutenant Governor, subparagraph 4 i of subsection 3(1) of the Act is amended by striking out "a private hospital within the meaning of the *Private Hospitals Act*". (See: 2017, c. 25, Sched. 9, s. 109(1))

Note: On a day to be named by proclamation of the Lieutenant Governor, subparagraph 4i of subsection 3(1) of the Act is amended by striking out "an independent health facility within the meaning of the *Independent Health Facilities Act*" at the end and substituting "a community health facility within the meaning of the *Oversight of Health Facilities and Devices Act, 2017*". (See: 2017, c. 25, Sched. 9, s. 109(2))

    ii. A long-term care home within the meaning of the *Long-Term Care Homes Act, 2007*, a placement co-ordinator described in subsection 40(1) of that Act, or a care home within the meaning of the *Residential Tenancies Act, 2006*.

    iii. A retirement home within the meaning of the *Retirement Homes Act, 2010*.

    iv. A pharmacy within the meaning of Part VI of the *Drug and Pharmacies Regulation Act*.

    v. A laboratory or a specimen collection centre as defined in section 5 of the *Laboratory and Specimen Collection Centre Licensing Act*.

    vi. An ambulance service within the meaning of the *Ambulance Act*.

    vii. A home for special care within the meaning of the *Homes for Special Care Act*.

    viii. A centre, program or service for community health or mental health whose primary purpose is the provision of health care.

5. An evaluator within the meaning of the *Health Care Consent Act, 1996* or an assessor within the meaning of the *Substitute Decisions Act, 1992*.

6. A medical officer of health of a board of health within the meaning of the *Health Protection and Promotion Act*.

7. The Minister, together with the Ministry of the Minister if the context so requires.

8. Any other person prescribed as a health information custodian if the person has custody or control of personal health information as a result of or in connection with performing prescribed powers, duties or work or any prescribed class of such persons.[2]

[2] See also health information custodians prescribed by O. Reg. 329/04.

Personal health information – Section 4(1)

In this Act,

"personal health information", subject to subsections (3) and (4), means identifying information about an individual in oral or recorded form, if the information,

(a) relates to the physical or mental health of the individual, including information that consists of the health history of the individual's family,

(b) relates to the providing of health care to the individual, including the identification of a person as a provider of health care to the individual,

(c) is a plan of service within the meaning of the *Home Care and Community Services Act, 1994* for the individual,

(d) relates to payments or eligibility for health care, or eligibility for coverage for health care, in respect of the individual,

(e) relates to the donation by the individual of any body part or bodily substance of the individual or is derived from the testing or examination of any such body part or bodily substance,

(f) is the individual's health number, or

(g) identifies an individual's substitute decision-maker.

Identifying information – Section 4(2)

In this section,

"identifying information" means information that identifies an individual or for which it is reasonably foreseeable in the circumstances that it could be utilized, either alone or with other information, to identify an individual.

Mixed records – Section 4(3)

Personal health information includes identifying information that is not personal health information described in subsection (1) but that is contained in a record that contains personal health information described in that subsection.

Relevant excerpts from O. Reg. 329/04 made under the Act for Chapter 1 of the Toolkit (current as of June 1, 2018):

Note: references are listed in the order in which they appear in O. Reg. 329/04.

Disclose – Section 1(3)

In the definition of "disclose" in section 2 of the Act, the expression "to make the information available or to release it to another health information custodian or to another person" does not include a person's providing personal health information to someone who provided it to or disclosed it to the person, whether or not the personal health information has been manipulated or altered, if it does not contain any additional identifying information.

Health information custodians – Sections 3(3), (4), (6) and (8)

(3) The Ontario Agency for Health Protection and Promotion,

(a) is prescribed as a health information custodian;

(b) is prescribed as a single health information custodian with respect to all its functions; and

(c) shall be deemed to be included in the list of types of custodians referred to in subsections 20(2) and (3) and clause 38(1)(a) of the Act.

(4) The Minister of Health Promotion, together with the Ministry of Health Promotion, if the context so requires, is prescribed as,

(a) a health information custodian; and

(b) a single health information custodian with respect to all of its functions of the Minister and the Ministry.

(6) Every municipality that operates a communications service within the meaning of the *Ambulance Act* is prescribed as,

(a) a health information custodian; and

(b) a single health information custodian with respect to all of its functions in operating the communications service.

(8) Every local health integration network,

(a) is prescribed as a health information custodian;

(b) is prescribed as a single health information custodian with respect to all of its functions; and

(c) shall be deemed to be included in the list of types of custodians referred to in subsections 20(2) and (3), clause 38(1)(a) and subclause 39(1)(d)(i) of the Act.

Relevant excerpts from the Act for Chapter 2 of the Toolkit (current as of June 1, 2018):

Note: references are listed in the order in which they appear in the Act.

Information practices – Section 2

"Information practices", in relation to a health information custodian, means the policy of the custodian for actions in relation to personal health information, including,

(a) when, how and the purposes for which the custodian routinely collects, uses, modifies, discloses, retains or disposes of personal health information, and

(b) the administrative, technical and physical safeguards and practices that the custodian maintains with respect to the information;

Accuracy – Section 11

(1) A health information custodian that uses personal health information about an individual shall take reasonable steps to ensure that the information is as accurate, complete and up-to-date as is necessary for the purposes for which it uses the information.

(2) A health information custodian that discloses personal health information about an individual shall,

(a) take reasonable steps to ensure that the information is as accurate, complete and up-to-date as is necessary for the purposes of the disclosure that are known to the custodian at the time of the disclosure; or

(b) clearly set out for the recipient of the disclosure the limitations, if any, on the accuracy, completeness or up-to-date character of the information.

Steps to ensure collection – Section 11.1

A health information custodian shall take steps that are reasonable in the circumstances to ensure that personal health information is not collected without authority.

Security – Section 12(1)

A health information custodian shall take steps that are reasonable in the circumstances to ensure that personal health information in the custodian's custody or control is protected against theft, loss and unauthorized use or disclosure and to ensure that the records containing the information are protected against unauthorized copying, modification or disposal.

Notice of theft, loss, etc. to individual – Section 12(2)

Subject to subsection (4) and to the exceptions and additional requirements, if any, that are prescribed, if personal health information about an individual that is in the custody or control of a health information custodian is stolen or lost or if it is used or disclosed without authority, the health information custodian shall,

(a) notify the individual at the first reasonable opportunity of the theft or loss or of the unauthorized use or disclosure; and

(b) include in the notice a statement that the individual is entitled to make a complaint to the Commissioner under Part VI.

Notice to the Commissioner – Section 12(3)

If the circumstances surrounding a theft, loss or unauthorized use or disclosure referred to in subsection (2) meet the prescribed requirements, the health information custodian shall notify the Commissioner of the theft or loss or of the unauthorized use or disclosure.[3]

[3] See also Notice to Commissioner prescribed by O. Reg. 329/04.

Contact person – Section 15

(1) A health information custodian that is a natural person may designate a contact person described in subsection (3).

(2) A health information custodian that is not a natural person shall designate a contact person described in subsection (3).

(3) A contact person is an agent of the health information custodian and is authorized on behalf of the custodian to,

(a) facilitate the custodian's compliance with this Act;

(b) ensure that all agents of the custodian are appropriately informed of their duties under this Act;

(c) respond to inquiries from the public about the custodian's information practices;

(d) respond to requests of an individual for access to or correction of a record of personal health information about the individual that is in the custody or under the control of the custodian; and

(e) receive complaints from the public about the custodian's alleged contravention of this Act or its regulations.

(4) A health information custodian that is a natural person and that does not designate a contact person under subsection (1) shall perform on his or her own the functions described in clauses 3(b), (c), (d) and (e).

Written public statement – Section 16(1)

A health information custodian shall, in a manner that is practical in the circumstances, make available to the public a written statement that,

(a) provides a general description of the custodian's information practices;

(b) describes how to contact,

(i) the contact person described in subsection 15(3), if the custodian has one, or

(ii) the custodian, if the custodian does not have that contact person;

(c) describes how an individual may obtain access to or request correction of a record of personal health information about the individual that is in the custody or control of the custodian; and

(d) describes how to make a complaint to the custodian and to the Commissioner under this Act.

Agents and information – Sections 17(1) and (1.1)

A health information custodian is responsible for personal health information in the custody or control of the health information custodian and may permit the custodian's agents to collect, use, disclose, retain or dispose of personal health information on the custodian's behalf only if,

(a) the custodian is permitted or required to collect, use, disclose, retain or dispose of the information, as the case may be;

(b) the collection, use, disclosure, retention or disposal of the information, as the case may be, is necessary in the course of the agent's duties and is not contrary to this Act or another law; and

(c) the prescribed requirements, if any, are met.

Same

(1.1) A permission granted to an agent under subsection (1) may be subject to such conditions or restrictions as the health information custodian may impose.

Restriction, collection, use, etc. by agents – Section 17(2)

Subject to any exception that may be prescribed[4], an agent of a health information custodian may collect, use, disclose, retain or dispose of personal health information only if,

(a) the collection, use, disclosure, retention or disposal of the information, as the case may be,

(i) is permitted by the custodian in accordance with subsection (1),

(ii) is necessary for the purpose of carrying out his or her duties as agent of the custodian,

(iii) is not contrary to this Act or another law, and

(iv) complies with any conditions or restrictions that the custodian has imposed under subsection (1.1); and

(b) the prescribed requirements, if any, are met.

Responsibilities of health information custodian – Section 17(3)

A health information custodian shall,

(a) take steps that are reasonable in the circumstances to ensure that no agent of the custodian collects, uses, discloses, retains or disposes of personal health information unless it is in accordance with subsection (2); and

(b) remain responsible for any personal health information that is collected, used, disclosed, retained or disposed of by the custodian's agents, regardless of whether or not the collection, use, disclosure, retention or disposal was carried out in accordance with subsection (2).

[4] See exceptions to section 17(2) prescribed by O. Reg. 329/04.

Responsibilities of agent – Section 17(4)

An agent of a health information custodian shall,

(a) comply with the conditions or restrictions imposed by the health information custodian on the agent's collection, use, disclosure, retention or disposal of personal health information under subsection (1.1); and

(b) notify the custodian at the first reasonable opportunity if personal health information that the agent collected, used, disclosed, retained or disposed of on behalf of the custodian is stolen or lost or if it is used or disclosed without authority.

Relevant excerpts from O. Reg. 329/04 made under the Act for Chapter 2 of the Toolkit (current as of June 1, 2018):

Note: references are listed in the order in which they appear in O. Reg. 329/04.

Notice to Commissioner – Section 6.3

(1) The following are the circumstances in which a health information custodian is required to notify the Commissioner for the purposes of subsection 12(3) of the Act:

1. The health information custodian has reasonable grounds to believe that personal health information in the custodian's custody or control was used or disclosed without authority by a person who knew or ought to have known that they were using or disclosing the information without authority.
2. The health information custodian has reasonable grounds to believe that personal health information in the custodian's custody or control was stolen.
3. The health information custodian has reasonable grounds to believe that, after an initial loss or unauthorized use or disclosure of personal health information in the custodian's custody or control, the personal health information was or will be further used or disclosed without authority.
4. The loss or unauthorized use or disclosure of personal health information is part of a pattern of similar losses or unauthorized uses or disclosures of personal health information in the custody or control of the health information custodian.
5. The health information custodian is required to give notice to a College of an event described in section 17.1 of the Act that relates to a loss or unauthorized use or disclosure of personal health information.
6. The health information custodian would be required to give notice to a College, if an agent of the health information custodian were a member of the College, of an event described in section 17.1 of the Act that relates to a loss or unauthorized use or disclosure of personal health information.

7. The health information custodian determines that the loss or unauthorized use or disclosure of personal health information is significant after considering all relevant circumstances, including the following:

    i. Whether the personal health information that was lost or used or disclosed without authority is sensitive.

    ii. Whether the loss or unauthorized use or disclosure involved a large volume of personal health information.

    iii. Whether the loss or unauthorized use or disclosure involved many individuals' personal health information.

    iv. Whether more than one health information custodian or agent was responsible for the loss or unauthorized use or disclosure of the personal health information.

(2) In this section,
"College" means a College as defined in subsection 17.1(1) of the Act.

Annual report re: theft, loss, etc. – Section 6.4

(1) On or before March 1 in each year starting in 2019, a health information custodian shall provide the Commissioner with a report setting out the number of times in the previous calendar year that each of the following occurred:

1. Personal health information in the custodian's custody or control was stolen.

2. Personal health information in the custodian's custody or control was lost.

3. Personal health information in the custodian's custody or control was used without authority.

4. Personal health information in the custodian's custody or control was disclosed without authority.

(2) The report shall be transmitted to the Commissioner by the electronic means and format determined by the Commissioner.

Exception to s. 17(2) of the Act – Section 7

The following are prescribed as exceptions to subsection 17(2) of the Act:

2. An agent of a health information custodian may disclose personal health information acquired in the course of the agent's activities for or on behalf of the custodian, as if the agent were a health information custodian for the purposes of,

    i. subsection 40(1) of the Act,

    ii. clauses 43(1)(b), (c) and (d) of the Act, or

    iii. disclosures to the Public Guardian and Trustee or a children's aid society under clause 43(1)(e) of the Act.

Relevant excerpts from the Act for Chapter 3 of the Toolkit (current as of June 1, 2018):

Note: references are listed in the order in which they appear in the Act.

Elements of consent – Section 18(1)

> If this Act or any other Act requires the consent of an individual for the collection, use or disclosure of personal health information by a health information custodian, the consent,
>
> (a) must be a consent of the individual;
>
> (b) must be knowledgeable;
>
> (c) must relate to the information; and
>
> (d) must not be obtained through deception or coercion.

Knowledgeable consent – Section 18(5)

> A consent to the collection, use or disclosure of personal health information about an individual is knowledgeable if it is reasonable in the circumstances to believe that the individual knows,
>
> (a) the purposes of the collection, use or disclosure, as the case may be; and
>
> (b) that the individual may give or withhold consent.

Notice of purposes – Section 18(6)

> Unless it is not reasonable in the circumstances, it is reasonable to believe that an individual knows the purposes of the collection, use or disclosure of personal health information about the individual by a health information custodian if the custodian posts or makes readily available a notice describing the purposes where it is likely to come to the individual's attention or provides the individual with such a notice.

Withdrawal of consent – Section 19(1)

> If an individual consents to have a health information custodian collect, use or disclose personal health information about the individual, the individual may withdraw the consent, whether the consent is express or implied, by providing notice to the health information custodian, but the withdrawal of the consent shall not have retroactive effect.

Conditional consent – Section 19(2)

> If an individual places a condition on his or her consent to have a health information custodian collect, use or disclose personal health information about the individual, the condition is not effective to the extent that it purports to prohibit or restrict any recording of personal health information by a health information custodian that is required by law or by established standards of professional practice or institutional practice.

Implied consent – Section 20(2)

A health information custodian described in paragraph 1, 2 or 4 of the definition of "health information custodian" in subsection 3(1), that receives personal health information about an individual from the individual, the individual's substitute decision-maker or another health information custodian for the purpose of providing health care or assisting in the provision of health care to the individual, is entitled to assume that it has the individual's implied consent to collect, use or disclose the information for the purposes of providing health care or assisting in providing health care to the individual, unless the custodian that receives the information is aware that the individual has expressly withheld or withdrawn the consent.[5]

Permitted use – Sections 37(1)(a) and 37(1)(j)

A health information custodian may use personal health information about an individual,

(a) for the purpose for which the information was collected or created and for all the functions reasonably necessary for carrying out that purpose, but not if the information was collected with the consent of the individual or under clause 36(1)(b) and the individual expressly instructs otherwise;[6]

(j) for research conducted by the custodian, subject to subsection (3), unless another clause of this subsection applies;

Permitted use for research – Section 37(3)

Under clause (1)(j), a health information custodian may use personal health information about an individual only if the custodian prepares a research plan and has a research ethics board approve it and for that purpose sections 44(2) to (4) and clauses 44(6)(a) to (f) apply to the use as if it were a disclosure.[7] (see below)

Permitted disclosure related to providing health care – Section 38(1)(a)

A health information custodian may disclose personal health information about an individual,

(a) to a health information custodian described in paragraph 1, 2 or 4 of the definition of "health information custodian" in subsection 3(1), if the disclosure is reasonably necessary for the provision of health care and it is not reasonably possible to obtain the individual's consent in a timely manner, but not if the individual has expressly instructed the custodian not to make the disclosure;

[5] See also "Notification if no consent" set out in O. Reg. 329/04.

[6] See also "Notification if no consent" set out in O. Reg. 329/04.

[7] See section 15 of O. Reg. 329/04 for requirements that must be met by a research ethics board. See section 16 of O. Reg. 329/04 for additional requirements that must be set out in research plans.

Disclosures related to risks – Section 40(1)

A health information custodian may disclose personal health information about an individual if the custodian believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.

Disclosure for research – Section 44(1)

A health information custodian may disclose personal health information about an individual to a researcher if the researcher,

(a) submits to the custodian,

(i) an application in writing,

(ii) a research plan that meets the requirements of subsection (2), and

(iii) a copy of the decision of a research ethics board that approves the research plan;[8] and

(b) enters into the agreement required by subsection (5).

Research plan – Section 44(2)

A research plan must be in writing and must set out,

(a) the affiliation of each person involved in the research;

(b) the nature and objectives of the research and the public or scientific benefit of the research that the researcher anticipates; and

(c) all other prescribed matters related to the research.[9]

Agreement respecting disclosure – Section 44(5)

Before a health information custodian discloses personal health information to a researcher under subsection (1), the researcher shall enter into an agreement with the custodian in which the researcher agrees to comply with the conditions and restrictions, if any, that the custodian imposes relating to the use, security, disclosure, return or disposal of the information.

[8] See section 15 of O. Reg. 329/04 for requirements that must be met by a research ethics board. See section 16 of O. Reg. 329/04 for additional requirements that must be set out in research plans.

[9] See section 16 of O. Reg. 329/04 for additional requirements that must be set out in research plans.

Compliance by researcher – Section 44(6)

A researcher who receives personal health information about an individual from a health information custodian under subsection (1) shall,

(a) comply with the conditions, if any, specified by the research ethics board in respect of the research plan;[10]

(b) use the information only for the purposes set out in the research plan as approved by the research ethics board;[11]

(c) not publish the information in a form that could reasonably enable a person to ascertain the identity of the individual;

(d) despite subsection 49(1), not disclose the information except as required by law and subject to the exceptions and additional requirements, if any, that are prescribed;

(e) not make contact or attempt to make contact with the individual, directly or indirectly, unless the custodian first obtains the individual's consent to being contacted;

(f) notify the custodian immediately in writing if the researcher becomes aware of any breach of this subsection or the agreement described in subsection (5); and

(g) comply with the agreement described in subsection (5).

Disclosure outside Ontario – Section 50(1)(e)

A health information custodian may disclose personal health information about an individual collected in Ontario to a person outside Ontario only if,

(e) the disclosure is reasonably necessary for the provision of health care to the individual, but not if the individual has expressly instructed the custodian not to make the disclosure;

Relevant excerpts from the Act for Chapter 4 of the Toolkit (current as of June 1, 2018):

Health care practitioner acting for an institution – Section 51(3)

This Part [Part V – Access to Records of Personal Health Information and Correction] does not apply to a record in the custody or under the control of a health care practitioner who is employed by or acting for an institution within the meaning of the *Freedom of Information and Protection of Privacy Act* or the *Municipal Freedom of Information and Protection of Privacy Act* that is not a health information custodian if the individual has the right to request access to the record under one of those Acts.

Permission to disclose – Section 51(4)

When subsection (3) applies to a record, the health care practitioner may disclose the record to the institution to enable the institution to process the individual's request under the *Freedom of Information and Protection of Privacy Act* or the *Municipal Freedom of Information and Protection of Privacy Act*, as the case may be, for access to the record.

[10] See section 15 of O. Reg. 329/04 for requirements that must be met by a research ethics board. See section 16 of O. Reg. 329/04 for additional requirements that must be set out in research plans.

[11] See section 15 of O. Reg. 329/04 for requirements that must be met by a research ethics board. See section 16 of O. Reg. 329/04 for additional requirements that must be set out in research plans.

Individual's right of access – Section 52(1)

Subject to this Part, an individual has a right of access to a record of personal health information about the individual that is in the custody or under the control of a health information custodian unless,

(a) the record or the information in the record is subject to a legal privilege that restricts disclosure of the record or the information, as the case may be, to the individual;

(b) another Act, an Act of Canada or a court order prohibits disclosure to the individual of the record or the information in the record in the circumstances;

(c) the information in the record was collected or created primarily in anticipation of or for use in a proceeding, and the proceeding, together with all appeals or processes resulting from it, have not been concluded;

(d) the following conditions are met:

(i) the information was collected or created in the course of an inspection, investigation or similar procedure authorized by law, or undertaken for the purpose of the detection, monitoring or prevention of a person's receiving or attempting to receive a service or benefit, to which the person is not entitled under an Act or a program operated by the Minister, or a payment for such a service or benefit, and

(ii) the inspection, investigation, or similar procedure, together with all proceedings, appeals or processes resulting from them, have not been concluded;

(e) granting the access could reasonably be expected to,

(i) result in a risk of serious harm to the treatment or recovery of the individual or a risk of serious bodily harm to the individual or another person,

(ii) lead to the identification of a person who was required by law to provide information in the record to the custodian, or

(iii) lead to the identification of a person who provided information in the record to the custodian explicitly or implicitly in confidence if the custodian considers it appropriate in the circumstances that the identity of the person be kept confidential; or

(f) the following conditions are met:

(i) the custodian is an institution within the meaning of the *Freedom of Information and Protection of Privacy Act* or the *Municipal Freedom of Information and Protection of Privacy Act* or is acting as part of such an institution, and

(ii) the custodian would refuse to grant access to the part of the record,

(A) under clause 49(a), (c) or (e) of the *Freedom of Information and Protection of Privacy Act*, if the request were made under that Act and that Act applied to the record, or

(B) under clause 38(a) or (c) of the *Municipal Freedom of Information and Protection of Privacy Act*, if the request were made under that Act and that Act applied to the record.

Severable record – Section 52(2)

Despite subsection (1), an individual has a right of access to that part of a record of personal health information about the individual that can reasonably be severed from the part of the record to which the individual does not have a right of access as a result of clauses (1)(a) to (f).

Severable record – Section 52(3)

Despite subsection (1), if a record is not a record dedicated primarily to personal health information about the individual requesting access, the individual has a right of access only to the portion of personal health information about the individual in the record that can reasonably be severed from the record for the purpose of providing access.

Relevant excerpts from O. Reg. 329/04 made under the Act for Chapter 3 of the Toolkit (current as of June 1, 2018):

Note: references are listed in the order in which they appear in O. Reg. 329/04.

Notification if no consent – Section 8.1

For the purposes of subsection 20(2) and clause 37(1)(a) of the Act, if a health information custodian described in paragraph 1, 2, 3 or 4 of the definition of "health information custodian" in subsection 3(1) of the Act or a health information custodian prescribed by subsection 3(3) or (5) of this Regulation provides personal health information about an individual to an agent of the custodian for the purpose of providing health care or assisting in the provision of health care to the individual and if the custodian does not have the consent of the individual to provide all the personal health information about the individual that the custodian considers reasonably necessary for that purpose, the custodian shall notify the agent to whom the custodian provides the information of that fact.

Exclusions from access provisions – Section 24(3)

Part V of the Act does not apply to entitle a person to a right of access to information about the person that is contained in a record that is dedicated primarily to the personal health information of another person.

Relevant excerpts from the Act for Chapter 4 of the Toolkit (current as of June 1, 2018):

Note: references are listed in the order in which they appear in the Act.

Substitute decision-maker – Section 5(1)

In this Act,

"substitute decision-maker", in relation to an individual, means, unless the context requires otherwise, a person who is authorized under this Act to consent on behalf of the individual to the collection, use or disclosure of personal health information about the individual.

Decision about treatment – Section 5(2)

A substitute decision-maker of an individual within the meaning of section 9 of the *Health Care Consent Act, 1996* shall be deemed to be a substitute decision-maker of the individual in respect of the collection, use or disclosure of personal health information about the individual if the purpose of the collection, use or disclosure is necessary for, or ancillary to, a decision about a treatment under Part II of that Act.

Capacity to consent – Section 21(1)

An individual is capable of consenting to the collection, use or disclosure of personal health information if the individual is able,

(a) to understand the information that is relevant to deciding whether to consent to the collection, use or disclosure, as the case may be; and

(b) to appreciate the reasonably foreseeable consequences of giving, not giving, withholding or withdrawing the consent.

Persons who may consent – Section 23

(1) If this Act or any other Act refers to a consent required of an individual to a collection, use or disclosure by a health information custodian of personal health information about the individual, a person described in one of the following paragraphs may give, withhold or withdraw the consent:

1. If the individual is capable of consenting to the collection, use or disclosure of the information,

   i. the individual, or

   ii. if the individual is at least 16 years of age, any person who is capable of consenting, whom the individual has authorized in writing to act on his or her behalf and who, if a natural person, is at least 16 years of age.

2. If the individual is a child who is less than 16 years of age, a parent of the child or a children's aid society or other person who is lawfully entitled to give or refuse consent in the place of the parent unless the information relates to,

   i. treatment within the meaning of the *Health Care Consent Act, 1996*, about which the child has made a decision on his or her own in accordance with that Act, or

   ii. counselling in which the child has participated on his or her own under the *Child, Youth and Family Services Act, 2017*.

3. If the individual is incapable of consenting to the collection, use or disclosure of the information, a person who is authorized under subsection 5(2), (3) or (4) or section 26 to consent on behalf of the individual.

Note: On a day to be named by proclamation of the Lieutenant Governor, paragraph 3 of subsection 23(1) of the Act is amended by striking out "(3) or (4)" and substituting "(3), (3.1) or (4)". (See: 2017, c. 25, Sched. 5, s. 71)

4. If the individual is deceased, the deceased's estate trustee or the person who has assumed responsibility for the administration of the deceased's estate, if the estate does not have an estate trustee.

5. A person whom an Act of Ontario or Canada authorizes or requires to act on behalf of the individual.

(2) In subsection (1),

"parent" does not include a parent who has only a right of access to the child.

(3) If the individual is a child who is less than 16 years of age and who is capable of consenting to the collection, use or disclosure of the information and if there is a person who is entitled to act as the substitute decision-maker of the child under paragraph 2 of subsection (1), a decision of the child to give, withhold or withdraw the consent or to provide the information prevails over a conflicting decision of that person.

Factors to consider for consent – Section 24(1)

A person who consents under this Act or any other Act on behalf of or in the place of an individual to a collection, use or disclosure of personal health information by a health information custodian, who withholds or withdraws such a consent or who provides an express instruction under clause 37(1)(a), 38(1)(a) or 50(1)(e) shall take into consideration,

(a) the wishes, values and beliefs that,

(i) if the individual is capable, the person knows the individual holds and believes the individual would want reflected in decisions made concerning the individual's personal health information, or

(ii) if the individual is incapable or deceased, the person knows the individual held when capable or alive and believes the individual would have wanted reflected in decisions made concerning the individual's personal health information;

(b) whether the benefits that the person expects from the collection, use or disclosure of the information outweigh the risk of negative consequences occurring as a result of the collection, use or disclosure;

(c) whether the purpose for which the collection, use or disclosure is sought can be accomplished without the collection, use or disclosure; and

(d) whether the collection, use or disclosure is necessary to satisfy any legal obligation.

Incapable individual: persons who may consent – Section 26(1)

If an individual is determined to be incapable of consenting to the collection, use or disclosure of personal health information by a health information custodian, a person described in one of the following paragraphs may, on the individual's behalf and in the place of the individual, give, withhold or withdraw the consent:

1. The individual's guardian of the person or guardian of property, if the consent relates to the guardian's authority to make a decision on behalf of the individual.
2. The individual's attorney for personal care or attorney for property, if the consent relates to the attorney's authority to make a decision on behalf of the individual.
3. The individual's representative appointed by the Board under section 27, if the representative has authority to give the consent.
4. The individual's spouse or partner.
5. A child or parent of the individual, or a children's aid society or other person who is lawfully entitled to give or refuse consent in the place of the parent. This paragraph does not include a parent who has only a right of access to the individual. If a children's aid society or other person is lawfully entitled to consent in the place of the parent, this paragraph does not include the parent.
6. A parent of the individual with only a right of access to the individual.
7. A brother or sister of the individual.
8. Any other relative of the individual.

Requirements for persons who may consent for an incapable individual – Section 26(2)

A person described in subsection (1) may consent only if the person,

(a) is capable of consenting to the collection, use or disclosure of personal health information by a health information custodian;

(b) in the case of an individual, is at least 16 years old or is the parent of the individual to whom the personal health information relates;

(c) is not prohibited by court order or separation agreement from having access to the individual to whom the personal health information relates or from giving or refusing consent on the individual's behalf;

(d) is available; and

(e) is willing to assume the responsibility of making a decision on whether or not to consent.

Relevant excerpts from the Act for Chapter 5 of the Toolkit (current as of June 1, 2018):

Note: references are listed in the order in which they appear in the Act.

Notice to governing College, Definition – Section 17.1(1)

In this section,
"College" means,

(a) in the case of a member of health profession regulated under the *Regulated Health Professions Act, 1991*, a College of the health profession named in Schedule 1 to that Act, and

(b) in the case of a member of the Ontario College of Social Workers and Social Service Workers, that College.

Termination, suspension, etc. of employed members – Section 17.1(2)

Subject to any exceptions and additional requirements, if any, that are prescribed, if a health information custodian employs a health care practitioner who is a member of a College, the health information custodian shall give written notice of any of the following events to the College within 30 days of the event occurring:

1. The employee is terminated, suspended or subject to disciplinary action as a result of the unauthorized collection, use, disclosure, retention or disposal of personal health information by the employee.

2. The employee resigns and the health information custodian has reasonable grounds to believe that the resignation is related to an investigation or other action by the custodian with respect to an alleged unauthorized collection, use, disclosure, retention or disposal of personal health information by the employee.

Termination, suspension, etc. of custodian's agent – Section 17.1(4)

The health information custodian shall give written notice of any of the following events to a College within 30 days of the event occurring:

1. The agent's employment is terminated or suspended, or the agent is subject to disciplinary action with respect to his or her employment, as a result of his or her unauthorized collection, use, disclosure, retention or disposal of personal health information.

2. The agent resigns from his or her employment and the health information custodian has reasonable grounds to believe that the resignation is related to an investigation or other action by the custodian with respect to an alleged unauthorized collection, use, disclosure, retention or disposal of personal health information by the agent.

Member's privileges revoked, etc. – Section 17.1(5)

Subject to any exceptions and additional requirements, if any, that are prescribed, if a health information custodian extends privileges to, or is otherwise affiliated with, a health care practitioner who is a member of a College, the custodian shall give written notice of any of the following events to the College within 30 days of the event occurring:

1. The member's privileges are revoked, suspended or restricted, or his or her affiliation is revoked, suspended or restricted, as a result of the unauthorized collection, use, disclosure, retention or disposal of personal health information by the member.

2. The member relinquishes or voluntarily restricts his or her privileges or his or her affiliation and the health information custodian has reasonable grounds to believe that the relinquishment or restriction is related to an investigation or other action by the custodian with respect to an alleged unauthorized collection, use, disclosure, retention or disposal of personal health information by the member.

Contents of notice – Section 17.1(6)

A notice made under this section shall meet the prescribed requirements, if any.

Relevant excerpts from the Act for Chapter 6 of the Toolkit (current as of June 1, 2018):

Note: references are listed in the order in which they appear in the Act.

Complaint to Commissioner – Section 56(1)

A person who has reasonable grounds to believe that another person has contravened or is about to contravene a provision of this Act or its regulations may make a complaint to the Commissioner.

Time for complaint – Section 56(2)

A complaint that a person makes under subsection (1) must be in writing and must be filed within,

(a) one year after the subject-matter of the complaint first came to the attention of the complainant or should reasonably have come to the attention of the complainant, whichever is the shorter; or

(b) whatever longer period of time that the Commissioner permits if the Commissioner is satisfied that it does not result in any prejudice to any person.

Time for complaint, refusal of request – Section 56(3)

A complaint that an individual makes under subsection 54(8) or 55(7) or (12) shall be in writing and shall be filed within six months from the time at which the health information custodian refuses or is deemed to have refused the individual's request mentioned in the applicable subsection.

Commissioner's self-initiated review – Section 58(1)

The Commissioner may, on his or her own initiative, conduct a review of any matter if the Commissioner has reasonable grounds to believe that a person has contravened or is about to contravene a provision of this Act or its regulations and that the subject-matter of the review relates to the contravention.

Powers of Commissioner – Section 61(1)

After conducting a review under section 57 or 58, the Commissioner may,

(a) if the review relates to a complaint into a request by an individual under subsection 53(1) for access to a record of personal health information, make an order directing the health information custodian about whom the complaint was made to grant the individual access to the requested record;

(b) if the review relates to a complaint into a request by an individual under subsection 55(1) for correction of a record of personal health information, make an order directing the health information custodian about whom a complaint was made to make the requested correction;

(c) make an order directing any person whose activities the Commissioner reviewed to perform a duty imposed by this Act or its regulations;

(d) make an order directing any person whose activities the Commissioner reviewed to cease collecting, using or disclosing personal health information if the Commissioner determines that the person is collecting, using or disclosing the information, as the case may be, or is about to do so in contravention of this Act, its regulations or an agreement entered into under this Act;

(e) make an order directing any person whose activities the Commissioner reviewed to dispose of records of personal health information that the Commissioner determines the person collected, used or disclosed in contravention of this Act, its regulations or an agreement entered into under this Act but only if the disposal of the records is not reasonably expected to adversely affect the provision of health care to an individual;

(f) make an order directing any health information custodian whose activities the Commissioner reviewed to change, cease or not commence an information practice specified by the Commissioner, if the Commissioner determines that the information practice contravenes this Act or its regulations;

(g) make an order directing any health information custodian whose activities the Commissioner reviewed to implement an information practice specified by the Commissioner, if the Commissioner determines that the information practice is reasonably necessary in order to achieve compliance with this Act and its regulations;

(h) make an order directing any person who is an agent of a health information custodian, whose activities the Commissioner reviewed and that an order made under any of clauses (a) to (g) directs to take any action or to refrain from taking any action, to take the action or to refrain from taking the action if the Commissioner considers that it is necessary to make the order against the agent to ensure that the custodian will comply with the order made against the custodian; or

(i) make comments and recommendations on the privacy implications of any matter that is the subject of the review.

Damages for breach of privacy – Sections 65(1) and (2)

(1) If the Commissioner has made an order under this Act that has become final as the result of there being no further right of appeal, a person affected by the order may commence a proceeding in the Superior Court of Justice for damages for actual harm that the person has suffered as a result of a contravention of this Act or its regulations.

(2) If a person has been convicted of an offence under this Act and the conviction has become final as a result of there being no further right of appeal, a person affected by the conduct that gave rise to the offence may commence a proceeding in the Superior Court of Justice for damages for actual harm that the person has suffered as a result of the conduct.

Damages for mental anguish – Section 65(3)

If, in a proceeding described in subsection (1) or (2), the Superior Court of Justice determines that the harm suffered by the plaintiff was caused by a contravention or offence, as the case may be, that the defendants engaged in wilfully or recklessly, the court may include in its award of damages an award, not exceeding $10,000, for mental anguish.

Offences – Section 72(1)

A person is guilty of an offence if the person,

(a) wilfully collects, uses or discloses personal health information in contravention of this Act or its regulations;

(b) makes a request under this Act, under false pretences, for access to or correction of a record of personal health information;

(c) in connection with the collection, use or disclosure of personal health information or access to a record of personal health information, makes an assertion, knowing that it is untrue, to the effect that the person,

(i) is a person who is entitled to consent to the collection, use or disclosure of personal health information about another individual,

(ii) meets the requirement of clauses 26(2) (b) and (c),

(iii) holds the beliefs described in subsection 26(5), or

(iv) is a person entitled to access to a record of personal health information under section 52;

(d) disposes of a record of personal health information in the custody or under the control of the custodian with an intent to evade a request for access to the record that the custodian has received under subsection 53(1);

(e) wilfully disposes of a record of personal health information in contravention of section 13;

(f) contravenes subsection 34(2), (3) or (4) or clause 47(15)(a), (e) or (f);

(g) wilfully obstructs the Commissioner or a person known to be acting under the authority of the Commissioner in the performance of his or her functions under this Act;

(h) wilfully makes a false statement to mislead or attempt to mislead the Commissioner or a person known to be acting under the authority of the Commissioner in the performance of his or her functions under this Act;

(i) wilfully fails to comply with an order made by the Commissioner or a person known to be acting under the authority of the Commissioner under this Act; or

(j) contravenes section 70.

Penalty – Section 72(2)

A person who is guilty of an offence under subsection (1) is liable, on conviction,

(a) if the person is a natural person, to a fine of not more than $100,000; and

(b) if the person is not a natural person, to a fine of not more than $500,000.

Appendix B

RESOURCES FOR HEALTH INFORMATION CUSTODIANS ON THE WRITTEN PUBLIC STATEMENT REQUIRED UNDER SECTION 16(1)

Sample Written Public Statements on Website

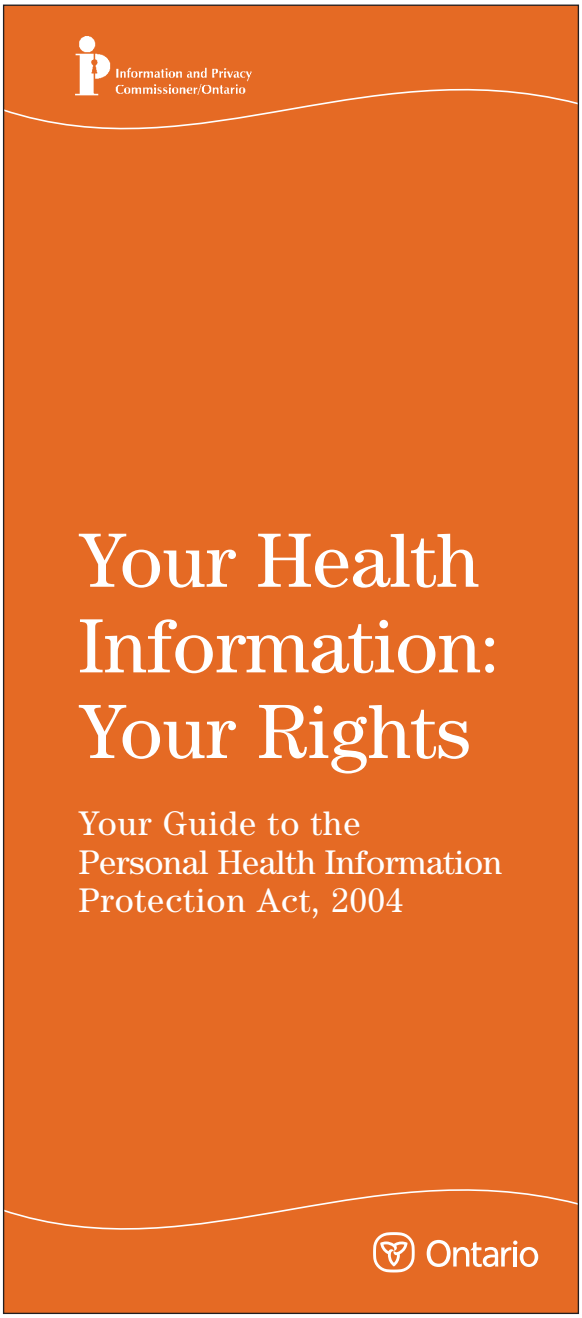
- Children's Hospital of Eastern Ontario (Ottawa) written public statement is available at: https://www.cheo.on.ca/en/about-us/privacy-and-confidentiality.aspx
- Hamilton Health Sciences' (Hamilton) "Statement of Information Practices" is available at: https://www.hamiltonhealth.com/patients-visitors/patient-resources/notice-privacy-practices/
- Markham Stouffville Hospital's (Markham Stouffville) "A Guide for Patients" is available at: https://www.msh.on.ca/sites/default/files/documents/Privacy-Brochure.pdf
- Peel Region's (Region of Peel) written public statement available at: https://www.peelregion.ca/privacy/privacy-statement.asp
- St. Joseph's Healthcare's (Hamilton) "Statement of Health Information Practices" is available at: https://www.stjoes.ca/patients-visitors/privacy-information-security/privacy-at-st.-joe's?resourceID=8128
- York Region's Community and Health Services Department's (Region of York) "Notice of Privacy and Information Practices" is available at: https://www.york.ca/wps/wcm/connect/yorkpublic/bf5106b3-e547-439b-9a52-0ff8ed76d59b/PHIPA+Notice+of+Privacy+and+Information+Practices.pdf?MOD=AJPERES&CVID=muljp9G

Sample Pamphlet/Brochure Written Public Statements

- Cambridge Memorial Hospital's (Cambridge) "A Guide to Understanding Cambridge Memorial Hospital's Privacy Program" is available at: https://www.cmh.org/sites/default/files/page-assets/patients-visitors/patient-information/patient-privacy/privacy-brochure-4317-46076.pdf
- Sunnybrook Health Science Centre's "Protecting Your Personal Health Information" is available at: https://sunnybrook.ca/uploads/PrivacyPatientNotificationDec2006.pdf
- Unity Health's (St. Joseph's Health Centre, St, Michael's Hospital, Providence Healthcare) "How we protect your privacy" is available at: https://unityhealth.to/wp-content/uploads/2019/08/how-we-protect-your-privacy.pdf

Appendix C

BROCHURE FOR CLIENTS ON THEIR HEALTH INFORMATION RIGHTS FROM THE INFORMATION AND PRIVACY COMMISSIONER/ONTARIO



Appendix C

BROCHURE FOR CLIENTS ON THEIR HEALTH INFORMATION RIGHTS FROM THE INFORMATION AND PRIVACY COMMISSIONER/ONTARIO CONTINUED

Each time you visit a healthcare provider, have a test done or receive care in your home, the hospital or any other healthcare setting, information about your health is recorded in a personal health record.

On November 1, 2004, the Personal Health Information Protection Act, 2004 (PHIPA) came into force. This new law:

- sets out the rules that healthcare providers (or, "health information custodians") must follow when collecting, using and sharing your personal health information
- gives you the right to see your health records and correct any mistakes.

To whom does *PHIPA* apply?

PHIPA applies to individuals and organizations involved in the delivery of healthcare services. Under the act, they are referred to as "health information custodians". They include:

- healthcare providers such as doctors, nurses, dentists, psychologists, optometrists, physiotherapists, chiropractors, massage therapists, dieticians, naturopaths and acupuncturists
- hospitals
- long-term care homes and homes for special care
- Community Care Access Centres
- pharmacies
- medical laboratories
- local medical officers of health
- ambulance services
- community mental health programs
- the Ministry of Health and Long-Term Care.

What Are Health Information Custodians Required to Do?

Under PHIPA, health information custodians are required to:

- collect only the information they need to do their job
- take steps to safeguard your personal health information
- take reasonable steps to ensure your health records are accurate and complete for the work they do
- provide a written description of the practices they use to protect your information, and the name of the person to contact if you have any questions or concerns about your personal health records.

What Are Your Rights Under PHIPA?

PHIPA gives you the right to:

- give permission (consent) to how your personal health information is collected, used and shared
- request access to your health records
- make corrections to your records.

Appendix C

BROCHURE FOR CLIENTS ON THEIR HEALTH INFORMATION RIGHTS FROM THE INFORMATION AND PRIVACY COMMISSIONER/ONTARIO CONTINUED

1. Giving Consent

Under PHIPA, you have the right to consent to how your information will be collected, used and shared – except in specific circumstances where the law authorizes healthcare providers to collect, use or share a person's information without consent, such as reporting for public health safety.

The act allows for two types of consent:

- **implied consent**. In general, your healthcare provider will assume that you give consent for the sharing of your health information to provide healthcare to you without directly asking you or requiring you to sign a consent form. For example, when your family physician refers you to a specialist, he or she will assume that you give permission to share your health information with the specialist – unless you specifically refuse. In practice, PHIPA permits your healthcare provider to assume your implied consent to collect, use or disclose your health information with other healthcare providers who are involved in your care unless you state otherwise.
- **express consent**. In certain situations, your healthcare provider is required to request your consent – either orally, in writing or electronically – before sharing your health information. This is called "express consent." For example, if your healthcare provider is asked to disclose your personal health information to someone who is not a health information custodian under PHIPA, like your employer, he or she must obtain your express consent.

2. Accessing Your Health Records

Under PHIPA, you have the right to access your personal health records.

If you want to see your records, you may make a request to the person identified by the health information custodian.

If your request is in writing, a health information custodian has 30 days to respond to your request but, in certain situations, may require an extension of up to 30 days. You can request faster access where you can show that you urgently need the information. When giving you access or providing a copy of your personal health record, your healthcare provider may charge a reasonable fee to cover costs.

Under PHIPA, health information custodians can only deny you access to your record of personal health information in certain situations, such as when health information was collected as part of an investigation. Generally, health information custodians who deny you access to your record or a part of your record must give you an explanation. If you are not satisfied with a custodian's decision, you may complain to the Information and Privacy Commissioner of Ontario.

Appendix C

BROCHURE FOR CLIENTS ON THEIR HEALTH INFORMATION RIGHTS FROM THE INFORMATION AND PRIVACY COMMISSIONER/ONTARIO CONTINUED

3. Correcting Your Health Records

Under PHIPA, you have the right to have information in your personal health records corrected.

If you believe that the information in your personal health record is not accurate or complete, you may make a request to have it corrected. You should make your request to the contact person designated by the health information custodian.

If your request is in writing, a health information custodian has 30 days to respond but, in certain situations, may require an extension of up to 30 days.

Health information custodians must correct an incomplete or inaccurate record, but they are not required to change professional opinions or correct records that they did not create.

Health information custodians who refuse to make a correction must explain why they refused. You have the right to attach a statement conveying your disagreement to your record and to complain to the Information and Privacy Commissioner of Ontario.

What Does the Information and Privacy Commissioner Do?

The Information and Privacy Commissioner of Ontario (IPC) is appointed by the Ontario Legislature and is independent of the government. The commissioner is responsible for ensuring that health information custodians comply with the law.

Under PHIPA, the IPC has the power to investigate and make rulings about complaints. If you believe that a health information custodian or anyone else is not following PHIPA, you may file a complaint with the IPC.

The following table lists the reasons and time periods for filing a complaint.

Reason to Complain to Commissioner	Time to File a Complaint
A health information custodian or other person has collected, used or shared your personal health information contrary to PHIPA.	Within 1 year of the time that you became aware of the problem (The commissioner can extend this deadline.)
Your request to see your personal health record or part of that record has been denied.	Within 6 months of the health information custodian's decision.
Your request to have your personal health information corrected has been denied.	Within 6 months of the health information custodian's decision.

When the commissioner receives a complaint, a mediator may be appointed to try to solve the problem. The IPC has various powers to resolve complaints, including the power to order a health information custodian to:

- change or stop the way your information is collected, used or shared
- provide you with access to your record of personal health information
- correct your record of personal health information.

Appendix D

OTHER *PERSONAL HEALTH INFORMATION PROTECTION ACT, 2004* RESOURCES

Information and Privacy Commissioner/Ontario:
http://www.ipc.on.ca

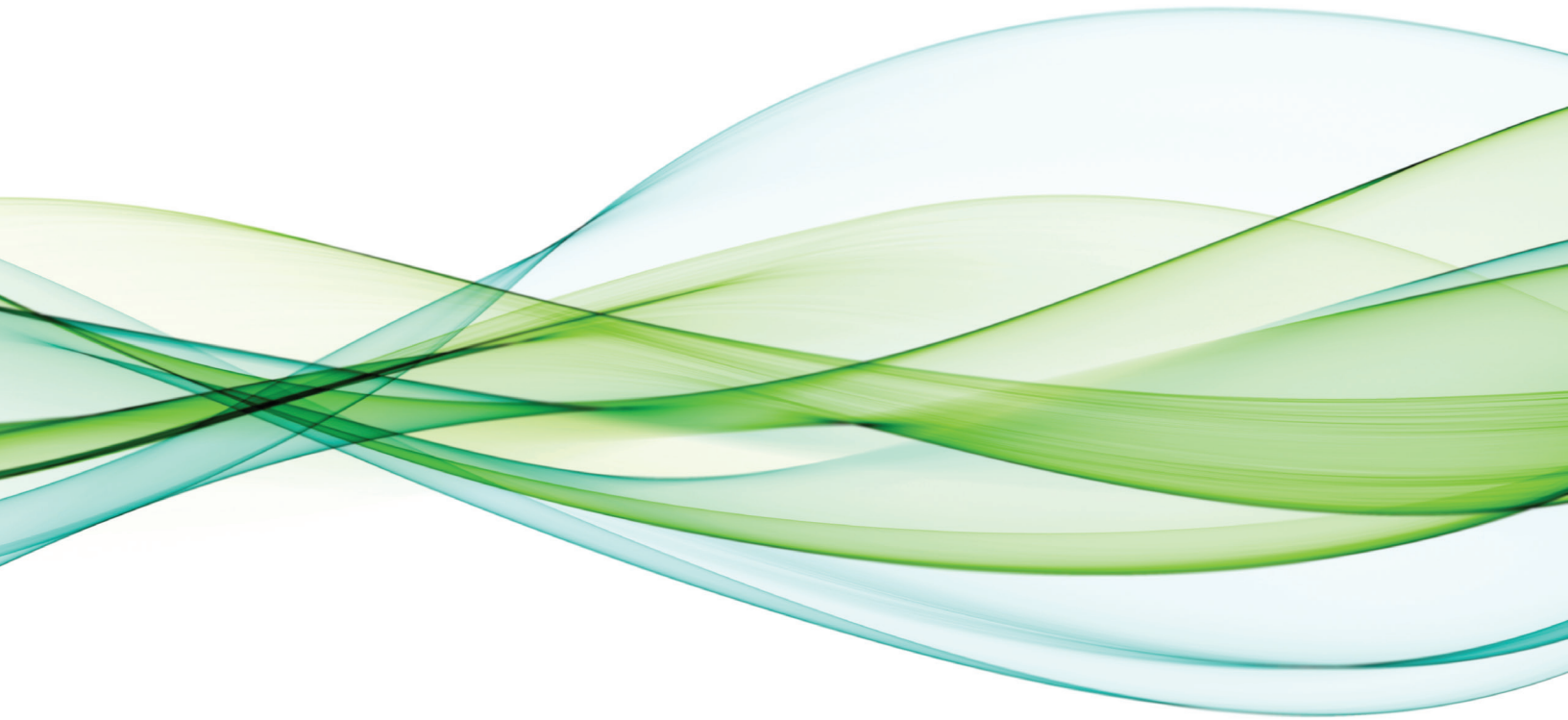
Ministry of Health and Long-Term Care, *Personal Health Information Protection Act, 2004:* An Overview, November 2004:
http://www.health.gov.on.ca/english/providers/project/priv_legislation/overview_leg.pdf

Ontario College of Social Workers and Social Service Workers

250 Bloor Street E.
Suite 1000
Toronto, ON
M4W 1E6

Ordre des travailleurs sociaux et des techniciens en travail social de l'Ontario

Phone: 416-972-9882
Toll Free: 1-877-828-9380
Fax: 416-972-1512
ocswssw.org



10615977.4 (Rev. June 28, 2018)

Ontario College of
Social Workers and
Social Service Workers

Ordre des travailleurs
sociaux et des techniciens
en travail social de l'Ontario

Practice Guidelines for Performing the Controlled Act of Psychotherapy

Guidelines for Social Work and
Social Service Work Members of the
Ontario College of Social Workers
and Social Service Workers

Effective December 30, 2017

If you require this document in an alternate format, contact the College at 1-877-828-9380 or info@ocswssw.org.

Practice Guidelines for Performing the Controlled Act of Psychotherapy

Guidelines for Social Work Members of the Ontario College of Social Workers and Social Service Workers

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

The Ontario College of Social Workers and Social Service Workers would like to thank the many members and stakeholders who reviewed drafts of these guidelines and provided their feedback, and the members of the Standards of Practice Committee for their diligence and hard work.

STATUS OF GUIDELINES

The following guidelines contain information and practice advice which should be considered by social work and social service work members of the Ontario College of Social Workers and Social Service Workers. These guidelines are designed to assist social work and social service work members in interpreting and applying the College's standards to particular circumstances or contexts of practice and to provide additional guidance to members on practice issues.

It should be noted that these guidelines are not themselves standards of practice and have not been enacted by regulation or College by-law. The College's standards, which are the minimum standards applicable to all College members, are the ones set out in the Social Work and Social Service Work Act, 1998, the regulations under the Act, the College's Code of Ethics and Standards of Practice and the College's by-laws. Those College standards prevail over these guidelines. However, the guidelines may still be used by the College (or other bodies) to assist in determining whether appropriate standards of practice and professional conduct have been maintained by a College member in a particular case.

Introduction

Psychotherapy has been referred to as a "complex mosaic" with the therapeutic relationship as its central element[1]. Because of the intensity of the intervention and the intimacy of the therapeutic relationship, clients receiving psychotherapy services are at increased risk of harm from incompetent, unqualified or unfit practitioners. Changes to the Regulated Health Professions Act, 1991 (the "RHPA") reflect this heightened risk, and make psychotherapy one of fourteen controlled acts. A "**controlled act**" is an activity defined under the RHPA, the performance of which is restricted to members of certain professions, due to the risk of harm that it poses to the public. The **controlled act of psychotherapy** is defined in the RHPA as follows:

> 14. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning.[2]

As a result of these important legislative changes to the RHPA, a member of the Ontario College of Social Workers and Social Service Workers (the "College") is authorized to perform the controlled act of psychotherapy in compliance with the Social Work and Social Service Work Act, 1998 (the "SWSSWA"), its regulations and by-laws.[3] A College member may also supervise another College member in performing that controlled act, but may not delegate the performance of the controlled act.[4]

The College's Code of Ethics and Standards of Practice Handbook, 2nd Edition, contains a definition of **psychotherapy services** which is different from the controlled act of psychotherapy. **Psychotherapy services** are defined as "any form of treatment for psycho-social or emotional difficulties, behavioural maladaptations and/or other problems that are assumed to be of an emotional nature, in which a College member establishes a professional relationship with a client for the purposes of promoting positive personal growth and development."[5] **Counselling services** are defined as "services provided within the context of a professional relationship with the goal of assisting clients in addressing issues in their lives by such activities as helping clients to find solutions and make choices through exploration of options, identification of strengths and needs, locating information and providing resources, and promoting a variety of coping strategies, but do not include psychotherapy services."[6]

Distinguishing between the controlled act of psychotherapy and "psychotherapy services" as defined in the College's Handbook could prove to be challenging in practice. Ultimately, it is anticipated that the courts and College discipline committees will provide guidance on what is or is not included within the controlled act of psychotherapy. Although it is possible that not all psychotherapy would be found to fall under the definition of the controlled act, this cannot yet be determined with any precision or certainty. Members should therefore be very cautious when assessing their practice, and would be well-advised to assume that these Practice Guidelines apply to **all** psychotherapy practice.

Additionally, amendments to the SWSSWA provide that a member of the College who is authorized to perform the controlled act of psychotherapy may use the title "psychotherapist" if the member complies with the following conditions, as applicable:

1. When describing himself or herself orally as a psychotherapist, the member must also mention that he or she is a member of the Ontario College of Social Workers and Social Service Workers, or identify himself or herself using the title restricted to him or her as a member of the College.
2. When identifying himself or herself in writing as a psychotherapist on a name tag, business card or any document, the member must set out his or her full name, immediately followed by at least one of the following, followed in turn by "psychotherapist".

    i. Ontario College of Social Workers and Social Service Workers,

    ii. the title that the member may use under this Act.

3. The member may only use the title "psychotherapist" in compliance with this Act, the regulations and the by-laws.[7]

To sum up, members of the College may perform the controlled act of psychotherapy and use the title "psychotherapist", provided they do so in compliance with the SWSSWA, the regulations and the by-laws.

FOOTNOTES

1. Holman, Julieta B., William B. Jaffee and David H. Brendel "Introduction: The Complex Mosaic of Psychotherapy in the Twenty-First Century" in Harvard Review of Psychiatry, 15, 2007. Print. p. 265 and p. 267
2. Regulated Health Professions Act, 1991, section 27 (2)14 retrieved from http://www.e-laws.gov.on.ca
3. Regulated Health Professions Act, 1991, section 27 (4)
4. The Regulated Health Professions Act, 1991, section 27(1)(6) allows for the **delegation of controlled acts.** This formal process enables a regulated health professional who is authorized to perform a controlled act to delegate it to another person in accordance with any applicable regulations governing the regulated health professional's profession. The Regulated Health Professions Act, 1991 does not allow for the delegation of the controlled act of psychotherapy by OCSWSSW members who are authorized to perform the controlled act. (NOTE: Because of the central importance of the relationship in psychotherapy, and because of the risk of harm to clients posed by unfit, incompetent or unqualified practitioners, the regulated health professions authorized to perform the controlled act of psychotherapy have taken the position that the controlled act of psychotherapy cannot and should not be delegated).
5. Code of Ethics and Standards of Practice, Second Edition, 2008, p. 41
6. Code of Ethics and Standards of Practice, Second Edition, 2008, p. 40. The controlled act of psychotherapy, psychotherapy services and counselling may be practised with individuals, couples, families or groups, in a variety of settings.
7. Social Work and Social Service Work Act, 1998, section 47.2 retrieved from http://www.e-laws.gov.on.ca

Purpose of the Guidelines

All members of the College are bound by the **Code of Ethics and Standards of Practice, 2nd Edition**, which sets out the minimum standards for professional practice and conduct. According to the Standards of Practice, members of the College must ensure that they are "aware of the extent and parameters of their competence and their professional scope of practice and limit their practice accordingly."[8] These **Practice Guidelines for Performing the Controlled Act of Psychotherapy** are intended to:

- address issues to be considered in the performance of the controlled act of psychotherapy about which members should be particularly informed;
- highlight the principles in the **Code of Ethics and Standards of Practice, 2nd Edition**, that have particular relevance to the performance of the controlled act of psychotherapy; and
- assist members in identifying what factors they should consider in order to determine if they are competent to perform the controlled act of psychotherapy.

After a careful review of these Guidelines, members are advised to consider completing the checklist in Section D to assess whether they have the necessary preparation to perform the controlled act of psychotherapy. It is important to note that these Practice Guidelines are intended primarily to help members assess their own situation in relation to the essential elements of competent psychotherapy practice. Members will need to use their professional judgment when considering the elements, as this self-assessment may not be a black and white process. Members should ensure that they could provide a sound rationale for their self-assessment based on the guidelines if they were required to do so.

Additionally, members should ensure that they are familiar with the **Code of Ethics and Standards of Practice Handbook, 2nd Edition** (which prevails over these guidelines), giving special attention to those standards with particular relevance to the performance of the controlled act of psychotherapy. To augment their self-assessment, they should also seek input/consultation from supervisors and/or others familiar with their practice.

FOOTNOTES

8. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle II, Competence and Integrity, interpretation 2.1.1

Competence to Perform the Controlled Act of Psychotherapy: Essential Elements

This section addresses the essential elements which members should consider when assessing whether they are competent to perform the controlled act of psychotherapy: education and experience, supervision, and continuing competence.

1. EDUCATION AND EXPERIENCE

Performance of the controlled act of psychotherapy is not an entry-to-practice competency, and the necessary grounding in theory and practice goes beyond what would be attained through completion of a social work degree or a social service work diploma alone. Competent performance of the controlled act of psychotherapy is firmly rooted in an integrated and well-developed knowledge base which includes a comprehensive understanding of biopsychosocial theories and models of psychotherapy, as well as mastery of a range of intervention skills and therapeutic modalities.[9] Ideally, members should ensure that their diploma in social service work or degree in social work has a clinical focus. While this level of education might provide a sound base upon which to build the knowledge and skills required to perform the controlled act of psychotherapy competently, it is not in itself sufficient.[10] Members should engage in post diploma/degree training programs with a specific focus on psychotherapeutic theory, clinical modalities and techniques before performing the controlled act of psychotherapy. Optimally, such training should include an integrated program of study, an opportunity for clinical observation and demonstration of mastery of fundamental psychotherapeutic techniques. The training program should have an evaluative component and provide evidence of successful completion (e.g. certificate, diploma, or degree). In addition, members should obtain significant practice experience in a clinical setting in which they are engaged in clinical activities (in addition to supervision and ongoing post diploma/degree training, which will be covered in subsequent sections) before engaging in the performance of the controlled act of psychotherapy.

It should be noted that the Standards of Practice provide that members may represent themselves as specialists in certain areas of practice only if they can provide evidence of specialized training, extensive experience or education.[11]

Members are advised to consider the setting in which they obtained their practice experience when determining whether they are adequately prepared to perform the controlled act of psychotherapy. Agency settings (in which there may be more opportunities for supervision, consultation, informal support and a more varied caseload) rather than private practice (which may be more isolated with fewer supports, and may provide more limited exposure to a diverse caseload) are more likely to ensure an appropriate grounding in theory and practice. Members are not fully prepared to perform the controlled act of psychotherapy until they have completed two to three years (or 2000 to 3000 hours) of supervised experience.[12]

2. SUPERVISION

Competence in performing the controlled act of psychotherapy requires not only formal education and extensive experience, but also ongoing clinical supervision. Indeed, clinical supervision is the "central mode of learning psychotherapy."[13] The need for supervision does not end after a certain period in practice, but evolves and continues throughout a member's career. A distinction must be made between **clinical supervision**, which is associated with assessment, intervention and evaluation of client interventions as well as critical self-reflection, and **administrative supervision**, which is primarily concerned with the instrumental aspects of workers' roles in agencies. **Administrative supervision** typically focuses on record-keeping, accreditation, organizational policies, mandate and caseload.[14] While administrative supervision is important and necessary, it is not adequate or sufficient for members wishing to perform the controlled act of psychotherapy.

Supervision — Members with less than 3 years' post-graduate experience

When assessing their competence to perform the controlled act of psychotherapy, members should consider whether they have adequately prepared themselves. Such preparation would include an extensive and more intensive period of clinical supervision upon completion of their degree or diploma. Ideally, this period of supervision should:

- take place individually and/or in a small group;
- occur regularly and with a frequency that is appropriate to the member's level of experience;
- provide opportunities to engage in case discussion and the learning of new skills and perspectives;
- include at least some direct observation of a member's practice (which may be in the form of audio or videotapes, one-way mirrors, co-therapy or reflecting teams);
- provide opportunities for in-depth experiential and didactic learning in an interactional and supportive environment; and
- enable members opportunity for critical self-reflection.[15]

Supervision — Members with experience

As members gain experience, less frequent and more informal models of supervision may be appropriate. Members should seek supervision/consultation[16] with experienced colleagues throughout their careers, particularly in areas of practice in which they are less experienced, when they are aware of a strong reaction — positive or negative — to the client, and/or when the client could benefit from members gaining an additional perspective, outside expertise, and/or a new skill or approach. The Standards of Practice require that each member of the College ensures that "(as) part of maintaining competence and acquiring skills in social work or social service work practice ... (they) engage in the process of self review and evaluation of their practice and seek consultation when appropriate."[17] The supervision obtained by members with more experience:

- should occur regularly and with a frequency that is appropriate to the member's level of experience;
- may be less formal and structured;
- may use a group and/or peer consultation model, in addition or as an alternative to individual or small group supervision with an experienced supervisor;
- should be sufficiently accessible that members may obtain assistance in challenging or complex clinical work in a timely manner; and
- should be provided in an environment which enables members to examine their own reactions to their clinical work.

Regardless of their experience, members should be mindful of the supervision literature which suggests that rapport, trust and caring, in addition to clinical expertise and knowledge, are key aspects of all successful supervisory relationships.[18] Members using any model of supervision are personally accountable to bring forth challenging cases. Many find a structured format to be most effective, however at minimum, members should ensure that supervision is easily accessible. When face-to-face meetings are not possible, members may wish to consider on-line or teleconference options, though issues of security and confidentiality take on a heightened importance with these arrangements. Whatever the model chosen, members should ensure that the person or people who are providing supervision are competent clinicians who either practise or have experience in the relevant area. Members may be supervised by someone from outside the profession who has relevant expertise and experience in their area of practice and/or setting. In this case, they should consider whether the supervisor has an understanding of the profession's values, ethics and standards of practice, and determine whether additional input from other sources may be required to obtain the profession-specific supervision that they need. Whatever their profession, supervisors should be members in good standing with their respective regulatory body.

Supervision and Confidentiality

Regardless of the extent of their experience or the model of supervision or consultation used, members should ensure that they "fully inform clients early in their relationship of the limits of confidentiality of information ... and explain to clients the needs for sharing pertinent information with supervisors."[19] Members should also be aware that Principle V: Confidentiality in the Standards of Practice distinguishes between consultation and supervision in the area of sharing client information, when it notes that "in consultation, clients are not identified."[20]

Supervision — Providing Supervision

Clinical supervision requires specialized skills that do not evolve automatically from direct practice. Although the College does not define specific qualifications or experience required for members who provide clinical supervision, members are again reminded that Principle II: Competence and Integrity requires members to practice within their competence and their professional scope of practice.[21] Members who wish to provide clinical supervision should therefore explore opportunities to develop their supervisory skills, whether through additional

formalized training, supervision of their supervision, or mentorship. Members would also be wise to consider whether they have the cumulative experience in performing the controlled act of psychotherapy (which would include formal education, ongoing training, and supervised practice) as well as the specific experience and expertise in the setting in question, and with the client population served, to provide competent clinical supervision.

Supervisors affect the quality of psychotherapy services provided to clients through their influence on supervisees. They therefore share responsibility for the services provided and could be held accountable for inadequate supervision when a supervisee's conduct is in question.[22] In relation to such accountability, members should be aware that the Professional Misconduct Regulation, O. Reg. 384/00 made under the SWSSWA defines as an act of professional misconduct "failing to supervise adequately a person who is under the professional responsibility of the member and who is providing a social work service or a social service work service."[23] Thus, in addition to ensuring that they are competent to supervise members in the performance of the controlled act of psychotherapy, members should ensure that they make sound decisions about the amount of time and the structure required to provide adequate supervision to members with various levels of expertise and training.[24] When providing supervision in a group format, members should ensure that the size and duration of the group are conducive to participation by all supervisees.[25]

3. CONTINUING COMPETENCE

Formal education, experience and ongoing supervision are not the only factors which contribute to competent performance of the controlled act of psychotherapy. Members are required by the Registration Regulation, O. Reg. 383/00 made under the SWSSWA to provide evidence of their continuing competence to practise social work/social service work in accordance with the guidelines approved by Council and published and distributed to members.[26] All members of the College are required to participate in the Continuing Competence Program (CCP), a flexible, adult-education model which was launched by the College in 2009. Members must, at any time required by the College, provide evidence satisfactory to the College that they have completed the CCP. It is expected that members who perform the controlled act of psychotherapy ensure an appropriate emphasis on increasing their psychotherapy knowledge and skills in their CCP goals and learning activities.

While learning activities in the CCP could include reading or online learning, as well as brief workshops, members who perform the controlled act of psychotherapy are strongly encouraged to regularly include at least some more intensive, face-to-face training in their overall Professional Development Plan. While members might typically engage in numerous workshops in a given year, it is advisable for members to engage also in more intensive training, such as certificate programs (which would involve a series of courses or workshops), externships, and in-depth courses. A sound, psychotherapeutic knowledge base is made up of both theory and practice, and at least some of a member's learning activities should include opportunities for direct practice and/or direct observation of practice, or opportunities to observe interventions

conducted by others. Because technology has such a significant impact on practice, members should ensure that they are technologically competent. Their CCP self-assessment and learning goals should reflect this requirement.

Just as the need for supervision does not end, so, too, is lifelong learning through the CCP a requirement for experienced as well as less-seasoned members. Experienced members may tailor their learning activities to reflect their years of experience; however they have an ongoing professional obligation to ensure that they remain current in treatment modalities and approaches.

FOOTNOTES

9. American Board of Examiners in Clinical Social Work "Professional Development and Practice Competencies in Clinical Social Work: A Position Statement of the American Board of Examiners in Clinical Social Work" March, 2002, http://www.abecsw.org Web. April 30, 2012. p. 4
10. One example of this might be a member who completes a Masters of Education in counselling, as well as a diploma in social service work.
11. Code of Ethics and Standards of Practice, Second Edition, 2008, Principle VII, Advertising, interpretation 7.3.1
12. The first two to three years, or 2000–3000 hours of practice, are an essential training period, during which the member requires more intensive, close and frequent supervision. Similar standards are set for social workers in other jurisdictions, including, for example, the clinical specialty certificate, British Columbia College of Social Workers http://www.bccollegeofsocialworkers.ca.
13. Stovel, Laura and Paul Ian Steinberg "Learning Within Psychotherapy Supervision" in Smith College Studies in Social Work, Vol. 78(2-3), 2008. Print. p. 321
14. Dill, Katharine and Marion Bogo "Moving Beyond the Administrative: Supervisors' Perspectives on Clinical Supervision in Child Welfare" in Journal of Public Child Welfare, Vol. 3, 2009, Print. p. 88–89
15. Dill and Bogo, p. 88
16. Barker defines consultation as a problem-solving process which occurs on an ad hoc or temporary basis and has a specific goal and focus. The consultant has no special administrative authority over those to whom consultation is provided. Supervision, on the other hand, is relatively continuous and encompasses many areas of concern. It is both an administrative and educational process which focuses on enhancing skills, improving staff morale and providing quality assurance for clients. Barker, Robert L.: The Social Work Dictionary, 4th Edition, Washington: NASW Press, 1999.
17. Code of Ethics and Standards of Practice, Second Edition, 2008, Principle II, Competence and Integrity, interpretation 2.1.5
18. Shulman, L. The skills of helping individuals, families, groups and communities (5th edition), Belmont, CA: Thomson Brooks/Cole, 2006, cited in Mizrahi, Terry and Larry E. Davis, editors, The Encyclopedia of Social Work, Online Version, Oxford University Press, 2012
19. Code of Ethics and Standards of Practice, Second Edition, 2008, Principle V, Confidentiality, interpretation 5.4
20. Code of Ethics and Standards of Practice, Second Edition, 2008, Principle V, Confidentiality, interpretation 5.8
21. Code of Ethics and Standards of Practice, Second Edition, 2008, Principle II, Competence and Integrity, interpretation 2.1.1
22. National Association of Social Workers "Supervision and the Clinical Social Worker", Practice Update, Volume 3, Number 2, June 2003, Web. 10 January 2012
23. S. 2.4, O. Reg. 384/00 (Professional Misconduct) made under the Social Work and Social Service Work Act, 1998 www.e-laws.gov.on.ca Web
24. They should also obtain suitable professional liability insurance, a point that will be covered later in these Practice Guidelines.
25. New York State Office of the Professions, NYS Social Work, Practice Guidelines: Using and Providing Supervision www.op.nysed.gov/prof/sw/swsupervision.htm Online. May 11, 2012

26. S. 6.3, O. Reg. 383/00 (Registration) made under the Social Work and Social Service Work Act, 1998 www.e-laws.gov.on.ca Web

Issues Requiring Special Consideration

Formal education, experience, supervision and continuing competence are essential elements in the competent performance of the controlled act of psychotherapy. However, this section addresses other themes and issues about which members who perform this controlled act should be aware. Members should be familiar with all eight principles in the Code of Ethics and Standards of Practice Handbook, 2nd Edition, as all are relevant to performing the controlled act of psychotherapy. This section of the Practice Guidelines for Performing the Controlled Act of Psychotherapy addresses issues of boundaries and sexual misconduct, termination, consent and confidentiality, professional liability insurance, and emphasizes some of the Standards of Practice that are of heightened relevance.

1. BOUNDARIES AND SEXUAL MISCONDUCT

Members are in a position of power and responsibility with clients.[27] All clients, including those receiving psychotherapy services, must be "protected from abuse of such power during and after the provision of professional services.[28] Therefore, members who perform the controlled act of psychotherapy must take great care to "establish and maintain clear and appropriate boundaries … for the protection of clients. Boundary violations include sexual misconduct and other misuse and abuse of the member's power. Non-sexual boundary violations may include emotional, physical, social and financial violations."[29]

While not all boundary issues pose a risk of harm, provided that they are appropriately handled, the high risk of boundary violations requires that members exercise great caution, and go through a careful process of decision-making, including consultation and reflection, when confronted with boundary issues of any kind.[30] The Standards of Practice require that members "do not engage in professional relationships that constitute a conflict of interest or … situations in which … (they) ought reasonably to have known that the client would be at risk in any way". They must not "provide a professional service to the client while … in a conflict of interest". This is achieved by "evaluating professional relationships and other situations involving clients or former clients for potential conflicts of interest and seeking consultation to assist in identifying and dealing with such potential conflicts of interest", "avoiding conflicts of interest and/or dual relationships with clients or former clients … that could impair members' professional judgement or increase the risk of exploitation or harm to clients" and "if a conflict of interest situation does arise, declaring the conflict of interest and taking appropriate steps to address it and to eliminate the conflict."[31]

Boundary crossings in the therapeutic relationship include but are not limited to dual relationships, self-disclosure, touch, location and timing of sessions, fees, and giving and receiving gifts.[32] Members' views about, and approaches to, some boundary issues will be influenced to some degree by their therapeutic orientation and by the client's culture.[33] At times, members' professional competence may be impaired by personal issues such as personal stress or burnout. This impairment could lead to blurred boundaries and boundary violations resulting from decreased objectivity and judgment, and gratification of their own needs (whether minor or more serious) at the expense of clients.[34]

It is the responsibility of members to be aware of when they are faced with a decision involving boundaries, to demonstrate that they have consulted appropriately, and to be able to articulate a sound rationale for how they have approached the situation. Any departure from accepted standards in the field should be approached with extreme caution. In some instances, in order to ensure that they are "distinguish(ing) their needs and interests from those of their clients" and ensuring that "clients' needs and interests remain paramount,"[35] members may decide to seek personal therapy, increase their self-care and/or obtain further supervision.

Members should engage in a process of ethical decision-making when considering how to approach any boundary issues. This process should include:

- identifying that a dilemma/difficulty exists;
- informing clients that there is a dilemma;
- consulting with colleagues and supervisors, a lawyer or risk manager, as appropriate, the Professional Practice Department at the College and possibly others;
- reviewing relevant professional literature, policies, and the standards;
- designing a plan of action that addresses the boundary issues and protects clients to the greatest extent possible;
- documenting their decision and its outcome; and
- monitoring and evaluating the impact of their strategy/approach.[36]

The **use of technology**, such as e-mail, text messages, Facebook and other social media, raises a number of boundary issues which should be carefully considered by members who perform the controlled act of psychotherapy. Texting clients (even if the intent is to restrict the contact to the administrative details of the treatment, for example) could imply an informality and immediacy which could blur boundaries for clients. Responding to clients via e-mail outside the boundaries of regular office hours could create expectations of an immediate response to client communication on the part of the member, and could also imply a familiarity and informality which could create ambiguity around the boundaries of the therapeutic relationship. Accepting a friend request from a client on Facebook immediately puts a member into a dual relationship with its inherent risks, and is therefore strongly discouraged. Failing to use privacy settings could lead to unintended self-disclosure, which may reveal inappropriate information,

and will certainly have implications for the therapeutic relationship. Members performing the controlled act of psychotherapy must therefore be alert to the particular boundary issues posed by the use of technology.

Poor handling of boundaries may have a significant and lasting negative impact on the psychotherapy process, relationship and outcomes.[37] Sexual misconduct is the most serious and harmful of all boundary violations. Members are solely responsible for ensuring that sexual misconduct does not occur, and must avoid sexual intercourse and any other form of physical sexual relations with clients. "Touching, of a sexual nature …", and "behaviour or remarks of a sexual nature… other than behaviour or remarks of a clinical nature appropriate to the service provided" are forbidden.[38] Members must not "provide clinical services to individuals with whom they have had a prior relationship of a sexual nature" and sexual relationships between members and clients are prohibited.[39] Additionally, "sexual relations between College members and clients to whom the members have provided psychotherapy and/or counselling services are prohibited at any time following termination of the professional relationship" and members must not "engage in sexual activities with clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to the client or when such activities would compromise the appropriate professional boundaries between the member and the client."[40] If a member "develops sexual feelings toward a client," it is the member's obligation to seek supervision and develop an appropriate plan to ensure that the client is not harmed.[41]

In short, the onus is on members who perform the controlled act of psychotherapy to ensure that they do not harm clients by violating boundaries, sexual or otherwise. It is members' professional responsibility to address these and other ethical issues by familiarizing themselves with current and relevant literature, obtaining appropriate supervision and consultation (not only when ethical and/or clinical issues arise, but on an ongoing basis), and ensuring that they are knowledgeable about the Standards of Practice. Clear roles when the controlled act of psychotherapy is performed are of pivotal importance in the psychotherapy process, and clear boundaries "provide a foundation for … (the therapy) relationship by fostering a sense of safety and the belief that the clinician will always act in the client's best interest."[42]

2. INFORMED CONSENT AND CONFIDENTIALITY

Members who perform the controlled act of psychotherapy must ensure that they "provide clients with accurate and complete information regarding the extent, nature, and limitations" of psychotherapy services, and "inform clients of foreseeable risks as well as rights, opportunities, and obligations associated with the provision of professional services."[43] **Informed consent** to psychotherapy services is a critical aspect of ethical practice, and the basis of a sound therapeutic relationship.[44] Informed consent ensures that clients and members participate together in setting and evaluating goals, and share a common purpose.[45] It also promotes clients' right to self-determination and autonomy,[46] and increases their ownership over the psychotherapy process.[47] While it is good practice for members to obtain written consent regarding the parameters of psychotherapy treatment, informed consent is not obtained solely through the use of a written form, nor is it a one-time, all-or-nothing event.[48] Rather, it is a process which

must take into account factors such as clients' capacity to consent, the timing of their consent, the nature of the psychotherapeutic approach, the anticipated course of the therapy, fees, and other administrative arrangements. Members should not assume that their clients have experience with psychotherapy. In addition to administrative details (including the parameters of the sessions), members should take care to explain their therapeutic orientation, the objectives of the approach that they are using, and the nature of their interventions. Informed consent is an ongoing requirement as the relationship and therapeutic process mature.

Members must be familiar with current legislation governing their practice,[49] in order to determine first whether formal consent is required to provide services, and secondly from whom such consent should be obtained. Members performing the controlled act of psychotherapy with children and youth should be familiar with the College's Practice Guidelines on Consent and Confidentiality with Children and Youth,[50] should consult with a colleague and/or supervisor, and should seek legal advice in any circumstances in which they are uncertain about their obligations. When practising with minors or with incompetent adults for whom a parent, legally appointed guardian, or substitute decision-maker must make treatment decisions, members should nevertheless ensure that clients are given an appropriate explanation of services, that their clients' preferences and best interests are considered, and that they seek agreement from clients regarding the treatment.[51]

Confidentiality and consent to the disclosure of information are also critical for the protection of clients seeking psychotherapy services. Members performing the controlled act of psychotherapy must "respect the privacy of clients by holding in strict confidence all information about clients and by complying with any applicable privacy and other legislation. (They may) …disclose such information only when required or allowed by law to do so or when clients have consented to disclosure.[52] The Standards of Practice also require that members "comply with any applicable privacy and other legislation… (and) obtain consent to the collection, use or disclosure of client information including personal information, unless otherwise permitted or required by law.[53] Members must also "inform clients early in their relationship of the limits of confidentiality of information … (and) respect their clients' right to withhold or withdraw consent to, or place conditions on, the disclosure of their information."[54] As with consent to psychotherapy services, members must make every effort to ensure that their clients understand the limits of confidentiality; a consent form, while necessary in most circumstances, is not necessarily sufficient on its own. When seeing legally-dependent clients or more than one client together (e.g. couples, families or groups) members should clarify how each individual's confidentiality will be maintained, and how, in fact, in some circumstances it cannot be maintained.[55]

By seeking clients' informed consent and ensuring that they understand the limits of confidentiality, members performing the controlled act of psychotherapy demonstrate not only their respect for clients' autonomy and self-determination, but also strengthen the therapeutic relationship and enhance clinical outcomes.[56]

3. PROFESSIONAL LIABILITY INSURANCE

Professional liability insurance protects both the public and members who perform the controlled act of psychotherapy. Unlike general liability insurance, professional liability insurance coverage focuses on an alleged failure by the member to perform to an acceptable standard in the service provided, or for actions taken or not taken that have resulted in harm or loss to the client, whether intentional or not. In the event of a successful civil suit, professional liability insurance may ensure that clients are able to recover the costs of litigation as well as monetary compensation for the harm they have suffered. Professional liability coverage may also be something that clients assume or expect members to have in place, as it is required for regulated professions under the RHPA.[57]

Professional liability insurance may protect members from bearing the full cost of legal expenses associated with defending against a claim made by a client, and damages awarded in a civil proceeding. Certain policies providing coverage for professional liability may also protect members from bearing the full cost of defending against a complaint made by a client to the College.

Given that performing the controlled act of psychotherapy poses a heightened risk to the public, it is strongly recommended that all members who perform the controlled act of psychotherapy obtain adequate professional liability insurance. As discussed earlier, members who provide supervision for members performing the controlled act of psychotherapy may be seen to bear professional responsibility for those performing the controlled act of psychotherapy under their supervision, and should therefore ensure that they are adequately covered for this activity as well. Because coverage can vary, members should carefully review their professional liability insurance coverage (whether provided through their employer or obtained independently) to ensure that they understand the nature and extent of the coverage.

FOOTNOTES

27. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle II, Competence and Integrity, interpretation 2.2
28. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle II, Competence and Integrity, interpretation 2.2
29. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle II, Competence and Integrity, interpretation 2.2. Members may also wish to review Reamer, Frederic G. "Boundary Issues in Social Work: Managing Dual Relationships" in **Social Work,** Volume 48, Number 1, January 2003. Print. p. 121
30. Pope, Kenneth S and Patricia Keith-Spiegel "A Practical Approach to Boundaries in Psychotherapy: Making Decisions, Bypassing Blunders, and Mending Fences" in **Journal of Clinical Psychology: In Session,** Vol. 64 (5), 2008. Print. p. 642
31. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle II, Competence and Integrity, interpretation 2.2.1. Footnotes 6 and 7 in Principle II define "conflict of interest" and "dual relationship" respectively.
32. Barnett, Jeffrey E. "Psychotherapist Self-Disclosure: Ethical and Clinical Considerations" in **Psychotherapy** Vol. 48, 2011. Print. p. 320
33. Barnett, p. 316
34. Ibid, p. 320

35. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle I: Relationship with Clients, interpretation 1.6
36. Reamer, p. 130
37. Barnett, p. 316
38. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle VIII, Sexual Misconduct, interpretations 8.1 and 8.2 and Principle II, Competence and Integrity, interpretation 2.2.2
39. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle VIII, Sexual Misconduct, interpretations 8.5 and 8.6
40. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle VIII, Sexual Misconduct, interpretations 8.7 and 8.9
41. **Code of Ethics and Standards of Practice,** Second Edition 2008, Principle VIII, Sexual Misconduct, interpretation 8.3
42. Smith, D. and M. Fitzpatrick "Patient-centred boundary issues: An integrative review of theory and research" in **Professional Psychology: Research and Practice,** 26,1995, quoted in Barnett, p. 317
43. **Code of Ethics and Standards of Practice,** Second Edition 2008, Principle III, Responsibility to Clients, interpretations 3.1 and 3.6
44. Fisher, Celia B. and Matthew Oransky "Informed Consent to Psychotherapy: Protecting the Dignity and Respecting the Autonomy of Patients" in **Journal of Clinical Psychology: In Session,** Vol. 64 (5), 2008. Print. p. 576
45. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle I, Relationship with Clients, interpretation 1.1
46. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle I, Relationship with Clients, interpretation 1.3
47. Fisher and Oransky, p. 576
48. Ibid, p. 577
49. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle II, Competence and Integrity, interpretation 2.1.3
50. OCSWSSW, **Practice Guidelines on Consent and Confidentiality with Children and Youth,** Sept. 1, 2009
51. Fisher and Oransky, p. 578
52. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle V, Confidentiality
53. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle V, Confidentiality, interpretation 5.1
54. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle V, Confidentiality, interpretation 5.4
55. New York State Office of the Professions, **Social Work Practice Guidelines: Maintaining Confidentiality** www.op.nysed.gov/prof/sw/swconfidential Online. May 13, 2012
56. Fisher and Oransky, p. 587
57. Amendments to the RHPA concerning liability insurance are not yet in force, however liability insurance is currently a registration requirement for members of many RHPA colleges.

Conclusion

These Practice Guidelines have addressed critical elements in the competent and ethical practice of the controlled act of psychotherapy: education and experience; supervision; and continuing competence. They have also addressed boundaries and sexual misconduct, informed consent and confidentiality, and professional liability insurance. Members are advised to complete the checklist in Section D after reviewing the Practice Guidelines in their entirety, to ensure that they have made sound decisions regarding their readiness to perform the controlled act of psychotherapy competently.

Checklist

AM I PREPARED TO PERFORM THE CONTROLLED ACT OF PSYCHOTHERAPY?

In order to determine whether they are prepared to perform the Controlled Act of Psychotherapy, members are advised to seek input/consultation from supervisors and/or others familiar with their practice when completing the checklist below.

In addition to my degree in social work/ diploma in social service work, I have:

- a further degree or diploma with a clinical focus; and/or a certificate, or equivalent, from a program with a focus on performing the controlled act of psychotherapy; and
- post –degree/diploma experience in performing the controlled act of psychotherapy (2–3 years; 2000-3000 hours of supervised experience in performing the controlled act of psychotherapy).

My coursework and practica had a clinical focus.

I have engaged in a period of extensive clinical supervision with an experienced supervisor following the completion of my degree/diploma.

I continue to obtain regular supervision (individual, group, peer) appropriate to my level of experience related to performing the controlled act of psychotherapy.

My goals in the Continuing Competence Program are heavily weighted toward performing the controlled act of psychotherapy.

I am aware of confidentiality and boundary issues, including those raised by the use of technology, and have considered the impact of any technology I am using in my practice.

My learning activities include experiential learning and opportunities to practise and/or observe clinical interventions.

At least some of my ongoing training is more intensive (certificate programs, externships, in-depth courses).

I have reviewed, considered and understand the issues raised in the **Boundaries and Sexual Misconduct** section of the Practice Guidelines for Performing the Controlled Act of Psychotherapy.

I have reviewed, considered and understand the issues raised in the Informed Consent and Confidentiality section of the Practice Guidelines for Performing the Controlled Act of Psychotherapy.

I have reviewed the Standards of Practice in their entirety, and have considered the standards and interpretations relevant to performing the controlled act of psychotherapy.

I have taken steps to ensure that I am adequately covered by professional liability insurance.

Ontario College of Social Workers and Social Service Workers

250 Bloor St. E.
Suite 1000
Toronto, ON
M4W 1E6

Ordre des travailleurs sociaux et des techniciens en travail social de l'Ontario

Phone: 416-972-9882
Toll Free: 1-877-828-9380
Fax: 416-972-1512
ocswssw.org