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The Psychological Association of Manitoba/
L'Association Des Psychologues Du Manitoba

P.A.M. is legally constituted by the psychologists Registration Act (R.S.M. 1987) as the regulatory body for the practice of all branches of Psychology in Manitoba

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Registrar's Column

The past 6 months have been very busy ones for PAM and I am pleased to take this opportunity to update you on our activities. Perhaps the most exciting news involves PAM's recent acquisition of dedicated office space. Apart from a brief period of time in the late 1980s when PAM had outside office space, the remaining 46 years have seen the PAM office travel with the registrar. However, given the significant number of initiatives that are in progress at this time (e.g. coming under the RHPA, bringing school psychology into PAM), council has, for the past few years, been looking for affordable and accessible office space. I am pleased to announce that beginning sometime early in the new year, PAM will be moving into its new offices at Suite 208 – 584 Pembina Highway (at the corner of Pembina Highway and Grant Avenue). This office space will be easily accessible to all, features ample parking, is wheelchair accessible (via elevator), and will afford PAM the necessary space and resources to continue our regulatory work. As well, we will now be able to centralize our complaint committee meetings, oral examinations, jurisprudence examinations, and registration and membership committee meetings, in

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one place, thus removing the necessity to courier files to various committees, for these purposes. This will improve the efficiency of our operations, and we look forward to moving into this space in the new year.

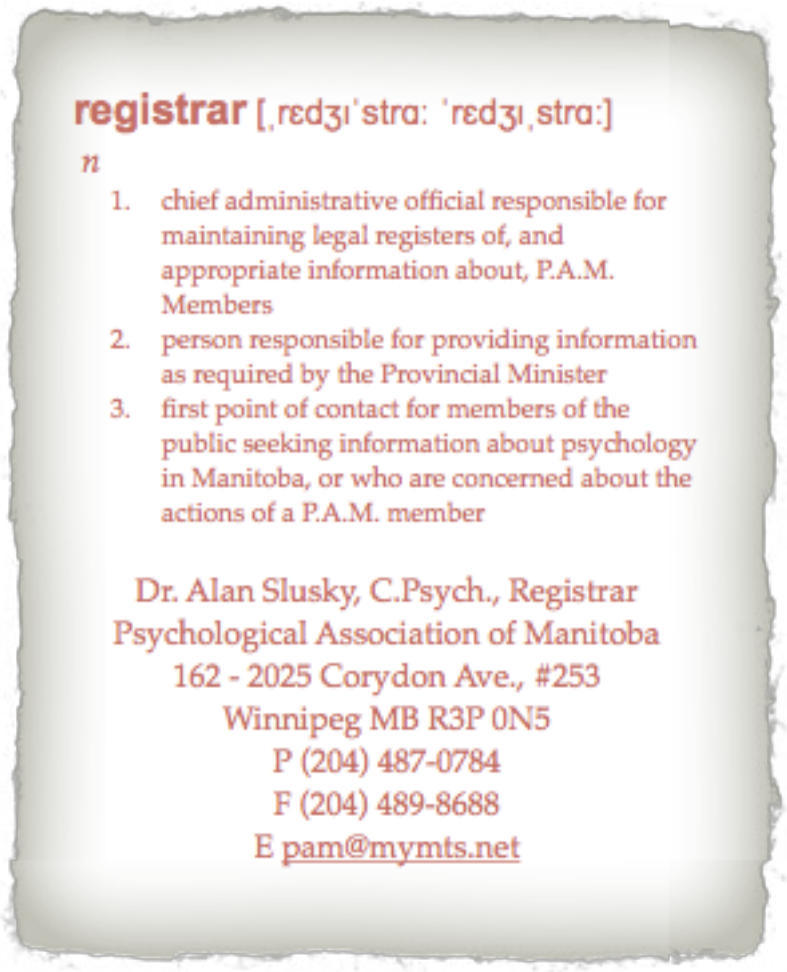
As mentioned above, working towards coming under the RHPA continues to be a major focus of Council activity. Early this fall Dr. John Arnett (PAM Council President), myself, and representatives from the Manitoba Association of School Psychologists, met with the Manitoba government ministers of Health and Education to discuss necessary next steps to bring school psychology under PAM regulation. In order to do so, PAM itself must come under the RHPA, and at this meeting we were officially given the "green light" by these government ministers to begin this work. Accordingly, council is reviewing potential consultants to assist us in this complex and time/resource intensive process. Despite the fact that considerable time will be required for this project, it is reassuring to know that our bylaws are quite current (relative to our other health regulatory counterparts) and this should aid us in making the remaining necessary revisions to be in compliance with the RHPA requirements. We will keep you, the membership, apprised of developments in this area as they occur.

Over the past 6 months, there have also been a number of noteworthy PAM committee changes. First and foremost, Dr. Michael Stambrook, who has faithfully served as PAM complaints committee chair for the past 4 years, stepped down over the summer, and a replacement for this position is currently being sought. PAM Council extends its deepest appreciation to Dr. Stambrook for his time, expertise, and commitment to this role. We are also indebted to Drs. Geri Brousseau and Daryl Gill, who are also retiring from the committee. Dr Gill has been a member of the committee for over 14 years and we are particularly grateful to him, for his dedication and very hard work. While a chair is being sought for this committee, several psychologists have volunteered to become new members, and we would like to welcome Drs. Feldgaier, Edmund, and Leslie-Toogood to the complaints committee. They begin their tenure in the new year. At that time we are anticipating the resignation of some of the committee's current members, and further information on that will be provided in the summer edition of the Manitoba Psychologist. Executive Council is also examining a number of other options to improve the efficiency of the complaints committee, and again you will be kept updated on this progress, as it occurs. As well, Dr. Hal Wallbridge has agreed to serve as Chair of the Standards committee, and we are again grateful for his active volunteerism with PAM. Finally, beginning in January, Dr. James Ediger has agreed to serve on the Registration and Membership committee.

We would also like to welcome Dr. Jennifer Volk, who has agreed to serve as chair of PAM's Publications Committee and editor of the Manitoba Psychologist. This edition represents Dr. Volk's first newsletter and we are grateful for her willingness to take on this important task. If members have

any ideas for future articles or material that they believe would be appropriate for upcoming editions of the newsletter, please don't hesitate to send them to us for consideration.

As many of you are aware, the Manitoba Ombudsman rendered a decision in the past 6 months, which compelled a current registrant to release raw test data to a client. The decision was made in view of the lack of an exemption for psychological test data under the Personal Health Information Act. Details of this decision can be found here: http://www.mbipa.ca/orders/reference-concerning-psychological-test-materials.pdf. In order to protect the security of these test materials and to further protect the public from inappropriate/unguided interpretation of this data, we are in the process of applying to Manitoba Health to have an exemption for psychological test data placed into the Manitoba PHIA. Such an exemption currently exists in Ontario, and as 2016 is a review year for PHIA, the time appears appropriate for such an application. We will keep you updated on the progress of this request and the implications for your practice.



As always, Executive Council and I are eager to hear your questions and concerns about PAM and its operations. We hope that you enjoy this newsletter and invite you to contact us at the PAM email address with any inquiries you may have.

Alan Slusky, Ph.D., C. Psych. Registrar

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Feedback and story suggestions are welcomed! Contact the Editor:
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The Psychological Association of Manitoba
Practice Guideline for Providers of Psychological Services

Minors' Consent to Psychological Treatment and Primary Care and Control

A. Introduction

The Psychological Association of Manitoba ("PAM") recognizes that client autonomy and respect for personal dignity are central to the psychologist-client relationship. In exercising their autonomy, every client has the legal right to consent to, or refuse, psychological treatment. PAM also recognizes that children should not be automatically deprived of their right to make decisions affecting their psychological treatment. Instead, children are entitled to a degree of decision-making autonomy that is reflective of their evolving intelligence and understanding.

- **Psychologists must obtain adequate informed consent from the client, or an individual or agency with legal authority to consent on the client's behalf, prior to providing psychological services to the client.[1] [2]**

PAM recognizes that some persons may not have the legal capacity to consent to psychological treatment. Where the person would benefit from psychological treatment, and where the psychologist wishes to provide that treatment, consent must be obtained from an alternative source. This Practice Guideline attempts to identify those individuals and agencies which most often will be called upon to act as substitute decision-makers to provide or withdraw consent to psychological treatment on behalf of a *minor* who lacks legal capacity.

- **As a general guideline, psychologists can presume that persons who are at least 16 years of age or older have the *legal* capacity to consent to psychological treatment.[3] Similarly, psychologists can presume that persons who are under 16 years of age do not have this capacity.[4]**

[1] There are four pre-requisites to a valid consent at law: 1) it must be voluntary; 2) the patient must have legal and mental capacity; 3) it must be specific to both the treatment and the person administering it; and 4) it must be informed, in that the patient must understand the nature of the procedure, the benefits, the risks and any alternative treatments.

[2] *PAM Code of Conduct*, Part 4.0.

[3] The law in Manitoba presumes that persons who are at least 16 years of age or older have the legal capacity to make their own health care decisions and that those under 16 years of age do not. Both of

B. Who may consent or refuse psychological treatment on behalf of a minor?

(i) The "Mature Minor"

PAM recognizes that the test of capacity to consent to psychological treatment is not necessarily age-dependent. Where a child, *regardless of his or her age*, has sufficient intelligence and understanding of the nature and consequences of the proposed psychological treatment, he or she is deemed to be a "mature minor" and is capable of consenting to such treatment.

- **In all cases where a psychologist is planning to provide psychological services to a minor client, it is the responsibility of the psychologist to conduct an individual assessment of the minor's physical, emotional and intellectual development and understanding. Psychologists are advised to make detailed notes of these assessments.**

- **If the psychologist is satisfied that the minor is mature enough to understand the nature and consequences of the proposed psychological treatment, *consent from the minor's parents will not be sufficient*.[5] Consent must be obtained from the "mature minor**".

- **If, following the individual assessment of the minor, the psychologist concludes that the child does not have sufficient intelligence and understanding of the proposed treatment to meet the requirements of a "mature minor", the child shall be considered an "immature minor". In those cases, consent must be obtained from a substitute decision maker prior to the psychologist providing psychological services.**

these presumptions are rebuttable where there is evidence to the contrary (see *The Health Care Directives Act*, C.C.S.M. c. H27, s.4).

[4] However, psychologists must recognize that some persons under 16 years of age may be mature enough to consent on their own behalf. An individual assessment as to whether a person under 16 years of age is a "mature minor" is required.

[5] The parental right to determine whether a minor child will receive psychological treatment terminates when the child achieves a sufficient understanding and intelligence to provide an informed consent.

(ii) Parents

PAM recognizes that parents have a duty to care for their child and that with this duty comes sufficient control or authority to permit them to make decisions which are in the best interests of the child, including the decision to consult a psychologist.

- **In treatment situations involving "immature minors", consent must be obtained from at least one of the minor's parents. To avoid potential disagreements between parents of the minor, PAM encourages the psychologist to obtain the consent of *both parents* prior to providing psychological services to a minor.[6]**

- **Where the parents of a minor never cohabited after the birth of their child, consent must be obtained from the parent with whom the minor resides.[7]**

- **Where the parents of a minor are separated, the psychologist must obtain the consent of the parent to whom that authority has been designated under the separation agreement. If no separation agreement exists, both parents have equal rights to consent or withdraw treatment on behalf of the minor. As above, PAM suggests that the consent of both parents be obtained.**

- **Where the parents of a minor are divorced, the psychologist must obtain the consent of the parent to whom that authority has been designated by court order.**

[6] The law considers parental rights, including the right to consent to treatment on behalf of a child, to be "joint rights". This means that both parents have an equal right to consent to or refuse psychological treatment on behalf of their child. To avoid scenarios where Parent A consents to their child receiving psychological treatment and Parent B disagrees and withdraws their consent, the psychologist should obtain the consent of both parents at the initial consultation.

[7] *The Family Maintenance Act*, C.C.S.M. c. F20, s.39(1).

(iii) Guardian

A court may have appointed an individual to be the guardian of a minor under *The Child and Family Services Act* (Manitoba). In this situation, consent must be obtained from the guardian prior to providing psychological treatment to the minor.

- **Where a minor has a court-appointed legal guardian, the consent of the guardian must be obtained prior to providing psychological treatment to the minor.**

(iv) Child and Family Services agency

In certain situations, a psychologist must obtain the consent of a Child and Family Services ("CFS") agency before providing psychological treatment to a minor. Where a minor under the age of 16 has been apprehended under *The Child and Family Services Act* (Manitoba) because he or she is in need of protection, a CFS agency has the authority to consent to medical *assessments* on behalf of the minor where consent from the minor's parents would otherwise be required.

Where a CFS agency is the legal guardian of a minor, either by court order or where the parents of a child have voluntarily surrendered guardianship, the CFS agency will have care and control of the minor and will act on the minor's behalf. Prior to providing psychological treatment to a minor who is under the care of a CFS agency, the psychologist must obtain the consent of the CFS agency.

- **Psychologists may provide psychological assessments to minors under the age of 16 without the consent of the minor's parents if the minor was apprehended under *The Child and Family Services Act* and a CFS agency consents to the assessment.**

- **Where a CFS agency has been appointed as the minor's guardian, the psychologist must obtain the consent of the CFS agency prior to providing psychological treatment to the minor.**

(v) Justice of the Court of Queen's Bench

In the context of a family proceeding,[8] a judge of the Court of Queen's Bench has the ability to order a psychological assessment of a child on its own initiative or in response to an application by a party to the proceeding. In these situations, the psychologist is acting for the benefit of the Court for the purposes of providing relevant evidence.

PAM recognizes that, where family proceedings are ongoing, problems may arise which are directly related to the issue of a minor's consent to psychological treatment. For example, Parent A may want a psychological assessment of their child for the purposes of "arming" themselves with evidence for a family proceeding to the disadvantage of Parent B. In this scenario, where there is no separation agreement, even though Parent A consents to the assessment, Parent B retains their parental rights to withdraw consent. In these situations, psychologists should avoid providing psychological treatment to a minor unless *both* parents provide their consent or there is a court order.

- **Where the psychologist has knowledge of or suspects there to be a marital dispute between the parents of a minor, the psychologist should obtain the consent of both parents or avoid providing treatment unless pursuant to a court order.**

[8] Section 41 of *The Court of Queen's Bench Act*, C.C.S.M. c. C280, defines "family proceeding" to include, among other things, a proceeding for the determination or variation of the custody, access or guardianship of the person of an infant.

(vi) Proxy

In very rare situations, a person appointed as a "proxy" may have to provide his or her consent to psychological treatment on behalf of a mature minor. This situation would arise where a mature minor has appointed a person to act as their proxy under a health care directive. The proxy's authority to make health care decisions on behalf of the mature minor is effective once the minor loses capacity with respect to a proposed treatment or the ability to communicate.[9] The proxy, acting in accordance with the mature minor's wishes, may consent to or refuse treatment on their behalf. It would be unusual for a psychologist to encounter this type of situation, given the unlikelihood that a person under 16 years of age would make a health care directive. Nonetheless, psychologists should be aware of this possibility.

- **Psychologists should inquire as to whether a minor has appointed a proxy to make health care decisions on their behalf. If the proxy's authority is effective, the psychologist must obtain the consent of the proxy prior to providing psychological treatment.**

Issue of Primary Care and Control:

To begin, it is important for the practitioner to see the document (usually a court order or separation agreement) that purports to grant authority to one parent or the other. From there, parental authority can be roughly categorized as follows:

1. Joint custody to both parents: where the court orders (or the parties agree) on joint custody, both parents share in the care and control of the child. Care and control includes providing for the day-to-day necessities of life, and decision-making authority about larger issues, such as education, religion, health treatment and other important areas of life. In such cases, both parents should be consulted about psychological treatment;

[9] *The Health Care Directives Act*, C.C.S.M. c. H27, s.6(1).

2. Primary care and control to one parent: where the court orders (or the parties agree) that one parent shall have primary care and control of the child, that parent has the right and duty to provide for the day-to-day necessities of life, and has the right and duty to make decisions about larger issues, such as education, religion, health treatment and other important areas of life, unless the order (or agreement) provides otherwise. Subject to what follows, where one parent has been granted primary care and control, that parent may make decisions on psychological treatment without consulting the other parent;

3. Final-decision making authority: in some cases, the court will order that one parent shall have primary care and control of the child, but that final-decision making authority in respect of larger issues shall be shared, or shall be given to the other parent. If the parent seeking psychological treatment for the child has final decision-making authority, that parent may make decisions on psychological treatment without consulting the other parent. If final decision-making authority is to be shared, then both parents must be consulted.

Thus, it is important that the practitioner review the order or agreement that purports to grant authority over a child, to see how the issue of decision-making authority has been dealt with.

This Practice Guideline should be read in conjunction with the provisions of The Psychological Association of Manitoba's existing Practice Guidelines, Code of Conduct and By-Laws so far as they relate to the issue of informed consent to psychological treatment.

RETHINKING REGULATION IN THE UK

RICHARD STEINECKE

Reprinted, with permission, from Grey Areas No. 199, September 2015.

Grey Areas has been published by the Toronto law firm Steinecke Maciura LeBlanc since July, 1992, and focuses on recent developments in professional regulation, analysis of recent studies, examination of recent cases, and scrutiny of recent legislation.

Last month, a United Kingdom agency released a major report entitled "Rethinking Regulation". The Professional Standards Authority (PSA) oversees statutory bodies that regulate health and social care professionals in the UK. The PSA developed the widely respected concept of "right touch regulation" in 2010. The report should be mandatory reading for regulators of all professions everywhere.
In the words of Harry Cayton, CEO of the PSA:

Regulation is asked to do too much - and to do things it should not do. We need to understand that we cannot regulate risk out of healthcare and to use regulation only where we have evidence that it actually works. Ironically, the regulations that are meant to protect patients and service users are distracting professionals from this very task.

The opening words of the report give a good indication of what the reader should expect:
The regulatory framework for health and care is rapidly becoming unfit for purpose.

Without reading the sources cited in its many footnotes, the report comes across as an opinion piece or guest editorial. Only a few examples are given to illustrate the assertions made, but many of the assertions will resonate with those involved in the regulation of professions.
For example, many readers will be able to relate to the report's description of the evolution of professional regulation:

Each new organisation, and each new regulatory intervention, has been created in response to specific stimuli without the benefit of an overarching design, a controlling intelligence, or a coherent set of principles. Regulation, which under the current system is an instrument of law, is dependent on detailed primary legislation and therefore parliamentary timetables and legislative resources. It is slow and generally behind the trend, neither keeping pace with current changes nor anticipating future needs. It has led to a vastly complicated and incoherent regulatory system where the costs and benefits are unquantified and unclear.

Role of Regulators

The report's first major discussion related to identifying the role of regulators, as well as the risks regulators are addressing. It discussed the evolution of professionalism shifting from the concept of autonomous, self-managing experts to the concept of a set of values, behaviours and relationships that underpin the trust the public has in the profession. As such, the regulator needs to clarify its focus and role and avoid "regulatory mission creep". Regulators need to:

…redefine the outcomes that they are seeking to achieve, and rethink how they will do so, based on evidence of what works, and drawing on a wide range of research and data.

The report also states:

We should also be careful not to perpetuate the idea that the business of regulation is the elimination of risk as opposed to the reduction of harms. … To eliminate all risk would probably also eliminate the possibility of any benefit for the patient ... [and] prevent beneficial innovation…

The report paraphrases Professor Malcolm Sparrow as saying "that the focus of regulation should move away from the efficient completion of process to a focus on the prevention of specific types of harm."

Relationship between Professional and System Regulation

The next portion of the report contains an intriguing discussion of how the practice context and environment often influence the behaviour and competence of practitioners more so than professional standards promulgated and enforced by regulators. The report states: "It seems strange to us therefore that people are regulated separately from the systems and places in which they work."

The report discusses some of the challenges of regulating both professions and systems and how such regulation works together. Controversially, the PSA suggested that while regulators should develop and promote compliance with professional standards, it was a mistake for regulators to take over the responsibility from practitioners and the workplace to achieve those standards or to become involved in pursuing continuous quality improvement:

Once a regulator becomes too intimately involved in putting improvement into effect it loses its objective and impartial advantage, ends up marking its own homework and being blamed more deeply for continuing problems. It also obscures achievement by pursuing continuous improvement rather than consistently measuring against a benchmark. It loses sight of the progress that has been made and becomes demoralised by the rediscovery of failure.

Supporting Professional Conduct

Another interesting section of the report addresses how regulators could creatively achieve their identified goals by such means as:

• Exploring preventative approaches to fulfilling professional standards;
• Using engagement techniques to help practitioners fulfill standards;
• Targeted regulation where feasible given human rights concerns (e.g., older workers);
• Transparent publication of data by or from practitioners (e.g., surgical outcomes); and
• Mobilizing others (e.g., other practitioners) to help achieve the regulator's purposes.

Governance

The report also contains a brief description of governance strategies that the PSA found helpful including:

• Smaller sized Councils / Boards;
• Equal numbers of professional and public members on Councils / Boards; and
• Transparency of the appointment process (which assumes that they are not elected by members of the profession).

Conclusion

The report ends with a summary of principles and a list of recommendations. The summary of principles includes:
Some important principles are becoming well established: these are the antiseptic power of transparency, a commitment to both personal and shared responsibility and a renewed engagement with patients and the public.
The recommendations include the following:
• A shared 'theory of regulation' based on right-touch thinking
• Shared objectives for system and professional regulators, and greater clarity on respective roles and duties
• Transparent benchmarking to set standards
• A rebuilding of trust between professionals, the public and regulators
• A reduced scope of regulation so it focuses on what works (evidence based regulation)…
• A drive for efficiency and reduced cost which may lead to mergers and deregulation
• To place real responsibility where it lies with the people who manage and deliver care

Whether one agrees or disagrees, the report provides a fascinating discussion of the direction of professional regulation. In addition, it is full of pithy statements that will be quoted liberally by regulators for years to come.
The Rethinking Regulation report can be found at: www.professionalstandards.org.uk.

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