TASK GROUP FOR COUNSELLOR REGULATION IN BRITISH COLUMBIA

SUBMISSION TO

THE B.C. MINISTRY OF HEALTH

RISKS OF HARM ASSOCIATED WITH COUNSELLING THERAPY SERVICES

September 22, 2011

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INTRODUCTION

On May 16, 2011, representatives of the Task Group for Counsellor Regulation (Task Group) and the Canadian Professional Counsellors Association (CPCA) met with senior officials of the Ministry of Health to discuss the designation of the counselling therapy professions under the *Health Professions Act*[1] (HPA). Such designation would result in the creation of a new College of Counselling Therapists of British Columbia[2] that would eventually regulate the profession.

During this meeting, the Ministry officials advised the association representatives that the critical information the Ministry requires before it would recommend to the Minister that designation should proceed is some analysis of the risks of harm. In particular, the Ministry would need objective and reliable information about the current risks to the public of not having counselling therapy professions regulated under the HPA, as well as the disadvantages and costs of designation.

The Ministry also explained that, to date, it has received few complaints from the public about harm at the hands of regulated or unregulated therapists.[3] The apparent lack of a public demand for the regulation of counselling therapy means that this issue has not become a priority for the government.

The Ministry noted that it is receptive to obtaining information about the risks of harm that are associated with counselling therapy, beyond the theoretical risks that were set out in the Task Group's 1998 submission, *Joint Response to the Discussion Paper on the Regulation of Counselling*. (An extract from the Task Group's 1998 document is set out in

[1] RSBC 1996, c. 183.

[2] The generic name for the profession, counselling therapy, and the name for the college, the College of Counselling Therapists of BC, was first proposed in April 2001 by Mary Falconer in a confidential draft of a regulation that would have designated the professions under the HPA. Since Ms. Falconer proposed these names, the Task Group has adopted and applied them to describe the various counselling professions that make up the Task Group membership, as well as other counsellors who could join the new College.

[3] One of the reasons the Ministry may not have received many complaints about counsellors is that the BCACC and other professional associations have been investigating and resolving complaints for the past 25 years or so. (See chapter 4 for details about the BCACC's experience with public complaints.) If the BCACC and the other professional associations were to give up their voluntary complaint investigation and resolution functions, they could then direct the public to complain about the conduct of unregulated therapists directly to the Ministry. No doubt this would result in an increased number of complaints being directed to the Minister or the Ministry.

Appendix "A" of this submission.) The Ministry indicated that it needed concrete and verifiable information that shows there is a real potential for physical, emotional or psychological harm to persons, harm that can be attributed to the incompetent or unethical provision of counselling therapy services.

In summary, the Minister is more likely to decide to proceed with designation of counselling therapy if the professional associations can demonstrate that there is a real and pressing need to regulate the various counselling professions under the HPA.

Purpose

The purpose of this submission is to provide the Ministry with the Task Group's best evidence on risks of harm to the public, in particular the risks associated with the lack of regulation of counselling therapy in British Columbia.[4] It is hoped this information will provide a basis for the Ministry to move forward (again[5]) with designation.

Outline

In this submission, the Task Group will present and comment on the following new sources of information concerning risks of harm that have been identified as flowing from incompetent or unethical counselling practices:

- Chapter 1: The harm to the public that has been described in reported legal cases from British Columbia resulting from incompetent or unethical counselling, psychotherapy or psychological services provided by unregulated therapists;
- Chapter 2: The risks of harm to the public that have been reported in claims filed with the major professional liability insurance company used by the vast majority of counsellors in BC;

[4] While the member organizations believe that they regulate their members under their respective bylaws, because this is a voluntary mandate and a member can escape such regulation by simply resigning their membership, the Ministry does not view the current voluntary form of self-regulation as true regulation.
[5] As noted, the last time the Ministry appeared to be prepared to designate counselling therapy under the HPA was when Mary Falconer circulated a confidential draft of a designation regulation in April 2001. While the Task Group supported that initiative and provided detailed commentary on the proposed regulation, that proposal was not pursued further.

- Chapter 3: The harms that have been reported in the public complaints that have been filed with the Inquiry Committee of the BC Association of Clinical Counsellors;
- Chapter 4: The harms that have been suffered by the clients of clinical counsellors at the hands of non-regulated persons, as reported to BCACC members.

Each of these four chapters presents information on risk of harm from different perspectives that, as will be explained, when viewed as a whole, provides a comprehensive picture of the sorts of problems that can arise if counselling therapy were to remain an unregulated health profession in British Columbia.

Chapter 5 considers the policy issues that the Task Group understands would inform a government decision to designate a health profession under the HPA. As the Task Group explained in its 2009 submission, *Options for the Self-Regulation of Counselling Therapists in B.C.*, while identifying the actual risks of harm is an important step in the decision to designate a health profession under the HPA, understanding which resulting regulatory model would best minimize if not eliminate those risks is the next critical step in the process. Therefore, this chapter will also propose a regulatory solution that the Task Group believes best responds to the identified risks.

About the Task Group

The Task Group was formed in 1998 in response to the recommendation by BC's Health Professions Council that counselling be regulated in British Columbia, albeit not under the HPA. Since that time, the Task Group has worked on creating the foundation for what it anticipates will be a new College of Counselling Therapists under the HPA.

The Task Group is currently comprised of (in alphabetical order): (i) the American Association of Pastoral Counsellors (BC Chapter), (ii) the BC Art Therapy Association, (iii) the BC Association of Clinical Counsellors, (iv) the Canadian Association for Spiritual Care (BC Chapter), (v) the Canadian Counselling and Psychotherapy Association (BC Chapter), and (vi) the Music Therapy Association of BC. These six member organizations represent about 2,500 counselling therapists working throughout the province.

CHAPTER 1: REPORTED COURT CASES

> It was inevitable that [this self-described sexual abuse counsellor's] method of counselling would result in the very conflicts that did develop. Not only did [she] have little formal education and limited practical experience, she was accountable to no one as she had no professional certification or membership; there was no direct supervision or audit of her sessions; and she insisted on crossing the usual relationship boundaries between client and counsellor. *(Lee v. Scott, 2001 BCSC 1281 at para. 35 (BCSC))*

Introduction

Legal research was undertaken to identify reported cases from the British Columbia courts and administrative tribunals that involved persons who provide counselling services like the services that are provided by the members of the Task Group organizations, but who are not regulated under dedicated provincial professional governance legislation (like the HPA). For the purposes of this submission, this group will be identified as "unregulated therapists."

Unregulated therapists include persons who provide counselling therapy services as their career, such as clinical or mental health counsellors, drug and alcohol counsellors, pastoral counsellors, marriage and family therapists, sex therapists, art or music therapists, psychotherapists, and child-care workers. However, for the purpose of this legal research, cases involving those who provide volunteer or free counselling services or who do not make a living providing counselling therapy were not included.

This research identified a number of reported civil cases from the British Columbia courts where an unregulated therapist was being sued for negligent conduct or was otherwise involved in some claim for damages, such as a claim that had been filed against that counsellor's employer. The research also identified a few criminal cases and some reported labour arbitration decisions where an unregulated therapist had caused harm to a client or a third party.

Only British Columbia cases reported over the past 15 years are summarized in this chapter. The legal research undertaken identified many cases from across Canada and covered a longer, 25-year span. While a summary of these other cases can be provided to the Ministry on request, the focus of this chapter is on those cases where recent events occurred in this province.

Summaries of reported legal cases

The identified cases are summarized in chronological order. This will be followed by a discussion of the nature of the risks of harm that can be extracted from these cases.

Legal case #1: In B.(D.C.) v. Boulianne,[6] the plaintiff DCB received counselling from the defendant, Boulianne, who was a drug and alcohol counsellor with Nanaimo National Native Alcohol and Drug Abuse Program (NNADAP). She claimed Boulianne sexually assaulted her by kissing her and touching her in a sexual manner, and then he later forced her to have non-consensual sex with him. The Court dismissed the claim against the Program, butt found that the defendant had assaulted the plaintiff, and – therefore – awarded her $11,000 in aggravated and punitive damages.

Legal case #2: In J.H. v. R.[7] the plaintiff was awarded $100,000 damages for having been wrongfully sent to a mental institution. The plaintiff had become a ward of the Province at an early age and was moved around from various foster homes and care facilities. He typically proved extremely difficult, and was removed. His placements were governed by a section of the Superintendent's office designated to oversee especially difficult placements. When he was 14 years of age, his current placement insisted that he must go, so in finding another placement quickly the Superintendent's office exaggerated the plaintiff's deficiencies to make him a high priority for entry to Woodlands, a secure facility for long-term care of the mentally ill. He was sent there despite the fact that he did not fit the criteria in terms of his IQ or the requisite medical approvals. He suffered at Woodlands, including being exposed to sexual abuse of other patients. Various Ministry staff (including social workers as well as staff who were not licensed social workers) were involved in the process that resulted in his

[6] B. (D.C.) v. Boulianne, 1996 CarswellBC 2369, [1996] B.C.W.L.D. 2945, [1996] B.C.J. No. 2183 (BCSC)
[7] J.H. v. R. (Superintendent of Child Welfare) 1998 CanLII 15125 (BCSC).

being evaluated and sent to Woodlands. The court found that his admission was negligent because no doctor examined him, as required for admission. This was just one of the ways in which proper protocols were not followed. While he was at Woodlands several employees including a psychologist there reported that his mental capacity was normal, and they repeatedly advised that he should be removed, although he remained there for over three years.

Legal case #3: In C.A. v. Critchley,[8] the British Columbia government had contracted with the defendant Critchley to operate a wilderness group home for troubled male youths, including the plaintiffs. Critchley repeatedly physically and sexually abused the plaintiffs who had been entrusted to his care. The trial judge assessed damages against the defendant and also against the government as Critchley's employer. The Court of Appeal upheld the trial judge's ruling.

Legal case #4: In Bazley v. Curry,[9] the Children's Foundation operated a residential care facility in Vancouver for emotionally troubled children. The children were housed and cared for by employees of the Foundation, who were responsible, as substitute parents, for the physical, mental, and emotional well-being of the children. This included everything from generally looking after them to bathing them and tucking them in at night. One of the employees, Curry, sexually abused some of the children, including an emotionally vulnerable young boy. Over time, Curry turned the bathing of the boy into sexual exploration and took to sexually abusing him when tucking him in at night. Eventually the Foundation learned of Curry's misconduct and discharged him. He was later convicted of 19 counts of sexual abuse, two of which related to this boy, who was awarded damages against both Curry and the Foundation.

Legal case #5: In F.S.M. v. Clarke,[10] a dormitory supervisor at an Indian residential school operated by the Anglican Church committed sexual assaults against the plaintiff and several other children. Clarke pleaded guilty to the criminal charges and was incarcerated.

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[8] C.A. v. Critchley (1998), 166 D.L.R. (4th) 475, [1998] B.C.J. No. 2587 (QL) (BCCA)

[9] Bazley v. Curry, [1999] 2 S.C.R. 534, 1999 CanLII 692, 174 DLR (4th) 45, [1999] 8 WWR 197, 43 CCEL (2d) 1, 62 BCLR (3d) 173 (SCC)

[10] F.S.M. v. Clarke, [1999] 11 W.W.R. 301, 1999 CanLII 9405 (BCSC)

Clarke's duties were to supervise the boys all day, escorting them to meals and overseeing their prayers, washing, dressing and curfews. He was described as the closest thing to a parent these boys had, and responsible for every aspect of their lives outside of education. Clarke's duty was to provide a safe, moral home for the boys and act in place of a parent. He abused them: he fondled them while they were in bed, inspected them physically when they were naked, and brought individual boys into his closed room where he assaulted them. Clarke resided beside the boys' dormitory in a room where his large record collection attracted the boys. The plaintiff was nine when the assaults started. There were many other boys who were also regularly assaulted, and became accustomed to it as part of life there. Clarke was there for eight years. Other teachers at the school knew. Another teacher told the principal she had overheard the boys talking about Clarke's assaults, so the principal interviewed some of the boys and heard stories of abuse, but did nothing. The principal was also known to be sexually assaulting young boys, giving them alcohol and taking a "special" one to a motel from time to time. The Court found that not only Clarke but also the Anglican Church and the Department of Indian Affairs were liable.[11]

Legal case #6: Lookout Emergency Aid Society Shelter v. BCGEU[12] is an example of improper behaviour by a person in a counselling-type role being addressed as a labour arbitration matter, not a civil action for negligence. The arbitrator pointed out that the alleged behaviour was "akin to resident or patient abuse in the health care industry." In Lookout, a shelter employee was dismissed for agitating a vulnerable shelter resident who had mental-health issues to a point where he became self-abusive. The shelter employee was training to be a support worker. Her role was to support and house the residents, some of whom had behaviour, substance, and mental-health issues, and make referrals to other agencies as needed. She became upset at what she believed was non-compliance by a resident with shelter rules, and she confronted the resident in a way that agitated that resident's companion so much that he began screaming and hitting his head against a wall, then left the shelter and

[11] The assaults committed by Clarke at the residential school have given rise to further action by other plaintiffs; see T.W.N.A. v. Canada (Ministry of Indian Affairs), 2003 BCCA 670, [2003] B.C.J. No. 2747 (QL). And there are other cases on similar abuse at residential schools settled or pending; see Cloud v. Canada (2004), 73 OR (3d) 401, 247 DLR (4th) 667.

[12] Lookout Emergency Aid Society v. British Columbia Government and Service Employees' Union (Viner Grievance), [2000] B.C.C.A.A.A. No. 224 (QL) (Gordon)

began hitting his head against a dumpster. The police and a psychiatric worker had to be called. An investigation found the worker had poor attitude and empathy, and she was dismissed. The arbitrator said the dismissal had been justified.

Legal case #7: In Rumley v. B.C.[13] the Supreme Court of Canada approved certification of a class action by former students of the Jericho Hill School, a residential school for the deaf. A special prosecutor (Thomas Berger, Q.C.) had gathered evidence and prepared a report in 1995 documenting physical and sexual abuse of the residents by both male and female counsellors and other school employees. Some of the residents admitted to repeating the abusive behaviour they had learned, abusing other students. One former student tried to kill himself after apparently abusing his younger siblings as he himself had been abused at the school. In the litigation a class action was certified, after which the defendants settled out of court.

Legal case #8: In Lee v. Scott,[14] the plaintiff was a self-described counsellor of sexual abuse victims. She had no formal training and employed unusual methods, which included caressing clients. Another therapist heard of this from a former patient, and warned some patients about the plaintiff. The warning included a slight exaggeration, saying that kissing occurred. The sexual abuse counsellor sued the second therapist for defamation. The judge found the second therapist was motivated by genuine concern in good faith, but had in fact perpetuated an exaggerated account, and awarded the plaintiff $100. Notably, the judge expressed concerns about the first counsellor's methods, and how lack of professional certification made her accountable to no one (at para. 35):

> It was inevitable that Lee's method of counselling would result in the very conflicts that did develop. Not only did Lee have little formal education and limited practical experience, she was accountable to no one as she had no professional certification or membership; there was no direct supervision or audit of her sessions; and she insisted on crossing the usual relationship boundaries between client and counsellor.

[13] Rumley v. B.C., 2001 SCC 69, [2001] 3 SCR 184 (SCC)
[14] Lee v. Scott, 2001 BCSC 1281 (BCSC)

Legal case #9: In HEABC v. HSABC,[15] when a patient disclosed that she had been involved in a sexual relationship with her psychological counsellor, and complained about his obsessive attentions, he was dismissed. He grieved the dismissal, denying there had been a relationship, but the arbitrator found a long history of contact (including phone calls and letters) outside professional boundaries, and found that the patient's story was more credible. The dismissal was upheld.

Legal case #10: In Krahn v. Krahn,[16] a marital breakdown was complicated by the wife's involvement with Elijah House, a Christian cult providing counselling and therapy, which included recovery of (false) memories of demonic possession and satanic ritual abuse. Among the misdeeds of the counsellors, they destroyed documentary evidence they had been ordered to produce. The court called the counselling "bizarre" and ordered the wife to refrain from mentioning it to the children when they were with her, which was rare because the court gave her only limited access and guardianship. She eventually agreed to distance herself from Elijah House's counselling and even commenced a lawsuit against them.[17]

Legal case #11: In V.C. v. B.C.,[18] a 19-year-old girl who had been sexually abused from age 11 to 15 by her father disclosed the abuse to a Jehovah's Witness Church elder. The elders convened healing and reconciliation sessions where she was forced to repeat the allegations and confront her father in two sessions before assembled Church elders, which she found so traumatic that she did not seek help again for years and suffered without treatment. The court found that the elders had acted negligently, and caused harm, and that they were not shielded from liability (either liability for breach of fiduciary duty or in negligence), by acting bona fide in the context of religious service.

Legal case #12: In Ness v. Cunningham,[19] the defendant operated a "residential eating disorder therapy centre" that was advertised to include a team of psychologists, art therapists, traditional Chinese medicine practitioners and "holistic therapists in various

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[15] Health Employers Assn. of British Columbia v. Health Sciences Assn. of British Columbia (Wolgien Grievance) (2002), 107 L.A.C. (4th) 44, [2002] B.C.C.A.A.A. No. 131 (QL) (Jackson)
[16] Krahn v. Krahn, 2000 BCSC 1516, Krahn v. Krahn, 2001 BCSC 1186, Krahn v. Krahn, 2002 BCSC 515
[17] "Brainwashed Mom Sues Counsellors," Oct. 13, 2006, *The Province*
[18] V.B. v. B.C. (2003), 65 OR (3d) 343, 2003 CanLII 2429 (SC)
[19] Ness v. Cunningham, 2003 BCPC 146 (BCPC)

fields." The plaintiff paid the defendant to attend a retreat at the centre, and found that the advertised promises were false. Programs were often cancelled, or never scheduled. No special meals of community-grown organic food were provided; instead, Kraft dinner and store-bought ravioli was provided by a woman who allegedly had a diploma as a nutritionist but whose credentials were never provided. The defendant claimed to have 20 years' experience as a yoga and dance teacher, including an "eating disorders component," but failed to provide any proof of credentials. The court found that everyone involved was a volunteer without qualifications, and there had been fraudulent misrepresentation. The plaintiff was awarded a partial refund (only partial, since she had already received a partial refund and had received some of the room and board as promised in the contract), plus costs (which is rare in Provincial Court) and transportation expenses. The judge also said that the only reason why the situation was not more serious is that the plaintiff had not been in a life-threatening situation when she sought help from the centre.

Legal case #13: In Blackwater v. Plint,[20] a dormitory supervisor and counsellor at an Indian residential school operated by the United Church inflicted various abuses on children in his care. Twenty-seven former residents brought claims against Plint. Only the cases of sexual assault proceeded, as other types of assault were statute barred as too late. The SCC agreed with the lower courts that damages allowed to individual claimants would differ and would depend on what abuse they suffered, how damaged they were from the abuse, and what other things in their lives contributed to their current difficulties. The SCC affirmed that both Canada and the Church were also liable for the abuses inflicted.

This was one of a series of cases, and the earlier decisions provided more details of the defendant's abuses and his role in the children's care. In Blackwater v. Plint (2001)[21] the victims described abuse at the school by other school employees before Plint arrived. Also, the abuse was secretive; they were not aware that there were other victims. When they told their teachers or nurses about it, they were not believed.

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[20] Blackwater v. Plint, 2005 SCC 58, [2005] 3 SCR 3, 258 DLR (4th) 275, [2006] 3 WWR 401, 46 CCEL (3d) 165, 48 BCLR (4th) 1 (SCC)
[21] Blackwater v. Plint, 2001 BCSC 997, 93 BCLR (3d) 228 (BCSC)

Legal case #14: In BCPSEA v. BCTF,[22] a school counsellor met with a pregnant student in Abbotsford. The student said she had decided to have an abortion, and had arranged to attend a clinic in Vancouver, but couldn't afford the bus fare. The counsellor supported the student's decision to leave school without telling her parents and travel to Vancouver for an abortion. The counsellor even gave the student some of her own money for the trip. The parents found out, and complained. The employer issued a letter of reprimand as discipline. The counsellor grieved the discipline, insisting she had done nothing wrong, and would do the same again. The arbitrator found that she had failed in her duty to offer options to a client without choosing one for her, and that she had harmed the school's reputation.

Legal case #15: In R. v. Mossing[23] the accused was employed in various capacities (including youth pastor) that gave him opportunities to gain access to and trust of young people. He sexually assaulted several children, including a relative and the children of friends, as well as children he was employed to shepherd at church events. He pled guilty to assaulting eight victims between the ages of six and 16.

Discussion

Of the 15 reported British Columbia cases identified by legal research covering the past 15 years, we can identify two general sources of the harm caused by the conduct of the unregulated therapists: (a) incompetence or lack of training, and (b) breaches of a fiduciary duty, in particular some form of sexual impropriety, abuse or assault.

The similarity in the facts of the cases that fall into these two classes is illustrated by the following brief descriptions of the core problem the court or tribunal identified in each one, as follows:

Cases involving lack of training or incompetence:

- Unregulated individuals overlooked protocols and contributed to wrongfully sending a young man to a mental institution (J.H. v. R., 1998).

[22] British Columbia Public School Employers' Assn. v. British Columbia Teachers' Federation (Merrick Grievance) (2009) 181 L.A.C. (4th) 426, [2009] B.C.C.A.A.A. No. 31 (QL)
[23] R. v. Mossing, 2010 BCPC 105

- A shelter worker was dismissed for agitating a vulnerable resident who had mental-health issues to a point where the resident became self-abusive (Lookout v. BCGEU, 2000).
- A self-described counsellor of sexual abuse victims lacked professional certification and was accountable to no one (Lee v. Scott, 2001).
- A bizarre counselling therapy group contributed to family breakup and contempt of court by prompting a client to recover (false) memories of demonic possession and satanic ritual abuse, then destroying documents they were ordered by the court to produce (Krahn v. Krahn, 2000-2002).
- Elders of a church conducted a negligent healing and reconciliation session between a teenager who had been sexually abused and her father who had abused her (V.C. v. B.C., 2003).
- An unqualified counsellor operating a residential eating disorder therapy centre was liable to a client for fraudulent misrepresentation, and the harm could have been much worse had the client been more fragile (Ness v. Cunningham, 2003).
- A school counsellor failed to give a pregnant student options to deal with her pregnancy other than an abortion (BCPSEA v. BCTF, 2009).

Cases involving breach of a fiduciary duty (sexual impropriety, abuse or assault):

- A drug and alcohol counsellor sexually assaulted a client (B. (D.C.) v. Boulianne, 1996).
- A counsellor sexually abused troubled teenage boys at his group home (C.A. v. Critchley, 1998).
- A childcare worker abused children at a residential care facility (Bazley v. Curry, 1999).
- A dormitory supervisor sexually assaulted young boys at a residential school (F.S.M. v. Clarke, 1999 and Blackwater vs. Plint, 2005).
- Counsellors and other school employees physically and sexually abused deaf children living in residential care (Rumley v. BC, 2001).
- A psychological counsellor had a long history of inappropriate contact and sexual relations with a client (HEABC v. HSABC, 2002).

- A youth pastor/counsellor sexually assaulted several children in his care (R. Mossing, 2010).

It is likely that these cases represent only a small sampling of many instances where unregulated therapists have provided incompetent or unethical counselling services resulting in various harms to vulnerable clients. As was mentioned earlier, some cases of sexual abuse proceeded to court because there was no limitation period, while cases involving alleged physical abuse by the same persons or at the same time would have been out of time, and never made it to court. For various reasons, many cases involving harm never come to court or come before a tribunal.

Court is not the only option for people who have been harmed. Indeed, as will be shown in chapter 2 (insurance claims) and chapter 3 (BCACC complaints), there are other avenues available to the public to seek redress for the harms they have suffered from incompetent or unethical counselling.

Commentary

There are least two significant factors that contribute to the risk of clients being harmed by incompetent or unethical counsellors: (a) counselling usually takes place in a private setting, and (b) counselling is almost always provided to persons who are vulnerable and susceptible to abuse.

The Task Group believes that it is self-evident that one or both of these factors contributed to the harms that are described in the 15 legal cases summarized above. Indeed, these reported cases serve to underscore the fact that the inherent power imbalance in a clinical counselling relationship can result in harm unless the therapist is very self-aware and understands the important of maintaining professional boundaries. Also, a client can project onto his or her relationship with the therapist a mistaken belief that there is more to their relationship than just their clinical sessions. Thus, the failure to properly control "transference" can also lead to serious problems. Finally, another set of underlying factors that is evident in some of these reported cases of harm is a distinct lack of proper clinical skills in assessing a client, or the incompetent provision of a therapy (or even the competent

provision of a questionable therapy). Regulatory mechanisms to help address these underlying problems will be discussed in more detail in chapter 5.

CHAPTER 2: FILED INSURANCE CLAIMS

Introduction

The information in this chapter was prepared with the assistance of Brad Ackles, Vice President of Programs for the Mitchell Abbott Group, from confidential insurance claim files that are maintained at his office.

The Mitchell Abbott Group is an Ontario-based independent insurance brokerage firm that arranges professional liability insurance coverage for a wide range of self-employed health care providers across Canada, including the approximately 2,300 members of the BC Association of Clinical Counsellors (BCACC). In turn, the coverage that Mitchell Abbott arranges for the BCACC is underwritten by Encon Group Inc., a well-known company that provides professional liability insurance policies as well as a range of other insurance policies for individuals, organizations and companies.

Encon produces a newsletter, *Claims Examples*, which summarizes real-life claims that Encon has been involved in and provides good examples of the sorts of errors or omissions that clinical counsellors and other health-care providers have made in their clinical practices that have resulted in claims.

Encon also produces *Loss Control Bulletin*, which provides guidance to its subscribers on how to reduce or eliminate the chance of having a claim. The failure to follow certain procedures (*i.e.*, obtaining informed consent) can increase an insured counsellor's exposure to loss, which represents an increased risk of harm to the client both from the failure to follow the procedure and also from the counsellor's exposure to losses that might disrupt the counsellor's business operation.

Useful information on risks of harm was extracted from a series of Encon insurance claims files, as well as from information published in *Claims Examples* and the *Loss Control Bulletin*. The information from these sources helps identify the sorts of problems that can arise in a counselling practice and the resulting harm to clients.

Summaries of claim cases

Clinical counsellors are required to notify the insurer if they are served with a writ or summons, or if they believe they may face a legal action as a result of an error or omission in their practice.

The claims summarized in this chapter are those where the adjuster's investigation of a filed claim found that there was a *bona fide* basis for the claim such that the aggrieved party should be offered compensation. Therefore, only "accepted" claims are summarized here.

If the insurer's investigation determined that a claim was not valid (*e.g.* that the counsellor was not negligent), then the insurer would take steps to defend the insured clinical counsellor against the unjustified or unsupported claim of professional negligence. As such, "rejected" claims are not summarized in this chapter.

Cases involving breach of confidentiality (personal privacy):

Claims case #1: An insured counsellor had improperly disclosed a client's personal information to the employer through the employer's Employee Assistance Program (EAP) without the client employee's consent.

Claims case #2: An insured counsellor received information from a third party about his client, also a beneficiary under an EAP, and released that information to another party without the client's consent.

Claims case #3: An insured counsellor released information obtained during a counselling session provided under an EAP; the information was released without the client's consent, and the client also claimed that it was not true.

Claims case #4: A counsellor released a document containing sensitive materials to a third party, and also disclosed the identity of an individual without that person's consent.

Cases involving negligent provision of counselling services:

Claims case #5: A husband and wife were attending grief counselling to help them deal with the loss of their young daughter. The counsellor was unprofessional and used vulgar language during their sessions, and the counsellor wrongfully and intentionally assaulted the husband.

Claims case #6: A counsellor provided marriage counselling to a husband and wife, and was asked to provide an opinion with respect to those services and the couple's prospect of reconciliation. The counsellor's opinion was biased, in that he failed to disclose important information about an allegation of abuse of their child at the hands of the estranged wife's new boyfriend.

Claims case #7: A counsellor was providing counselling to a child in relation to separation issues resulting from the breakdown of the parents' relationship. The counsellor saw the child either without both parents being present or without the consent of both custodial parents. The counsellor saw the child without the father's consent and failed to later advise the father of the counselling sessions. The father also accused the counsellor of providing false information in a custody and access report that had been filed in court.

Cases involving failure to meet practice standards:

Claims case #8: A counsellor was ordered by the court to produce documents, and produced a set of documents that were not up to professional practice standards. On investigation by the regulatory body, the counsellor admitted that he did not employ an adequate client- or file-tracking system, and agreed to revise his system to comply with the profession's practice standards.

Commentary

The information in this chapter is derived from claims that involved clinical counsellors who participate in a voluntary self-regulation program under the Bylaws of the BCACC. Therefore, these summaries do not reflect the sorts of problems that can arise by persons who are not regulated in any form in British Columbia, voluntary or otherwise. Nonetheless, the information that can be extracted from the insurance claim files is useful

because it is based upon an assessment of the risk in each claim, an assessment by an objective, third-party insurance adjustor who is experienced in identifying different forms of professional negligence as well as their root cause.

Also, because the claims summarized above resulted in some form of financial settlement, the issues in these cases did not proceed to court and, therefore, the types of harms described in these cases would not appear in the legal reports. Thus, these cases can be seen as providing a more expansive view of risks of harm than could be obtained by reviewing the reported legal cases set out in chapter 1.

As was the case for the reported British Columbia legal decisions summarized in the previous chapter, the claims filed with the BCACC insurer illustrate that even clinical counsellors with advanced training can, on occasion, make mistakes that result in harm to their clients. These insurance claim cases also show that, from time to time, clinical counsellors make errors in judgment or fail to follow standards of practice, the result of which causes sufficient harm to warrant a financial settlement by the counsellors' insurance provider. In other words, these claim files provide additional evidence that quantifiable risks of harm can result from the incompetent or unethical provision of counselling therapy services.

Chapter 5 of this submission will consider in some detail how designation of counselling therapy under the HPA is likely to help reduce the incidence of these insurance claims being filed against counsellors working in BC.

CHAPTER 3: BCACC COMPLAINTS

Introduction

The information in this chapter was prepared with the assistance of Shirley Halliday, chair of the British Columbia Association of Clinical Counsellors (BCACC) Inquiry Committee, Angela Burns, BCACC registrar, and John Gawthrop, BCACC deputy registrar.

As members of the BCACC are known as clinical counsellors, this chapter will refer to BCACC members by that term rather than the more general term of counselling therapist, which applies to all counsellors who are registrants of the member organizations that make up the Task Group.

The information extracted from the reported British Columbia legal cases in chapter 1 and the insurance claims files discussed in chapter 2 provided insight into risks of harm. So too studying the complaints that have been filed against clinical counsellors provides additional examples of situations where a counsellor has made an error that has caused the client some harm or distress.

Further, because the BCACC Inquiry Committee has successfully resolved every complaint to date where it found that the complaint was supported by its investigation, the sorts of solutions that the Committee employed in each of these complaint cases also serve to illustrate the steps that a college established under the HPA might take to resolve a problem or help to prevent similar events in the future.

Overview of the complaints filed against clinical counsellors

The BCACC began receiving and investigating complaints filed against its members in 1989. Since that time, the Inquiry Committee has received just over two hundred complaints against clinical counsellors.

The chart set out in Table One (next page) shows the number of complaints against clinical counsellors that have been filed with the BCACC each year over the past several decades:

Table One: Number of complaints per year (1989 to 2010)

Year complaint was received	Number of complaints received
2010	7
2009	9
2008	5
2007	7
2006	12
2005	4
2004	10
2003	10
2002	13
2001	10
2000	13
1999	7
1998	14
1997	14
1996	14
1995	15
1994	10
1993	12
1992	5
1991	4
1990	4
1989	3
Total	202

For some (but not all) of these 202 complaints, the BCACC Inquiry Committee found as a result of its investigations that at least one allegation in the complaint was valid. Each valid allegation was then dealt with by way of an alternative dispute resolution process, as set out in the BCACC Bylaws. Going back over the last two decades and beyond, the Committee

has been able to resolve by consent about two hundred *bona fide* complaints filed against clinical counsellors. To the best of the Association's knowledge, its work in investigating and resolving these complaints has provided the complainants with a useful avenue for resolving their concerns, an option that saves the complainant from having to pursue the counsellor in a legal action in the courts.

In some cases, the Committee found that the allegations were not supported by the information gathered during its investigation, or concluded that the counsellor in question did not breach either the ethical or practice standards of the Association. These findings led the Committee to advise the complainant that the Committee would be closing the complaint file.

Unfortunately, and unlike colleges established under the HPA, the BCACC has no legal ability to force a former member to cooperate with its complaint investigation and resolution procedures. Once a clinical counsellor resigns his or her membership, the Inquiry Committee loses jurisdiction over that former member. Over the past few decades, a total of seven members have quit the Association in the face of a complaint investigation. The Committee does not close these files. These complaints must be resolved before the former member would be considered again for membership in the Association.

Overview of the issues raised in the BCACC complaints

While some complaints raise only one allegation, in others the complainant may have provided information that indicated that two or more different issues needed to be investigated and resolved. The BCACC assigns the specific allegations within a complaint to one of seven classes of issues. These issue classifications are based in part upon the central principles of the Association's *Code of Ethics*, which are described in these terms:

> *Principle 1) Respect for the Dignity of all Persons and Peoples*
> Respect for the dignity of persons provides a foundation for many other ethical principles. It is intended to recognize the inherent worth of all human beings. This includes respect for peoples, since all human beings belong to unique societies, which create human interdependence, contribute to identity, and establish the connection of all human beings to all other human beings, including past and future generations. It is recognized that a relationship of respect and caring for the natural environment is also essential for the well-being and survival of humans individually and collectively.

Principle 2) Responsible Caring
Responsible caring means that all interactions involving clients are made for the client's benefit. This includes thorough assessment, as well as competency in skills appropriate to the situation, the client, and the social and cultural context.

Principle 3) Integrity in Relationships
Ethics and values are largely expressed in the relationships that RCCs have with self and with others. To have ethical integrity they remain aware of their values and the values of their communities. They are honest and straightforward in their communications, honestly assess and seek feedback on their performance, and avoid conflicts of interest that may compromise their professional activities.

Principle 4) Responsibility to Society
RCCs have a responsibility to the society in which they live and work and have dedicated themselves to the well being of human beings in that society.

In addition, the BCACC may classify an allegation raised in a complaint as one concerning matters that are not directly addressed in the Code of Ethics, but instead involve (a) a lack of or insufficient professional competence, (b) making inappropriate public statements, or (c) questionable billing or business practices.

The following table shows the breakdown of the types of issues that have been raised in the sustained complaints that the BCACC has received from 1989 through to 2010. The data in this table could change over time as ongoing investigations are completed or newer complaints are resolved.

Table Two: Allocation of Issues 1989 to 2010

Classification of issue raised in a public complaint	Number of cases where the issue arose
1. Lack of clinical competence, failure to obtain informed consent, *etc*.[(a)]	109
2. Failure to respect the dignity and rights of a client or other person	79
3. Lack of integrity in a clinical relationship	59
4. Breach of client confidentiality / unauthorized disclosure	47
5. Lack of a professional boundary / dual relationship	17
6. Questionable billing or business practices	6
7. Inappropriate public statements	2
Total	319

(a) Includes "failure to follow a court order" and "breach of a statutory duty to report."

Discussion of the data

The data that can be extracted from the BCACC complaint files suggests that, on average, about 10 complaints are filed against clinical counsellors every year.

The trend in the number of complaints, as set out in Table One, seems to indicate that the number of complaints in the past five years is going down, at least compared to the number of complaints the Association received during the last decade or so. This may reflect the fact that the BCACC has been tracking the source and nature of the complaints it receives, and then using that information to develop practice guidelines and other information to help its members improve their clinical skills and thus avoid being the subject of complaints.[24]

The data also shows that, for the years 2008 to 2010, the BCACC received a total of 21 complaints or, on average, seven per year. During this time, the Association had on

[24] The BCACC would be pleased to provide the Ministry, on request, with further details of its harm reduction strategies and programs.

average about 1,926 members in its active category. Therefore, the Association received about four complaints each year per 1,000 active members.[25]

The types of issues that are identified within the 202 complaints the BCACC has received over the past two decades indicate that, compared to its entire membership of about 2,000 clinical counsellors, (thankfully) only a few counsellors need to improve their clinical practices in particular areas. Complaints about counsellor competency account for about 34% of all the issues raised, and breaches of client confidentiality (15%) could also be included in this group of issues. These two types of complaints illustrate that some counsellors need to pay more attention to clarifying with clients what is involved in the clinical counselling session, and pay more attention to rules about privacy.

The classification of complaints relating to a counsellor's failure to respect the dignity and the rights of their clients or third parties (25% of issues), failure to maintain professional integrity within a clinical relationship (18% of issues), and a breach of client-counsellor boundaries or establishing a dual relationship (5% of issues) indicate that ethical or behavioural breaches can also be a problem. Collectively, these three classes make up about one-half of all issues that the BCACC Inquiry Committee investigates and works to resolve.

The relatively small number of complaints about a counsellor's business practices or billings (2% of all complaint issues) is probably due to the fact that the BCACC has had in place for many years clear standards of practice concerning maintaining clinical records, billing practices, and complying with the *Personal Information Protection Act*.

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[25] In contrast, the College of Psychologists of BC receives about 41 complaints each year for its average of 1,013 active psychologists, for a complaint rate of just over forty complaints per 1,000 registrants for the last three years reported.

The information that can be extracted from the annual reports of the College of Psychologists (ref.: http://www.collegeofpsychologists.bc.ca/annualreports.php) shows that the College has dealt with an average of 41 complaints each year over the past three reporting years (2008 to 2010). During this time, the College also closed 140 complaint files and of those 66 (47.1%) were resolved by an undertaking or consent agreement, 35 (25%) were closed due to lack of sufficient evidence to support the complaint and 31 (22.2%) were closed due to lack of jurisdiction, withdrawn complaint, a vexatious or frivolous complaint, or other error. Only one case in this period was referred to a discipline panel. From 2008 to 2010, the College had an average of 1,150 registrants each year. While most of these (about 88%) were full registrants, there were also several psychologists who were registered in various limited classes of registrants, including out-of-province, non-practicing and retired. So, on average, there were about 1,013 psychologists in active practice in British Columbia during this three-year period.

Summaries of BCACC complaint cases

The following are examples of some recent cases from the past five years that the BCACC Inquiry Committee has investigated and resolved to the satisfaction of both the complainant and the respondent member:

Complaint case #1: The clinical counsellor did not have or apply a safety plan and did not provide sufficient support for a female client who had been sexually abused as a child. While the counsellor did discuss with the client her options and future plans, it was inappropriate for the counsellor to insist that, as a clinical goal, the client should reconcile with her ex-spouse. The client was not ready for such a step. She remained bitter and hostile, and was stuck in a mutually abusive relationship with her ex-spouse. The resulting forgiveness ritual was more for the counsellor's benefit than the client's. As a result of the Committee's investigation, the counsellor agreed to enter into a consent agreement, and – through that agreement – provided an apology to the client, designed a new forgiveness ritual for future clients in appropriate circumstances, reviewed remedial materials on transference, and prepared a report to the Committee on how that material will improve the counsellor's future practice.

Complaint case #2: Without undertaking a sufficient assessment, the clinical counsellor wrote an opinion that the complainant presented a clear and present danger to his family. While the court did not order the opinion, the complainant's estranged wife submitted it in evidence at a hearing. During its investigation, the Committee ascertained that the counsellor did not follow the Association's standards for preparing clinical reports, and that the release of the report also breached the complainant's privacy rights. The counsellor's opinion contained no factual basis to support the conclusions, and was written without a sufficient understanding of the broader legal dispute that involved the parties. Finally, the counsellor's confidentiality agreement did not meet the Association's standards for such a document. The counsellor agreed to enter into a consent agreement, and – by that agreement – learned how to better deal with intimidating clients or third parties. The counsellor also agreed to re-write the original opinion to the accepted standards for such documents, and prepare new confidentiality and payment forms (all under the direction of a clinical supervisor approved by the Committee).

Complaint case #3: The clinical counsellor, together with her client's girlfriend, the girlfriend's father and a reverend from their church confronted the complainant client at his home about why the client had missed an appointment, and to support his girlfriend in breaking up with him. When asked to leave, the counsellor refused to do so. Later, when the complainant asked the counsellor to explain her actions, she put the blame on the girlfriend who had wanted the break-up. As a result of the Committee's involvement, the counsellor agreed by consent to write a letter of apology to the complainant and attend a clinical workshop on professional boundaries.

Complaint case #4: The clinical counsellor was providing counselling services to a male client. The client told the counsellor that he had sexually abused his sister when they were younger. The counsellor then called the sister at her home and workplace, apparently to discuss that history of abuse. The sister then complained that the counsellor had initiated a devastating conversation with her, without either her permission or sufficient facts. As a result of its investigation, the Committee found that the counsellor had initiated contact with the complainant sister with an insufficient clinical reason for doing so. The counsellor consented to taking an ethics course and entering into a period of supervised practice regarding sexual abuse. The counsellor also agreed to review how to obtain the consent of third parties who are not privy to a potentially serious clinical disclosure, and to do so without harming that party or appearing to be coercive or seeking a new client.

Complaint case #5: The clinical counsellor breached a client's confidence by forwarding to that client's ex-partner, without the client's consent, private emails sent by the client to the counsellor. The counsellor consented to several conditions: to change her practice regarding using email communications with clients, to issue an apology to the complainant client, to study clinical materials on maintaining proper professional boundaries, and to describe to the Committee how that material will help her to improve her clinical practice.

Complaint case #6: The counsellor made personal remarks to the husband during marital therapy sessions, and also in emails, that conveyed a degree of familiarity that was inappropriate in a clinical relationship. She also terminated her sessions with the husband in too abrupt a fashion, and without formal closure. Finally, while the counsellor was justified

in fearing for her own safety, she did not have a sufficient foundation to conclude that the husband constituted a risk of harm to his family. The counsellor agreed to study resource material on professional boundaries and undertake supervised training in couples therapy.

Complaint case #7: The clinical counsellor stated in an affidavit filed in court that, in his opinion, the ex-spouse of the complainant was not a pedophile, while a clinical report prepared by a psychologist found that the ex-spouse was an untreated pedophile. The counsellor also concluded that it was safe to let the daughters of the ex-spouse visit with him without supervision. As a result of the Committee's investigation, the counsellor agreed to take special training in the assessment and treatment of sexual offenders, and also to undertake more in-depth and detailed clinical assessment in such cases before providing any opinion, and all under clinical supervision. The counsellor also agreed that he had incorrectly assumed that the complainant would consult him, when the onus was on the counsellor to consult with the complainant. Finally, the counsellor agreed to improve his method of recording and maintaining clinical records.

Complaint case #8: During a meeting at his church, a clinical counsellor spoke about his clients and their problems, without their consent, while not using their names but in a context where they could be identified. This unethical disclosure was done to support his belief that the complainant should not be elected to the church board. Further, despite a restraining order the counsellor was aware of, the counsellor tried to resume couples therapy with the complainant and her ex-spouse. As a result of its investigation, the Committee found that the counsellor did not distinguish his role as a pastor from that of a counsellor, and also failed to apply proper professional boundaries. The counsellor agreed to enter into a consent agreement and – by that agreement – to work on improving his understanding of clinical boundaries, and to do so under supervision of an approved clinical supervisor at his expense.

Complaint case #9: The counsellor had not seen or provided any services to the complainant for over six years. However, he proceeded to provide information to a psychologist who was preparing a court-ordered custody and access report (under section 15 of the *Family Relations Act*[26]) and made inaccurate statements about the complainant to that

[26] RSBC 1996, c.126.

psychologist, which where then recorded in the filed report. As a result of its investigation, the Committee found that the counsellor had acted prematurely and should have followed a more rigorous protocol in both confirming the caller's identify and confirming that he had the complainant's consent to disclose information to the caller. The counsellor agreed by a consent resolution to obtain, as his expense, clinical supervision of his practice in the areas of informed consent and client confidentiality, and to later report to the Committee on how he would deal with a similar situation in the future.

Complaint case #10: After seeing the complainant and her husband for three sessions, the clinical counsellor provided the husband, as his request, with an assessment letter to be filed in court. Without the complainant's consent, the counsellor also disclosed confidential information in that letter about the complainant, and – without justification – questioned her parenting abilities. As a result of the Committee's investigation, the Committee found that the counsellor had acted hastily, and was inappropriately swayed by the client's claim of urgency. Further, despite the counsellor's admitted concern for the safety of the children, the counsellor did not act on his duty to report a potential risk as required under child-protection legislation. The counsellor agreed by consent to undertake clinical supervision, at his expense, to better understand the issues of consent/disclosure and risk assessment, and to improve his practice in these area in the future.

Complaint case #11: The clinical counsellor conducted an assessment of the complainant's six-year-old son without her consent, and contrary to an existing court order, while the complainant and her ex-husband had interim joint custody and access. As a result of its investigation, the Committee found that the counsellor had not been aware that an earlier court order had been replaced by a new one; still, the counsellor admitted that he had a responsibility to obtain the most current court order to then allow him to understand which parent (if not both) could consent. The counsellor also admitted to incomplete record keeping and failures in obtaining a parent's consent. Because the court ultimately rejected the counsellor's report, so it played no role in any subsequent judicial decision, the Committee recommended that the counsellor undertake further training under supervision in the area of child-custody assessment and section-15 FRA report writing, or simply cease to practice in this area.

Commentary

It is evident from the information in this chapter that the BCACC complaint files are a useful source of information about the risks of harm that can be associated with counselling. This information complements the descriptions of harms that were described in chapter 1 (reported court and tribunal decisions) and chapter 2 (filed insurance claims).

As will be discussed in chapter 5, the harms identified from the BCACC complaint cases can also be extended to describe the sorts of problems that unregulated therapists may potentially create for their clients. Clinical counsellors have agreed to be regulated by their professional association, and – in acting upon this voluntary public protection mandate – the BCACC has set standards for education and ethical conduct that all clinical counsellors must follow. Therefore, if privately regulated clinical counsellors are having problems (as reflected in the issues described in the Association's complaint cases), it follows that counsellors who do not belong to any sort of professional association are just as likely, if not more likely, to have the same types of problems. Unregulated therapists may even cause more frequent or greater harm to their clients. Compounding the risk posed by unregulated therapists is that clients who have been harmed by unregulated therapists can only turn to the courts to have their grievances adjudicated, which can be a very complicated and expensive course of action to pursue, and is typically a public process.

While the BCACC has focused a great deal of its attention and resources over the past decade on developing information and guidance for its members to help prevent harm to clients, this is a voluntary regulatory initiative that is not mandated by government. The Association, like the other members of the Task Group, struggles with its bifurcated mandate: supporting the profession, while also protecting the public. The Association believes that its self-imposed public protection function should be taken over by a new college established under the HPA. The Association would much prefer to divest itself of its regulatory functions, which now cost its members in the range of $120,000 per year,[27] and devote all of its resources toward supporting its members and advocating on their behalf.

[27] Average based on approximate costs in each of the past two years: $127,368 in 2011 and $112,662 in 2010.

CHAPTER 4: BCACC MEMBERSHIP SURVEY

Introduction

During August 2011 the BCACC undertook a survey of its membership to ascertain whether the clients of clinical counsellors had reported instances where an unregulated therapist did something (or failed to do something) that resulted in harm to the client. This chapter reports on the results of that membership survey.

The BCACC membership survey was conducted using an on-line, confidential "survey monkey." At the start of the survey on August 17th a total of 2,265 registered members were sent the following broadcast email inviting them to participate in the on-line survey:

> *BCACC Survey on Harms August 2011*
>
> RE: Brief survey documenting risks of harm in counselling and psychotherapy
>
> Dear Registered Clinical Counsellor,
>
> The provincial government is offering us active partnership in moving forward with an assessment of the need to move forward with the creation of a professional college for counsellors.
>
> In order to do this, they need to know and understand the risks of harm that make a college that regulates counselling and psychotherapy important to all members of the public.
>
> We have already provided our colleagues in government with detailed reports of statistics, research results, and analysis.
>
> But in addition to rigorous summaries, they need to know about local, particular experience. As you know, harms that come from improper practice of counselling and psychotherapy rarely get reported to authorities because they are too personal and painful to be made public. But this material is often shared with therapists. We would like you to take a very few minutes to share your experience with the harms that can arise from incompetent or negligent practice of our profession.
>
> We will not be asking you to step outside of any limits of confidentiality or privacy. Instead, we will ask you about your general experience, and then ask you to share a de-identified example of that experience, if possible.

Results will be compiled and shared with our partners in government.

To take the survey, click the following link: *[Link not included, as it is no longer active.]*

During the resulting three-week period, a total of 317 clinical counsellors responded to the invitation and completed the on-line survey.[28] Counsellors were asked the following questions:

Counselling and Psychotherapy Risks and Harms

The core of professional regulation is to protect the public from a risk of harm. As the provincial government moves toward creation of a college for our profession, those who communicate on behalf of government need to be able to describe these risks briefly, convincingly, and to a wide variety of audiences. We need to help them do this.

Cases and stories are a very effective way to communicate the importance of professional accountability. But all of this must be done within the limits of confidentiality and privacy. Indeed, it has been important to let government know that a key reason they do not hear about harms from unaccountable counselling and psychotherapy is that these experiences are too personal and painful to share in a public forum.

However, therapists hear these accounts almost routinely. Therefore, we would like you to: first, indicate what accounts of harm you have encountered in your practice; and, if you can, provide a very brief de-identified account of an instance of that harm. Note that a response is required to the questions numbered 1 through 7 (i.e., you must select a radio button); however, you are not required to write comments in the spaces that follow each numbered question.

This information will be shared with our partners in government so that they can get a sense of what harms occur and how frequently we hear these accounts of harm. This will help to provide powerful reasons for moving ahead quickly with a professional college.

Please submit your responses as soon as possible, but no later than Wednesday, August 31st.[29]

Thank you for your dedication and assistance!

[28] The survey protocols prevented a counsellor taking the survey repeatedly.
[29] They survey was kept open until Monday, September 6th.

Have your clients:

1) Described breaches of confidentiality by therapists?
( ) Never
( ) Once
( ) Occasionally
( ) Frequently

Please give a brief de-identified example helping us to understand the negative impact on the client.

2) Described breaches of personal or professional boundaries by therapists?
( ) Never
( ) Once
( ) Occasionally
( ) Frequently

Please give a brief de-identified example helping us to understand the negative impact on the client.

3) Reported incompetent care by therapists?
( ) Never
( ) Once
( ) Occasionally
( ) Frequently

Please give a brief de-identified example helping us to understand the negative impact on the client.

4) Reported inaccurate or misleading advice or information from therapists?
( ) Never
( ) Once
( ) Occasionally
( ) Frequently

Please give a brief de-identified example helping us to understand the negative impact on the client.

Have you:

5) Seen advertisements, websites, or literature from unregulated therapists that appear misleading, deceptive or inaccurate?
( ) Never
( ) Once
( ) Occasionally

( ) Frequently

Please give a brief de-identified example helping us to understand the negative impact on the client.

6) Had communication from other professionals about concerns related to unregulated therapists?
( ) Never
( ) Once
( ) Occasionally
( ) Frequently

Please give a brief de-identified example helping us to understand the negative impact on the client.

7) Observed colleagues or fellow employees engage in conduct that concerned you because it could cause harm by not adhering to a standard of ethics and practice?
( ) Never
( ) Once
( ) Occasionally
( ) Frequently

Please give a brief de-identified example helping us to understand the negative impact on the client.

Thank You!
Thank you for taking our survey. Your response is very important to us.

The results of the BCACC membership survey are summarized in Table Three, on the following page.

Table Three: Summary of Survey Responses	*Frequency of this breach within all responses*			
Types of error or omission that resulted in harm	Never	Once	Occ.	Freq.
1) Client(s) described breaches of confidentiality by unregulated therapist	128	35	142	12
	40.4%	12.0%	44.8%	3.8%
2) Client(s) described breaches of personal or professional boundary by unregulated therapist	104	57	140	16
	32.8%	18.0%	44.2%	5.0%
3) Client(s) reported incompetent care provided by unregulated therapist	91	47	153	26
	28.7%	14.8%	48.3%	8.2%
4) Client(s) reported inaccurate or misleading advice or information provided by unregulated therapist	120	33	147	17
	37.9%	10.4%	46.4%	5.4%
5) Counsellor has seen misleading, deceptive or inaccurate information given by unregulated therapist at a website or in advertisements or other literature	104	26	134	53
	32.8%	8.2%	42.3%	16.7%
6) Counsellor has communicated with other professionals about concerns re: unregulated therapists	146	22	119	30
	46.1%	6.9%	37.5%	9.5%
7) Counsellor has observed other counsellors/employees engaging in conduct that could cause harm to client because of failure to adhere to an ethical or practice standard	133	35	121	28
	42.0%	11.0%	38.2%	8.8%

Discussion of the data

The data from the membership survey set out in Table Three suggests that unregulated therapists breach their duty of confidentiality to their clients fairly frequently. Of the 317 counsellors who responded to this survey question, almost 60% reported at least one instance, as reported by clients, of an unregulated therapist breaching confidentiality. (In the next section of this chapter, ten examples of such breaches will be summarized.) While the survey was not limited to reporting situations from a defined period of time, nor does the Association have data on the total number of unregulated therapists, this survey result does suggest that the failure of unregulated therapists to respect client confidentiality is a problem.

Breaches of professional boundaries also appear to be a common transgression amongst unregulated therapists, with more than two-thirds of all responding counsellors

reporting that they were told of at least one situation where an unregulated therapist had failed to maintain proper counsellor-client boundaries. (Again, examples of these boundary violation cases will be summarized below.)

While it is more difficult to attach as much validity to a report of incompetent care (compared to situations where it would be clearer that an unregulated therapist breached either confidentiality or professional boundaries), reports of unregulated therapists providing incompetent counselling services were the most frequent type of report received by counsellors, with over 70% of clinical counsellors reporting that their clients told them of at least one instance of such an event.

Situations where clients told their counsellor of their experiences with an unregulated therapist providing inaccurate or misleading advice or information could perhaps be included in the previous class of incompetent care. However, treating them as a separate classification, just over 60% of counsellors reported at least one situation where a client told them of such a problem.

In response to the fifth question, clinical counsellors were asked to report on their own observations of situations where an unregulated therapist was advertising his or her services in a misleading, deceptive or inaccurate fashion. While just over two-thirds of the 317 responding clinical counsellors reported at least one instance of such a problem, the greatest number of respondents (almost 17%) reported that this was a frequent occurrence compared to the other types of problems covered in the survey.

Interestingly, the fewest number of respondents (about 54%) reported situations where they had talked with other counsellors or regulated professionals about their experiences with unregulated therapists. Nonetheless, as the case summaries will illustrate, this source of concerns about the conduct of unregulated therapists does provide a useful perspective on the broader problems covered in the previous survey questions.

In the final question in the survey, clinical counsellors were asked to report on how often they had themselves observed colleagues or fellow employees engaging in conduct that could cause harm where such a person was not following an ethical standard or professional practice. Similar to the responses to the previous questions, just under 60% of counsellors

reported seeing at least one such situation. Again, the examples of these situations will be summarized below.

Examples

In addition to providing responses to the number of instances of each of the above-noted events, clinical counsellors were also encouraged to provide a description of the problem about the conduct of an unregulated therapist that had been reported to them by their clients. Counsellors were asked to provide these summaries without identifying any of the parties. The following are representative examples of such descriptions taken from each of the above categories.

1) Breach of confidentiality by unregulated therapist:

189 counsellors responded to this survey question by indicating that they had heard of at least one example where an unregulated therapist had breached client confidentiality; they provided 160 de-identified examples of such breaches. The following is a sample of ten of those examples.

Example #1: A teen client had a lot of conflict with her single-parent dad, who sometimes hit her when he was drunk. She didn't want her dad to know that she was talking to a counsellor, as he had forbidden it. The other counsellor called the dad, which led to a very shaming and aggressive scene when the girl was alone with her dad at home.

Example #2: I worked with a family that had two teenager girls who disclosed to an unregulated therapist that they had eating disorders. The therapist told them that they had a week to tell their parents and, if they had not by that time, the therapist would tell them. Immediately after that conversation, the counsellor told the mother, asking her not to tell her daughters that he had told her. The mother panicked, told the daughters and they both refused further treatment of any kind, saying that would never trust a counsellor again. It was a few weeks before the mother could convince her daughters to even go to the family doctor to address their concerns. Had the eating disorders been more serious it may have been life-threatening.

Example #3: A client's friend overheard an unregulated therapist describe clients' issues in a coffee shop.

Example #4: An unregulated therapist approached a client in public and, within earshot of others, discussed their sessions, making it clear to those nearby that this person had been a client.

Example #5: An unregulated therapist (who also did not have a counselling degree) disclosed information about a woman's mental health (at least the therapist's perspective on it) to her husband. The therapist was a fundamentalist Christian and felt the husband was responsible for her condition. When the woman came to see me, she had been referred by her family physician and was deeply mistrustful. It took several sessions before she was able to say much of anything to me with any confidence.

Example #6: The unregulated therapist was a member of the client's church and spoke outside of the counselling environment to others in the church about the client's issues. The client was also a member of this church. This was an egregious breach of confidentiality; news travels fast in a church community, and the client felt that she could no longer attend either the counselling or the church.

Example #7: A client was seeing an unregulated therapist who knew his employer. The therapist passed on information to the employer that compromised the client's employment relationship and ultimately contributed to the client's dismal from his job.

Example #8: I work in a health centre in a small community. I have been called to the local hospital to counsel clients who have attempted suicide or have had suicidal ideation. One of the clients at the hospital refused to see me at the health centre because that client had seen the last counsellor who worked there before me, and that counsellor had talked about the client in the community. This counsellor was unregulated and the level of her training was not clear. I have since heard from other community members that they did not feel comfortable seeing a counsellor at the health centre based on the past actions of the previous counsellor. They reported feeling unsafe and that they could not trust counsellors to not repeat what their clients have said.

Example #9: An adult client with a disability who reported to an unregulated therapist that she had been sexually abused by her brother when they were younger was told by that therapist that she should let bygones be bygones. The therapist, without the client's permission, then contacted the brother to set up a meeting. My client went into panic and it has been very hard for her to come to another counsellor, since she now fears counsellors will ignore her wishes and break confidentiality. She believes it is her right to decide to whom and when she wants to disclose such personal and traumatizing information. Her alleged offender is the last person who should have been contacted by the unregulated therapist.

Example #10: One client was seeing a counsellor who was a colleague of her father. The counsellor informed the client that her father was gay, information that the father should have told his daughter.

2) Breach of personal or professional boundary by unregulated therapist:

Of the 213 clinical counsellors who responded positively to this question, 186 counsellors provided de-identified examples of a breach of personal or professional boundaries by an unregulated therapist. Not surprisingly, many of the examples are of cases where a therapist crossed the boundary and initiated an intimate, often sexual relationship with a client. The following is a sample of ten cases that fall under this broad heading.

Example #11: A client told a story in our first session of a previous therapist having breached personal boundaries with her, such that she felt emotionally betrayed. During their sessions, the unregulated therapist shared personal information about her own sexual abuse history with my client. My client is a survivor of complex trauma, including sexual abuse. The client ended her relationship with this therapist and eventually became my client. This incident occurred in a small town outside of Vancouver where government-sponsored therapy resources are limited. The client expressed her grief and sense of betrayal many years after this incident occurred. It was among the first stories of psychological trauma she shared in session.

Example #12: A client described the unregulated therapist getting up in the middle of the session to welcome her children home from school (she worked from a home office) and leaving the door to the office open so she, the client, was visible to the children.

Example #13: A client was seeing an unregulated therapist, who had an intimate relationship with her after therapy ended. The client later did some work for the therapist and helped build/market the therapist's practice.

Example #14: One of my clients with no financial resources was seeing an unregulated therapist at a non-profit agency. The client became confused, upset, distrustful and humiliated when, at the end of their final session, the therapist introduced a "business option" he was involved in (*e.g.*, direct marketing) as both a potential income resource for the client and as a potential product sale to a client.

Example #15: An unregulated therapist who had done an on-line degree from an unknown university borrowed a large sum of money from my vulnerable client.

Example #16: An unregulated therapist was trying to initiate an intimate relationship with a male client, and she was calling and emailing him frequently, as well as visiting him at his home. The client became very infatuated with this therapist, but later challenged her about her unethical behaviour. She then attempted to blame him, and he reported that he was "devastated, hurt, and angry." This client has struggled with deep attachment issues for many years and the therapist's unethical behaviour sent this client into a deep depression with despair and suicidal ideation.

Example #17: During marriage counselling, the counsellor agreed to meet one of the clients (the husband) after the counselling was over, to pursue other business interests, which led to a breakdown of trust by the wife.

Example #18: An unregulated therapist offered to adopt a client's child when she was considering either to have an abortion or give the child up for adoption.

Example #19: The client had been taking psychology classes. Her teacher was a member of [a national professional counselling association]. He began giving her counselling services while she was still in classes with him. There were formal sessions paid for

separately by her, but held in his home or office. He also had her over for dinner, and included her as a member of his family. She began to think of herself as such, like one of his kids. After several months, when she had developed the inevitable dependence on him, he cut her off and suggested she not enroll in any more classes. He then gave her a "laundry list" of things that were wrong with her. In our subsequent sessions, we had to resolve the sense of betrayal and "what if he's right and I am just a bad person," before we could even begin work on her boundary issues and their source, a history of being sexually abused as a child.

Example #20: An unregulated therapist befriended the joint clients and began to have their sessions over lunch; the clients were expected to pay for the session and lunch. Then the therapist decided that the three of them should start staying at the clients' house to continue their work together, and the clients paid for daily four-hour sessions while also paying the full cost of the therapist living with them. The clients called me to ask how to get the therapist to leave, as they were running out of money. They liked the therapist, but truly had no idea that what had occurred was completely unethical.

3) Incompetent care provided by an unregulated therapist:

226 clinical counsellors responded positively to this question and, in turn, provided 187 de-identified descriptions of situations their clients had told them about where an unregulated therapist had provided incompetent counselling services. Ten examples from this set are provided below.

Example #21: One of my clients reported that a hypnotherapist she had been seeing had expected her to remove her shirt for the treatment.

Example #22: A client told me of an unregulated therapist who illegally provided her with controlled medicines and illicit drugs.

Example #23: A gay client experienced negative judgment from a therapist for his sexual orientation. This made it difficult for the client to approach therapy again to work on some issues he needed help with.

Example #24: I have a client who had an obvious problem with substance abuse. The previous therapist was apparently impressed with the client's charm and ability to articulate

the circumstances. This unregulated therapist told the client that the client didn't have a problem and did not need therapy. However, my client continued to have an additional unresolved problem, despite cheerfully telling everyone about having been “pronounced okay” by the therapist.

Example #25: One of my clients told me about a situation where the therapist did not employ collaborative goal setting to arrive at an agreed purpose to the counselling. The therapist’s personal opinion was that a two-parent family is ALWAYS better than separation. The father had physically abused children and the mother had gone to a shelter. This unregulated therapist could not separate her personal opinion from the client's need for safety.

Example #26: I received multiple reports from clients that a previous counsellor who worked in this community gave a lot of bad advice and would become frustrated if the clients did not meet her goals. This counsellor was also afraid to address issues related to suicide, due to a lack of training, and would not collaborate with outside agencies to support community members in this area. This counsellor had limited training.

Example #27: A client I saw briefly was very mistrustful of any counsellor after having seen a spiritual counsellor for 12 years. During that time she reported she had recovered memories of Satanic ritual abuse. She presented as very uncertain of herself and had difficulty trusting a counsellor; because of this she was not able to form a therapeutic alliance. I saw her only twice and believed there was a good possibility that the counselling she had received before had disempowered her and caused loss of self-esteem.

Example #28: A counsellor left for vacation and did not tell her client, an aboriginal male who had suicide ideation and had family members who had committed suicide in the past. After the client called for an appointment and found out that she was on vacation, he committed suicide.

Example #29: I knew a couple who had gone to an unregulated therapist to have help with a pornography addiction in the husband, which was seriously affecting his professional work and home life. The therapist blamed the wife for the husband’s addiction. The couple separated after the session, despite the goal of going to the session being to get help and heal

within the family.

Example #30: A client with post-traumatic stress disorder was given eye movement desensitization and reprocessing treatment by an unregulated therapist, which the client said made all the symptoms worse. The client experienced an increase in sleep disruption and anxiety, and had to take a leave from work.

4) Inaccurate or misleading advice or information provided by an unregulated therapist:

The 197 clinical counsellors who responded positively to this question provided 146 examples where clients described unregulated therapists who had given them inaccurate or misleading advice or information. The following are ten examples from this set.

Example #31: An unregulated therapist told a client that medication was an unnecessary part of treatment for schizophrenia.

Example #32: A client was told by an unregulated therapist to stop taking medication prescribed by a medical doctor for depression.

Example #33: A client with an eating disorder was told by her previous (unregulated) therapist that she would "outgrow" the disorder, so there was no need to discuss it.

Example #34: A client reports that a previous (unregulated) therapist said that if a couple is not having sex at least twice a week, the marriage is already dead and they should just work on ending it.

Example #35: Unregulated therapists who have no training in how culture and heritage plays a role in family dynamics, and especially in parent-child relationships, have given improper advice that has put clients' futures at stake.

Example #36: One very fragile client traumatized by childhood abuse by her father reported that a previous counsellor had told her the "only way" to deal with her abuse was to confront her father. She was too scared, and ended the therapy instead, which left her isolated and feeling hopeless about her prospect of recovery, thereby delaying her recovery for many years.

Example #37: One client reported seeing an unregistered therapist whose advice to treat social anxiety was to change her friends. This same client was also advised by this therapist not to attend a particular graduate school but to attend one the therapist was considering. This same therapist assured the client that their sessions were covered by insurance (this information was incorrect). The client later enlisted the aid of the Better Business Bureau, but she spent months struggling over these fees. This client reported the unregulated therapist's bad advice caused increased levels of stress and frustration, and left her feeling used, intruded upon and violated rather than supported.

Example #38: A client, who was being abused by her husband, was told by an unregulated therapist that it was her duty to stay with him. She endured further beatings until she was hospitalized, where a social worker provided counselling and support.

Example #39: My client takes medication for his bipolar disorder. An unregulated therapist told him that he didn't need his medication: if he simply practised meditation, ate a special diet, and took a powder (sold by the therapist) then he would be fine. He ended up going into a manic phase and being arrested by police.

Example #40: An unregulated therapist told a mother that her child's condition was "hopeless." This was far from the truth, and it had a serious detrimental impact on the mother and, consequently, on her child.

5) Misleading, deceptive or inaccurate information given by an unregulated therapist:

Over two hundred clinical counsellors responded positively to this question. In turn, those counsellors provided 159 de-identified examples of situations where the counsellor had seen or heard misleading, deceptive or inaccurate advertisements, websites or literature prepared by unregulated therapists. The following are ten examples from this set.

Example #41: I have seen advertisements by a therapist who calls himself a "Jungian" therapist but has no formal training in that field.

Example #42: A family seeking bereavement counselling asked whether they ought to see me or go to the "Family Counsellor" at the funeral home. I learned that the funeral home staff wore name tags that said "Family Counsellor," although the staff offered sales

advice for caskets and funeral services, not counselling advice. Calling them “counsellor” is confusing and not based on facts.

Example #43: After one session with me, a client started advertising herself as a “healer,” but – in my professional opinion – she has significant unresolved issues and I am concerned for people seeking her services who might be in a vulnerable state.

Example #44: I have seen people advertise themselves as relationship or addiction counsellors after taking one diploma course. This means that they only understand one aspect of what might be going on for people, and only have one model to assist the client. This leads to a mismatch between what the therapist can do and the clients' needs or issues. One model does not fit all, just as a hammer is not the right tool for all jobs.

Example #45: A person who advertises services as a crisis/trauma counsellor only has a diploma in criminology.

Example #46: Most counsellors who advertise say that Post Traumatic Stress Disorder is an area of their expertise, but very few actually have training in that area. The impact on the client is that it becomes a crapshoot guessing whether a particular therapist is competent. A lack of expertise can lead to serious mental health issues for the client.

Example #47: There are newspaper advice columns by unqualified therapists that give poor advice on personal questions. I saw incorrect advice on workplace relationships that would probably make the situation worse.

Example #48: I have seen websites where “therapists” promise to provide a cure in two sessions. It is unethical to make such a promise without any assessment.

Example #49: A couple advertises themselves as clinical counsellors, but they have no formal training. They tell clients their problems will be solved if they become born-again Christians.

Example #50: A local counsellor claims to have counselling credentials including a master’s degree, but it is a degree in business, not in counselling.

6) Other professionals' concerns about unregulated therapists:

From the 171 clinical counsellors who responded positively to this question, 106 examples were provided where the counsellors had heard reports from other health professionals of concerns they had about the conduct of unregulated therapists. Ten examples from this set are provided below.

Example #51: I heard that a client was touched inappropriately by an unregulated therapist and felt betrayed by that therapist. She was angry that there was no professional recourse because the therapist was not regulated by a college.

Example #52: Over nearly 20 years of practice, a few of these concerns have come to my attention each year. In one case an unregulated therapist read a client's aura and said there was damage to the aura that would require extensive work. After thousands of dollars for treatment, which the client's partner did not approve of, eventually their marriage broke down.

Example #53: Group counselling was offered by an untrained and unregulated therapist. At one session a vulnerable participant was retraumatized by the group experience and was subsequently hospitalized.

Example #54: A non-registered reflexologist with a science degree but no counselling credentials provided counselling and biofeedback services to a suicidal, depressed client. These services took three hours instead of the one hour they had agreed to. The client was told, if he really wanted to kill himself, how he could do it more effectively. The therapist demanded payment for the three hours and drove the client to his bank to get the money. He called me to ask how to report her conduct. The client felt unsafe, humiliated, used, overpowered and helpless. Another client complained about this same person having an office assistant doing computer work in the office while the client was discussing intimate information. That client felt angry and anxious.

Example #55: I have heard of a counsellor who has asked clients to remove their clothes to perform "bona-fide" reiki therapy. The clients who did so became very uncomfortable and felt violated.

Example #56: A client was asked to release her anger by taking off her shirt and hitting pillows. She had suffered childhood sexual abuse and was retraumatized by this process, which caused new problems in her intimate relationship.

Example #57: A so-called "therapist" facilitated a workshop using guided imagery. One participant became so unstable as to require hospitalization, while the facilitator never even noticed that the client was in real crisis.

Example #58: A particularly vulnerable client was influenced by an untrained therapist to accuse her family members of sexual abuse. A huge family crisis was created and alienation followed. These false allegations were only rescinded after years of therapy with another competent therapist, which cost thousands of dollars for treatment and had devastating effects on the family.

Example #59: A fellow therapist has expressed concern that one of her clients who has issues with drug and alcohol abuse was seeing a "mental health professional" who was retriggering the client, and not helping at all.

Example #60: I know a program where a new practitioner (with an undergraduate degree) is advertised as a "sex therapist" but works with children who have been sexually abused. This population is extremely vulnerable and the potential harm is great. Other professionals do not refer clients to this therapist because of the known lack of expertise and because the therapist has spoken in public places about clients.

7) Conduct of colleagues or other employees that could cause harm to clients:

181 clinical counsellors responded positively to this question and, in turn, provided 146 examples of situations involving the conduct of other colleagues or fellow counsellors that could or did cause harm to clients. Ten examples are set out below.

Example #61: A hypnotherapist expected a female client to remove her shirt for the treatment.

Example #62: One counsellor described numerous issues with conduct of non-clinical counsellors that are common at a "high end" provider of mental health services:

harassment, boundary violations, racism, sexism, lack of regard for personal property, bullying, yelling, sexual impropriety, cruel and inappropriate treatment, and a lack of basic medical or psychological foundation for treatment.

Example #63: Some therapists are making diagnoses that are outside their scope of practice. They are providing legal assessments or opinions and making parenting capacity assessments, sometimes without ever having met the client. Sometimes regulated professionals do this too, but in those cases there are complaint procedures to address the problem and educate or discipline the professional. There is no recourse or remedy when the problem involves an unregulated therapist.

Example #64: Therapists sometimes make their clients dependent upon them. They breach confidentiality. They cast blame on family members rather than working to resolve the harm, sometimes causing increased conflict within the family.

Example #65: I have known other therapists who talk too much about their own lives to clients or meet with clients in a social setting. The negative impact on the client is confusion about where the boundaries are. The client knows too much about the therapist's personal life, which interferes with a professional therapy relationship and damages the client's growth and healing.

Example #66: I have seen or heard of other therapists violating confidentiality, engaging in dual relationships with clients, and even failing to complete risk assessments when clients admit feeling suicidal.

Example #67: My client and his wife had started marriage counselling with a therapist who became "friends" with the wife and then refused to counsel them jointly. At that point my client began to see me, but his former counsellor refused to communicate with me about the matter. This seemed to be an incident of a therapist completely taking sides and losing objectivity. The clients were negatively affected and this therapist's conduct contributed to the marriage breakdown rather than reconciliation.

Example #68: Some therapists try to solicit clients away from their current therapist by spreading lies about the current therapist. Some therapists practice outside their training or

scope of competence. I have known therapists who should act as role models but who exhibit racist, sexist and other discriminatory behaviour. I have known therapists to leave a client in crisis. I have known therapists – I will call them "voyeur therapists" – who search out vulnerable clients and put their own desires above their clients' needs.

Example #69: Some therapists basically force clients to engage in or purchase (sometimes expensive and often unhelpful) adjunct therapies by threatening to stop treating them if they refuse.

Example #70: One therapist telephones prospective clients following an initial contact and leaves detailed messages about the therapy on an answering machine or calls several times if there is no immediate reply. This is a breach of confidentiality and is also too aggressive.

Discussion

While there may be some shortcomings in the BCACC membership survey, the results are nonetheless consistent with the examples of risks of harm that can be identified by the reported legal cases (chapter 1), the summaries of insurance claim files (chapter 2) and the examples from the BCACC complaint files (chapter 3). When taken as a whole, all four sources provide as complete a picture as possible – short of an expensive and time-consuming survey of the BC public – regarding not only the sorts of incompetent or unethical conduct that unregulated therapists may engage in, but also the underlying reasons for these failures and their consequences for the client.

This now leads us to a consideration of the policy issues that would inform a decision to proceed with designation under the HPA.

CHAPTER 5: POLICY CONSIDERATIONS

Introduction

In the first four chapters of this submission, the Task Group has provided actual reported cases and concrete examples of the risks that are associated with incompetent or unethical counselling therapy services and the harms that have been caused to clients and third parties.[30] The next step is to demonstrate that establishing a College of Counselling Therapists under the HPA will reduce or prevent these harms, and that designating the counselling professions under the Act is therefore in the public interest.

To demonstrate the public benefit in regulating counselling therapists under the HPA, it is necessary to consider the policy issues that would inform a government decision to move forward with designating the various counselling professions in BC under a single regulatory umbrella. This chapter will offer such an analysis.

Does counselling therapy involve activities that can cause harm?

This is a threshold question, which if it cannot be answered in the affirmative, would effectively end the designation process. If no harms can be associated with the provision of counselling therapy, there would be no need to consider any of the subsequent policy questions.

Many examples of actual harm been identified in reported British Columbia legal cases, in the Encon insurance claims files, in the BCACC complaints files over the past two decades, and in the results of a recent survey of clinical counsellors. Each of these real-life examples can be assigned to one of four distinct categories of harm that results from the incompetent or unethical provision of counselling therapy:

[30] These "real life" examples make it clear that the examples of risks of harm that the Task Group first identified in its 1998 Joint Response are more than just "theoretical" risks. (See Appendix A.)

1. Breach of a fiduciary duty or lack of a professional boundary between the counsellor and the client, leading to dual relationships, abuse or exploitation of the client, and – in particular – sexual impropriety;
2. Breach of client privacy or confidentiality, by revealing personal information without client consent;
3. Various forms of professional incompetency, such as a lack of training in a particular technique, or failing to meet commonly accepted standards of clinical practice; and
4. Poor business practices, including sub-standard record keeping and questionable billing practices.

Almost all of the acts or omissions that can be assigned to one of these four categories are likely to result in emotional or psychological harms to clients rather than physical harm. While in some cases emotional or psychological harm may also manifest itself in physical ailments, such an outcome is not directly attributable to the incompetent or unethical provision of a counselling service.[31]

As the data and case summaries set out in the previous chapters illustrate, poor clinical judgment and a failure by a counsellor to recognize personal limitations can result in harm to clients and, in some cases, to innocent third parties. These harms arise most often because of a lack of counsellor training or experience, or a failure of the counsellor to understand or follow prescribed professional standards or codes. These harms can also result from specific and identifiable shortcomings in a therapist's behaviour or character.

Another critical feature of the provision of counselling therapy that contributes to potential risks is that often counsellors work with their clients in private settings, (literally) behind closed doors. Counselling therapists are not supervised, either directly or indirectly,

[31] Unlike the 22 restricted activities listed in the Ministry's March 19, 2010 consultation draft, *Heath Professions General Regulation: Restricted Activities*, there is no aspect of the provision of counselling therapy that is physically invasive or could clearly and directly result in physical harm if it were performed incompetently, such as causing bleeding or an infection. No doubt, if counselling therapy *did* involve the performance of one of the 22 proposed restricted activities, it would have become a regulated profession under the HPA years ago.

by a regulated health professional, such as a psychologist or psychiatrist.[32] While some counselling therapists may work in the same clinic as these other mental health practitioners, they provide their clinical services autonomously. And while counsellors may consult with either their peers or other mental health professionals, this is usually done after the clinical session has ended.

Counselling therapists deal with clients who are often emotionally or psychologically vulnerable. In this state, the clinical decisions that a therapist makes could worsen the client's situation. For example, if a therapist does not have the proper training to recognize when a particular approach or modality may be inappropriate for the client, the incompetent therapist could proceed to engage the client in a "therapy" that could cause further emotional or psychological harm.

A client's vulnerability is the source of another inherent problem that counselling therapists face in their daily practice – what is commonly referred to as a power imbalance. Counsellors have to be particularly self-aware so as to avoid exerting improper pressure on clients. Counsellors with inadequate training or dubious integrity might manipulate or exploit the vulnerable client, possibly even for their own personal benefit. An emphasis on understanding and respecting counsellor-client boundaries is a critical part of counsellor training, and it is perhaps one of the most important features of the counselling code of ethics.

Counselling therapists know that transference can be another significant risk, possibly even an "inherent" risk in the clinical setting. Because a therapist may offer compassionate but objective ways of assessing and responding to a client who is in emotional distress, that client may then redirect his or her feelings and desires to a new object, and sometimes that is the therapist. It takes expert training to recognize this problem, and it takes well-honed skills to provide a way to help the client avoid the further harm that can result when the therapist takes steps to (gently) end the transference.

[32] Supervision will occur during a counsellor's training, as would be the case for the training of any other regulated health professional.

The nature of the complaints that the BCACC deals with indicate that, even with their extensive training, clinical counsellors sometimes make bad decisions, which in turn can have devastating effects on their clients or others. Examples of incompetent or unethical practice can also be taken from the reported court cases, where clients have sued those who purport to provide some form of counselling, or from the Encon claim files, where counsellors have self-reported an error that led to compensation for harm to a client.

The result of substandard or abusive counselling practices may not be as obvious as the harms that are easier to identify in relation to the 22 restricted activities that the Ministry is currently proposing to regulate under what will become Part 4.1 of the HPA. But, based upon the stories of harm and the other data presented in the previous chapters, there is (unfortunately) a significant number of clear instances where therapists have demonstrated abusive or negligent behaviour that has resulted in serious consequences for their clients, if not also their families or close friends. In the Task Group's view, these risks are sufficiently serious as to warrant establishing a College of Counselling Therapists under the HPA.

What does the nature of the identified harms say about the best form of regulation?

In the Task Group's view, the types of harms that have been described in the previous chapters provide a basis for the government to designate counselling therapy under the HPA, but the nature of that designation needs to also be considered.

The Task Group proposes that, instead of designating counselling by granting the professions some form of a restricted activity, the designation of counselling therapy can take place by employing just the title-protection provisions of the HPA. The Group believes that title protection should be sufficient to help the public make informed decisions as to what sort of therapist they wish to see for counselling services.

Of course, if a restricted activity like Ontario's controlled act of psychotherapy[33] were added to BC's proposed list of physically invasive restricted activities, that would provide a

[33] *Psychotherapy Act, 2007*, S.O. 2007, c. 10, Sch. R, s. 4: "In the course of engaging in the practice of psychotherapy, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to treat, by means of psychotherapy technique delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or

clearer expression of the risks of harm that can arise in counselling therapy practice. (Many counsellors currently provide some form of psychotherapy as part of their clinical practice.) Indeed, identifying psychotherapy as a restricted activity would provide a very compelling reason to move forward with designating counselling therapists and – in turn – granting to them some capacity or ability to perform that newly restricted activity of psychotherapy. Such a move would indicate a policy decision by government that, in order to protect the public from harm, it is necessary to reduce the public's choice and allow only registered professionals with the necessary competencies, like counselling therapists, to provide psychotherapy.

However, in the absence of a government decision that psychotherapy will be added to the current list of restricted activities, the risks of harm and the nature of those risks as shown in the cases and information set out in the previous chapters would suggest that a different set of policy considerations should be applied.

The Task Group believes that the previous chapters have clearly illustrated that the public can be emotionally or psychologically harmed at the hands (sometimes literally) of unregulated therapists. One challenge remains. Because the reported resulting harms do not fit within the scope of the current set of "physically invasive" restricted activities, they do not provide the government with as clear a basis to move forward with designating counselling therapy under the restricted activity aspect of the HPA as exists for other currently regulated health professions. Instead, another aspect of the HPA comes into play: designation of the profession using only title protection. This option will be considered under the next set of subheadings. The first explores the essential functions of a college.

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memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning."

What are the essential functions of a college?

Under section 16 of the HPA, a college has been given a series of duties and objects that reflect its public interest mandate:

> *Duty and objects of a college*
> 16(1) It is the duty of a college at all times
> (a) to serve and protect the public, and
> (b) to exercise its powers and discharge its responsibilities under all enactments in the public interest.
> (2) A college has the following objects:
> (a) to superintend the practice of the profession;
> (b) to govern its registrants according to this Act, the regulations and the bylaws of the college;
> (c) to establish the conditions or requirements for registration of a person as a member of the college;
> (d) to establish, monitor and enforce standards of practice to enhance the quality of practice and reduce incompetent, impaired or unethical practice amongst registrants;
> (e) to establish and maintain a continuing competency program to promote high practice standards amongst registrants;
> (f) to establish, for a college designated under section 12 (2) (h), a patient relations program to seek to prevent professional misconduct of a sexual nature;
> (g) to establish, monitor and enforce standards of professional ethics amongst registrants;
> (h) to require registrants to provide to an individual access to the individual's health care records in appropriate circumstances;
> (i) to inform individuals of their rights under this Act and the *Freedom of Information and Protection of Privacy Act*;
> (i.1) to establish and employ registration, inquiry and discipline procedures that are transparent, objective, impartial and fair;
> (j) to administer the affairs of the college and perform its duties and exercise its powers under this Act or other enactments;
> (k) in the course of performing its duties and exercising its powers under this Act or other enactments, to promote and enhance the following:
> (i) collaborative relations with other colleges established under this Act, regional health boards designated under the *Health Authorities Act* and other entities in the Provincial health system, post-secondary education institutions and the government;
> (ii) interprofessional collaborative practice between its registrants and persons practising another health profession;
> (iii) the ability of its registrants to respond and adapt to changes in practice environments, advances in technology and other emerging issues.

From these prescribed duties and objects, it is possible to identify two essential functions that every college must perform: (a) harm prevention or reduction, and (b) harm correction. Each of these functions is in turn composed of a set of practices and elements that contribute to performing that function. While the corrective function was traditionally viewed as the primary role played by most regulatory bodies, in recent years the emphasis has shifted so that colleges are now expected to spend more time and resources on trying to prevent risks to the public from arising in the first place.

A range of practices go into performing these two basic functions. These various practices are reflected in the wording of section 16 of the HPA.

For example, practices aimed at harm prevention are identified:

- to establish the conditions or requirements for registration of a person as a member of the college (s.16(2)(c));
- to establish … standards of practice to enhance the quality of practice and reduce incompetent, impaired or unethical practice amongst registrants (s.16(2)(d));
- to establish and maintain a continuing competency program to promote high practice standards amongst registrants (s. 16(2)(e));
- to establish … a patient relations program to seek to prevent professional misconduct of a sexual nature (s. 16(2)(f));
- to establish … standards of professional ethics amongst registrants (s. 16(2)(g));
- to require registrants to provide to an individual access to the individual's health care records in appropriate circumstances (s. 16(2)(h));
- to establish and employ registration… procedures that are transparent, objective, impartial and fair (s. 16(2)(i.1));
- to promote and enhance … interprofessional collaborative practice between its registrants and persons practising another health profession (s. 16(2)(k)(ii));

- to promote and enhance … the ability of its registrants to respond and adapt to changes in practice environments, advances in technology and other emerging issues (s. 16(2)(k)(iii));

And practices aimed at harm correction are also identified:

- to … monitor and enforce standards of practice to enhance the quality of practice and reduce incompetent, impaired or unethical practice amongst registrants (s.16(2)(d));
- to … monitor and enforce standards of professional ethics amongst registrants (s. 16(2)(g));
- to establish and employ … inquiry and discipline procedures that are transparent, objective, impartial and fair (s. 16(2)(i.1)).

In summary, a college established under the HPA has many specific legislative mechanisms to help it achieve the public-interest mandate given to it under the Act. The question now becomes:

How could a College of Counselling Therapists reduce or eliminate the identified risks of harm?

As noted above, to perform the function of harm prevention and reduction, a range of practices could be employed to prevent the public from being injured, be this physically, emotionally, psychologically or even financially. For example, so long as a college's registration requirements are set at a particular level and are grounded on an objective assessment of the essential competencies that are necessary for safe and ethical care, the application of those registration criteria should then ensure that only applicants with sufficient competencies and ethical training become registrants of the college. Those who do not posses those competencies and ethical understanding should (hopefully) not become registrants. In other words, this screening practice should help to prevent incompetent or unethical persons from becoming registrants of the College of Counselling Therapists.

Another way of serving a prevention function is when a college sets standards of professional practice or develops a code of professional ethics. The practice standards are

intended to set the minimum requirements for competent and safe practice by the registrants. The code of ethics is intended to guide ethical decision-making after registration and in what can sometimes be difficult clinical situations. The standards and code can also be applied within the corrective functions of the College of Counselling Therapists to assess whether or not a respondent registrant fell below the minimum standards of practice. But their primary purpose is to guide registrants and to try to prevent harm from occurring.

The corrective function is aimed at trying to address harms that have affected the public *after* an act or omission has occurred. In particular, the investigative, mediation and disciplinary aspects of the corrective functions that the College of Counselling Therapists would employ are intended to help to rectify or modify a counselling therapist's sub-standard practice, or – as a final resort – to cancel that therapist's registration with the College. It is not uncommon that, as part of a mediated resolution to a *bona fide* complaint, an inquiry committee would obtain outcomes for a complainant that may also be available in the civil courts (*i.e.* the agreement to refund the complainant for any fees that were charged, or to pay some amount as compensation for a resulting harm). But a college committee can also obtain outcomes that are rarely if ever ordered by the courts (*i.e.* issuing a letter of apology, directing the therapist take remedial training, etc.).[34]

How would the preventive and corrective functions operate under a title-protection model?

As the Task Group explained in its 2009 submission to the Minister of Health, *Options for the Self-Regulation of Counselling Therapists in B.C.*, the member organizations believe that counselling therapy can be designated under the HPA but granted only title protection. The Task Group does not believe that it is necessary to go further and grant to the professions one or more restricted activities.[35] As such, the Group believes that – by giving

[34] In none of the reported BC civil cases identified in chapter 1 is there any indication that the court ordered anything more than financial compensation.

[35] As was explained in more detail in its 2009 Submission, if the Ministry does not accept the Health Professions Council's 2001 recommendations that there should *not* be a restricted activity of psychotherapy granted to psychologists, the Group would not be concerned that a new and previously non-identified restricted activity could be granted to BC health professions without the Group having an opportunity to comment. If, however, the Ministry decides to grant to any currently regulated health profession a restricted activity that may impact on the services that counselling therapists provide to the public, such as a psychotherapy restricted activity (like the one set out in Ontario's legislation, or otherwise), the Group would then want to have the opportunity to ascertain if counselling therapists should also be granted this or a similar restricted activity.

the new College of Counselling Therapists the more limited mandate to regulate occupational titles for the exclusive use of registrants – the College can still play a positive role in terms of applying the functions that the College would be mandated to undertake under section 16 of the HPA.

When the public is making decisions as to what types of therapist they would like to see for counselling services, their decisions can be informed by reference to the occupational titles that, under the HPA, only regulated therapists would be entitled to use. The public would be free to choose counselling services from any therapist, but a particular therapist's use of a regulated occupational title would give the public some assurance that the therapist had obtained the basic competencies and ethical training suited to providing the desired counselling services safely and responsibly.

A therapist's use of a particular exclusive title also tells the public that such a therapist is required to perform those required services at a minimum level of competency and in keeping within a framework of ethical decision making. Thus, not only is the college performing its function to prevent the public from being harmed, but the public can make more informed decisions as to what type of counselling therapist they would like to hire, knowing that if something goes wrong, they can at least file a complaint with that therapist's regulatory body. The public will come to associate the exclusive occupational titles with competency-based registration requirements, minimum standards of clinical practice, and professional accountability. This last benefit should not be underestimated.

Linking a college's complaint investigation, resolution and disciplinary functions to a grant of exclusive occupational titles also gives the public the further assurance that the therapist using that title will not only be accountable to his or her profession, but that an independent regulatory body can step in and resolve a complaint that may later arise. It would not be necessary for the client to always have to initiate legal proceedings to seek a remedy.

Over time, the public will start to associate the occupational titles that have been granted to registrants of the new College with corrective mechanisms that are available to them in case they have problems with their therapists. These mechanisms can be of particular

importance in relation to matters that clients cannot resolve directly with their therapists, whatever the reason. Indeed, unlike the current situation when member organizations of the Task Group are investigating public complaints, a College of Counselling Therapists would have the jurisdiction under the HPA to investigate and determine whether a remedy is required. Even more significantly, a College of Counselling Therapists would have the jurisdiction under the HPA to pursue former registrants if they resigned in the face of a complaint investigation.[36]

Designating a health profession under the HPA without also granting to that profession some form of a restricted activity is not unique. In effect, massage therapists have been designated under the Act without also being granted a restricted activity.[37]

Conclusions

In the previous chapters of this submission, the Task Group presented new evidence from various sources to demonstrate that more than just a theoretical risk of harm can arise from the incompetent or unethical provision of counselling therapy services.

Although clients who have been harmed may not show visible signs of damage, the damage is real, and sometimes it has been inflicted literally at the hands of a supposed therapist. The emotional or mental harm inflicted on vulnerable members of the public is no less real or important for being hidden. When the British Columbia government first decided to regulate psychologists, the fact that the clients who had been harmed by unregulated psychologists did not show outward signs of their bad experiences did not mean that regulation was not required. The very private nature of the clinical relationship between the client and the therapist, and the failure of an improperly trained therapist to correctly assess

[36] In Ross v. British Columbia Psychological Assn. (1986), 1 B.C.L.R. (2d) 380 (BSCS), affd. 19 B.C.L.R. (2d) 145 (BCCA), the Court explained that a member of a society who resigns his or her membership need no longer comply with the complaint investigation and disciplinary bylaws that applied when that person was a member of the registered society. If a member of a Task Group organization resigns in the face of a complaint investigation or disciplinary proceeding, in effect the organization no longer has jurisdiction over that former member.

[37] While the Massage Therapists Regulation does purport to give this profession a broad control over all aspects of "massage therapy," the Health Professions Council has recommended that this profession not be granted any of the proposed restricted activities that will eventually be controlled under Part 4.1 of the HPA. The Task Group understands that eventually the Ministry will act on this recommendation to amend this regulation, thus removing any restricted activity from the control of massage therapists. They would remain regulated health professions with only title protection under the Act.

or implement a specific therapeutic or clinical intervention, are both significant sources of these sometimes hidden harms.

Unless the Ministry is actively considering introducing a new restricted activity under the HPA similar to how Ontario dealt with psychotherapy, the Task Group considers the best option for regulating counselling therapy under the Act be the use of occupational titles. This approach would not prevent the public from seeking counselling services from whomever they may want to see. Instead, it would improve the ability of the public to make informed decisions that the registered counselling therapist they were planning to pay for counselling services possesses not only the essential clinical competencies, but is also bound to a code of professional ethics and standards of practice, and – ultimately – can be held accountable for failures to uphold those standards. Such a model is demonstrably in the public interest.

APPENDIX A: TASK GROUP'S LIST OF RISKS OF HARM

The following is an extract from section 2.3 of the Task Group's 1998 submission to the BC Ministry of Health, titled *Joint Response to the Discussion Paper on the Regulation of Counselling* (November 20, 1998).

2.3 A summary of risks of harm

Having described the importance of a risk of harm analysis in defining the best regulatory option and in creating the foundation for regulatory programs within that option, the Task Group now presents a summary of the risks of harm that can arise if someone is not sufficiently educated or experienced as a counsellor, or if they act in an unethical or impaired fashion.

In many of these examples, the resulting harm cannot be readily quantified. It will result in either a continuation of the original problem or a worsening of the situation, leading to continued or greater personal suffering.

Further, a harmful result of many of these examples of risk is usually going to be a unnecessary expenditure of funds by the person harm or others, in particular to correct the problem that resulted.

2.3.1 Harm resulting from incompetence

- Failure to obtain sufficient background information from the client (e.g. medical problems, family history, previous therapies, etc.) or failure to undertake a complete assessment of the client's problem and situation, leading to incorrect or inappropriate treatments, which can compound the true problem or be ineffective, resulting in further trauma to the client.
- Failure to correctly administer or interpret an assessment instrument, resulting in an incorrect assessment of the client, resulting in harm to the client.
- Inadequate, inappropriate or incorrect assessment of a client's underlying problem, leading to a treatment or therapy that either compounds the problem or is totally ineffective, resulting in further trauma to the client.
- Failure to correctly apply an appropriate treatment or therapy, which can compound the identified problem or be ineffective, resulting in greater or continued trauma to the client.
- Inappropriate use of hypnosis or guided imagery, such as with a client who has been hospitalized for psychosis or major depression, resulting in trauma to that client.
- Inappropriately advising a couple or individual client to end their relationship (or, conversely, to remain together) resulting in trauma to the client and others, such as children.
- Failure to inform a client that mental images which could emerge during certain therapeutic modalities may not be memories of actual events,

resulting in trauma to the client and others.

- Failure to provide an objective means of evaluating the client's progress, resulting in exploitation of the client.
- Failure to properly assess, prevent, and document the possibility and potential of the client being suicidal or homicidal, resulting in serious harm to or death of the client or others, or failure to take steps to inform the police or the potential victim of homicidal threats, resulting in serious harm to or the death of the victim.
- Failure to report to the police or other authorities, information disclosed by a client of an apparent situation of child abuse or neglect, resulting in trauma to or death of a child.
- Failure to recognize the possibility that the client may be suffering from a serious mental disorder which may require hospitalization, medication, or other treatment that is beyond the counsellor's abilities, and the further failure to refer the client with such a disorder to a psychiatrist or psychologists, resulting in trauma to or death of the client.
- Recommending the client discontinue use of a prescribed medication, resulting in trauma to or death of the client.

2.3.2 Harm resulting from unethical practice (i.e. therapist-client boundary problems)

- Failure to preserve the client's right to confidentiality (except when excused by law), resulting in public disclosure of sensitive or personal information that harms the client.
- Inappropriate touching of or communicating verbally with a client in a sexual or romantic way, resulting in a breach of trust and trauma to the client.
- Expressing personal anger or frustration to a client, resulting in trauma to the client.
- Introducing the therapist's religious beliefs into therapy without the client's consent, resulting in exploitation of the client.
- Becoming involved in a business relationship with a client (e.g. renting a basement suite to a client), resulting in exploitation of the client.

2.3.3 Harm resulting from impaired practice

- Providing a service to a client while the counsellor is impaired by alcohol, drugs, a physical or mental illness or some other dysfunction, resulting in trauma to the client.

2.3.4 Harm resulting from unprofessional practice

- Failure to ensure that the interview/therapy room or setting is located and arranged so as to ensure the client feels comfortable about meeting with the counsellor, resulting in discomfort or possible trauma to the client.
- Discriminating against a client based on sexual orientation, race, disability, etc., resulting in trauma to the client.
- Pressuring a client to remain in the counselling relationship against the client's expressed desire to terminate, resulting in trauma to and exploitation of the client.
- Making a record or signing or issuing a certificate, report, account or

similar document that is false, misleading or otherwise improper, resulting in trauma to the client.

- Failure to submit a required report that adversely affects compensation claim, such as through a national fund for victims of sexual abuse at residential schools.
- Charging a fee that is excessive in relation to the services provided, charging for services that were not provided or providing an unnecessary service, resulting in exploitation of the client.
- Requiring payment of the fee for service prior to service being provided, resulting in exploitation of the client.