Advanced Skills Workshop: Risk Management, Safety, and the Non-Pathologizing Therapist

When "First, Do No Harm" Meets the Client's Right to Say No

Workshop Synopsis

The CHCPBC Risk Management and Safety Practice Standard states clearly: *the public can expect licensed healthcare professionals to maintain practice environments that are physically, psychologically, and culturally safe*. This single opening sentence contains a tension that sits at the heart of a non-pathologizing philosophy of care — because the question of who defines safety, how safety is created, and what clinical authority the therapist has to impose safety on a client has never been more ethically complex. This workshop argues that the non-pathologizing framework does not resist the CHCPBC's risk and safety obligations — it is, in fact, the most clinically coherent way to fulfil them. Safety is not simply a standard to be met; it is the first and non-negotiable stage of all psychotherapeutic work. But what the profession has routinely misunderstood is that the therapist does not — and cannot — make a client safe. The therapist can only recognize, honour, and collaborate around the client's own mechanisms for achieving safety — mechanisms that the medical model has historically named as pathology.

The Problem the Workshop Addresses

Many psychotherapists were trained in risk and safety protocols that are themselves deeply pathologizing. The canonical example is the *safety contract* — a document in which a client agrees not to harm themselves, typically framed as a condition for continuing therapy or avoiding hospitalization. The safety contract is premised on the assumption that the therapist's role is to control the client's behaviour by extracting a commitment, and that the client's safety is primarily a clinical management problem rather than a relational and contextual one. The non-pathologizing framework identifies the safety contract as a form of *moralization* — a mechanism through which the therapist imposes an external behavioral standard on the client while framing it as care. The CHCPBC standard, when read carefully, provides no license for this. It requires therapists to promote *psychological safety*, which the standard's own glossary defines as circumstances in which *patients feel safe to express their ideas and authentic selves, ask questions, raise concerns, report mistakes, and acknowledge limitations without fear of adverse consequences*. That is precisely what a safety contract — experienced by many clients as coercive — undermines.

The standard also requires therapists to respond to *emerging risks*, report *dangerous practice or incompetence*, manage *inadequate resources that compromise safety*, address *cultural and psychological harm* in the practice environment, and complete *regular training in emergency procedures, anti-racism, and workplace safety*. These obligations span the therapist's physical

workspace, their clinical relationships, their interprofessional responsibilities, and their own capacity to practise. This workshop addresses all of these dimensions through the non-pathologizing triage lens.

The CHCPBC Standard: Ten Core Requirements

The Risk Management and Safety Practice Standard is organized around ten specific obligations:

1. Managing Resource Limitations
Therapists must manage unavoidable resource limitations in a manner that prioritizes safety and minimizes harm, and must refrain from delivering health services where inadequate resources compromise safety or the standard of care. For private practitioners, this requirement has direct implications: practising solo without adequate supervision, consultation, or backup resources when working with high-risk clients may itself constitute a safety risk that the standard requires the therapist to address proactively.

2. Infection Prevention and Control
Therapists must meet the BC Centre for Disease Control's infection prevention and control practices and all public health requirements. This requirement applies across all practice settings, including in-person, virtual, and community-based work.

3. Maintaining a Safe Physical Environment
Therapists must keep professional work areas clean and free from hazards in accordance with WorkSafeBC requirements; promptly remediate hazards such as spills, clutter, expired supplies, or malfunctioning equipment; and securely store items that, if stolen or accessed, could pose a risk to patients or others. For a non-pathologizing therapist, the physical environment communicates something to the client before a word is spoken — and a space that is cluttered, inaccessible, or sensory-overloading may itself be a barrier to the client's ability to feel safe enough to engage in the work.

4. Promoting Cultural and Psychological Safety
Therapists must take reasonable steps to create and foster a *culturally safe, inclusive, and accessible environment* for patients; take appropriate action when witnessing disrespectful, discriminatory, racist, or harassing behaviour directed at patients, staff, or colleagues; and report discriminatory behaviour to CHCPBC as required under the HPOA. This is the standard's most direct intersection with the non-pathologizing philosophy — and it expands the concept of safety far beyond physical harm into the relational, cultural, and systemic dimensions that the triage model has always prioritized.

5 & 6. Equipment and Resource Availability
Therapists must ensure that necessary equipment and safety devices are available and meet applicable safety standards; address defective, expired, or missing items immediately; and report concerns about availability and safety to those responsible. For the psychotherapy context, this

applies to the technological infrastructure of virtual practice as well as to physical practice tools and emergency resources.

7. Training and Preparedness
Therapists must regularly complete training appropriate to their practice setting, *considering infection control, equipment use and maintenance, emergency procedures, anti-racism and anti-discrimination, and workplace safety*, and must maintain up-to-date policies and procedures for infection prevention, equipment maintenance, and emergency preparedness. The inclusion of anti-racism and anti-discrimination within the training requirement — in the same breath as infection control and emergency procedures — signals that cultural and psychological safety are not optional enhancements but core safety obligations on the same level as physical safety.

8. Responding to Emerging Risks
Therapists must monitor for emerging safety risks — including public health concerns, environmental hazards, and changes in patient conditions that could affect safety — and adapt their practice accordingly. In the psychotherapy context, this requirement directly addresses the therapist's obligation to recognize shifts in client risk presentation across sessions, including increasing distress, suicidality, risk of harm to others, or deteriorating external safety circumstances.

9. Documenting and Reporting Safety Measures
Therapists must promptly address, document, and report actual and potential safety risks and errors, and participate in quality improvement activities to prevent recurrence. The CHCPBC Records Standard specifically requires therapists to document *critical thinking and decision making where deviating from expected standards*. This provision is significant: it creates a formal documentation obligation whenever a non-pathologizing therapist makes a clinical decision that diverges from the pathologizing norm — including when the therapist chooses not to use a safety contract, not to apply a particular diagnostic framework, or not to initiate a hospitalization.

10. Reporting Serious Safety Concerns
Therapists must report *dangerous practice, incompetence, or concerns about another licensed healthcare professional's ability to safely practise* to CHCPBC, as required under the HPOA. This obligation extends the safety standard beyond the therapist's own practice into their interprofessional accountability as a regulated professional.

Safety as the Foundation of Non-Pathologizing Practice

The textbook's (Protest Language) triage model begins with safety — not as a prerequisite to be quickly dispensed with so that the *real* therapy can begin, but as the ongoing relational foundation upon which all subsequent therapeutic work rests. The triage sequence — Safety → Grief and Loss → Identity and Differentiation → Trauma Work — makes the clinical logic explicit: no stage of deeper work can be safely entered without first establishing the conditions of the previous stage, and safety is the always-present layer beneath all others.

The critical non-pathologizing reframe in the triage model is this: *the therapist can never make the client safe. They can only contribute to and collaborate on the conditions that might help the client feel safe*. This is not a philosophical nicety — it is a clinical imperative. It means that the therapist's first task is not to assess whether the client meets the criteria for a safety protocol, but to understand what the client has already put in place — what their external control mechanisms are — and to recognize those mechanisms as adaptive rather than pathological.

External Control Mechanisms: The Non-Pathologizing Safety Assessment

The textbook identifies *external control mechanisms* as one of the primary expressions of safety-seeking in the non-pathologizing framework. These are the adaptive behaviours clients develop — often without conscious awareness — to regulate their experience of distress and maintain a survivable level of safety within their environment. They include behaviours that the medical model has historically pathologized: avoidance, dissociation, minimization, one-word answers, refusal to make eye contact, lateness, cancellation of appointments, and deflection.

The triage model teaches therapists to recognize and *celebrate* these mechanisms rather than treating them as obstacles to the therapeutic work. When a client avoids a particular topic, the non-pathologizing therapist does not identify this as *resistance* or *avoidance behaviour* to be worked through — they recognize it as the client's *no*, and understand that the client is not yet safe enough to engage with that material. The clinical question becomes not *how do I get the client to engage with this?* but *what would need to be different for the client to feel safe enough to go there?*

This reframe has direct clinical implications for how the CHCPBC safety standard is operationalized. Recognizing *changes in patient conditions that could affect safety* requires therapists to attend not only to explicit risk disclosures but to shifts in the client's protest language — an increase in one-word answers, a sudden return to deflection after a period of openness, unexplained cancellations — as potential indicators of a deteriorating safety experience that requires clinical attention.

The Central Tension: Autonomy, Moralization, and Mandatory Obligations

The CHCPBC Code of Ethics establishes *Patient Autonomy* — the right and ability of each patient to make informed, voluntary decisions about their healthcare — as one of its core ethical principles. The Code also establishes *Do Good; Prevent Harm* as an equally binding obligation. These two principles exist in productive tension throughout the non-pathologizing framework, and nowhere is that tension more acute than in clinical risk situations.

The workshop devotes significant attention to this tension across three categories of clinical scenario:

Suicidality and Self-Harm
Traditional clinical responses to suicidal ideation — including safety contracts, mandatory hospitalization, or directive safety planning imposed by the therapist — can themselves become pathologizing interventions that undermine the therapeutic relationship and, paradoxically, reduce the client's willingness to disclose future distress. The non-pathologizing approach does not abandon clinical responsibility for safety; it changes the architecture of that responsibility. Drawing on the triage model, the therapist works collaboratively with the client to understand what external control mechanisms they already have, what *they* identify as the conditions that create risk, and what *they* would need in order to feel safer — while the therapist maintains full clinical accountability for documenting their reasoning, initiating collaborative care where needed, and reporting to CHCPBC when risk presents a serious and imminent concern.

Risk of Harm to Others
The standard's requirement to monitor for *changes in patient conditions that could affect safety* extends to risk of harm to third parties. The workshop examines how the non-pathologizing principle of *externalization* — the clinical position that the problem is never the person — must be carefully distinguished from clinical minimization of genuine risk. Externalizing the problem does not mean externalizing responsibility for safety: the non-pathologizing therapist who identifies risk of harm to others maintains their full legal obligations while documenting their clinical reasoning transparently and ensuring that their response is proportionate, culturally informed, and as collaborative with the client as safety allows.

The Therapist's Own Safety and Capacity
The CHCPBC standard requires therapists to *monitor their own physical, mental, and emotional health* and to *refrain from practising when unable to do so competently, safely, or ethically*. The textbook's non-pathologizing framework applies directly here: one of the most consistent themes in the textbook is that moralization is not only applied to clients — it is applied to therapists themselves, often manifesting as shame when the therapist recognizes their own limits, distress, or need for support. A non-pathologizing approach to the therapist's own safety and capacity treats the therapist's experience with the same non-moralized curiosity they are trained to extend to their clients — asking not *what is wrong with me?* but *what is this response telling me about what I need, and how do I want to be known as a therapist?*

Clinical Reasoning Documentation: The CORE Standard

The CHCPBC Records Standard establishes a documentation requirement specifically for deviations from expected standards: therapists must document *critical thinking and decision making where deviating from expected standards*. For a non-pathologizing therapist working in risk and safety situations, this requirement is both a protection and an invitation — it formally acknowledges that clinical decision-making is not always linear or protocol-driven, and that the therapist's reasoning in moments of clinical complexity is itself a documentable clinical act.

The CORE documentation model is the non-pathologizing vehicle for this requirement. The CORE note — Collaborative Narrative, Observed Strengths and Resources, Resilience in Context, Evolution and Next Steps — provides a structured but non-pathologizing format for documenting safety-related clinical reasoning without reducing the client's experience to a symptom cluster or a risk category. The workshop teaches participants to apply the CORE format specifically to safety-relevant documentation: how to record the client's protest language as clinical data, how to document the therapist's reasoning when declining to implement a default safety protocol, and how to meet the CHCPBC standard's requirement for transparent clinical decision-making without pathologizing the client in the record.

The Practice Environment as a Safety Intervention

The CHCPBC standard's requirement to promote *cultural and psychological safety* in the practice environment — including fostering an *inclusive, accessible, and culturally safe* space and taking action when witnessing discriminatory behaviour — extends the clinical safety obligation beyond the therapeutic relationship into the broader organizational and environmental context of practice. For non-pathologizing therapists, this means attending to how the physical and organizational features of the practice environment communicate power, belonging, and safety to clients before a session even begins.

The CHCPBC glossary definition of *psychological safety* includes a requirement that healthcare professionals *actively address power imbalances, bias, and systemic barriers so that all voices — especially those from Indigenous communities and other equity-denied groups — are heard, respected, and valued*. The non-pathologizing principle that the client is never the problem — that the problem is always contextual, systemic, and external to the person's identity — is the philosophical foundation for this requirement. The workshop asks participants to audit their own practice environments through this lens: what does the physical space communicate about who is expected to be there? What does the intake documentation communicate about who has to explain themselves? What does the language of the consent form communicate about who holds the authority in the relationship?

Practical Exercises and Reflective Practice Components

The workshop includes five structured practice components:

1. Translating the Safety Assessment
Participants work through standard safety assessment language — including standard risk assessment frameworks — and translate each element through the protest language lens. The question is not *does this client meet the criteria for elevated risk?* but *what is this client saying no to, what is their relationship to safety right now, and what external control mechanisms are they already using?* This exercise applies the 9-step Translation Protocol to the safety context.

2. Recognizing External Control Mechanisms in Transcripts
Using session transcripts, participants practise identifying external control mechanisms in real-time clinical material — recognizing one-word answers, deflection, lateness, topic avoidance, and sudden emotional flatness as safety language rather than resistance, and naming what the client's *no* is communicating about the conditions for safety in the room.

3. CORE Documentation in High-Stakes Situations
Participants practise writing CORE notes for clinical scenarios involving elevated risk — including suicidal ideation, risk of harm to others, and client disclosure of unsafe living conditions — applying the Records Standard's requirement to document critical thinking when deviating from expected norms, while maintaining a non-pathologizing clinical record.

4. The Practice Environment Audit
Participants complete a structured self-audit of their practice environment using the CHCPBC cultural and psychological safety requirements as the framework — examining their physical space, intake documentation, consent language, booking processes, and communication tools for pathologizing assumptions about who needs to adapt to the environment and who the environment was built for.

5. Collaborative Safety Planning
As a direct contrast to the safety contract, participants develop and practise a *collaborative safety planning* approach grounded in the triage model: beginning with the client's existing external control mechanisms, building collaboratively toward conditions the client identifies as safety-promoting, and documenting the clinical reasoning transparently in a CORE format that meets the CHCPBC standard without pathologizing the client's experience.

Learning Outcomes

By the end of this workshop, participants will be able to:

- Articulate the ten requirements of the CHCPBC Risk Management and Safety Practice Standard and translate each into specific clinical obligations for psychotherapy practice
- Apply the non-pathologizing triage model — Safety → Grief and Loss → Identity → Trauma — as the clinical architecture for fulfilling the safety standard, with safety as the always-present foundation of all therapeutic work
- Recognize external control mechanisms — avoidance, deflection, one-word answers, cancellation, dissociation — as adaptive safety language rather than pathological resistance, and respond clinically to the *no* they contain
- Identify the tension between patient autonomy and the harm prevention obligation in risk situations, and apply the non-pathologizing framework to navigate that tension without moralizing the client's experience
- Document safety-related clinical reasoning in CORE format, meeting the Records Standard's requirement to record critical thinking when deviating from expected standards, without pathologizing the client in the clinical record

- Conduct a collaborative safety planning process — grounded in the client's own safety mechanisms and preferences — as a non-pathologizing alternative to the traditional safety contract
- Audit their practice environment for cultural, psychological, and physical safety using the CHCPBC standard's requirements and the non-pathologizing lens — examining what the space, language, and processes of their practice communicate about power and belonging
- Meet the CHCPBC standard's monitoring and reporting obligations — including reporting dangerous practice and responding to emerging risk in client presentations — while maintaining the relational and philosophical integrity of the non-pathologizing approach
- Apply the same non-pathologizing, non-moralizing self-awareness to their own professional capacity and safety as they extend to their clients — monitoring their own physical, emotional, and psychological readiness to practise as a continuous professional discipline