Ontario College of
Social Workers and
Social Service Workers

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

# Practice Guidelines for Performing the Controlled Act of Psychotherapy

Guidelines for Social Work and
Social Service Work Members of the
Ontario College of Social Workers
and Social Service Workers

Effective December 30, 2017



If you require this document in an alternate format, contact the College at 1-877-828-9380 or info@ocswssw.org.

# Practice Guidelines for Performing the Controlled Act of Psychotherapy

Guidelines for Social Work Members of the Ontario College of Social Workers and Social Service Workers

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## STATUS OF GUIDELINES

The following guidelines contain information and practice advice which should be considered by social work and social service work members of the Ontario College of Social Workers and Social Service Workers. These guidelines are designed to assist social work and social service work members in interpreting and applying the College's standards to particular circumstances or contexts of practice and to provide additional guidance to members on practice issues.

It should be noted that these guidelines are not themselves standards of practice and have not been enacted by regulation or College by-law. The College's standards, which are the minimum standards applicable to all College members, are the ones set out in the Social Work and Social Service Work Act, 1998, the regulations under the Act, the College's Code of Ethics and Standards of Practice and the College's by-laws. Those College standards prevail over these guidelines. However, the guidelines may still be used by the College (or other bodies) to assist in determining whether appropriate standards of practice and professional conduct have been maintained by a College member in a particular case.

# Introduction

**Psychotherapy** has been referred to as a "complex mosaic" with the therapeutic relationship as its central element[1]. Because of the intensity of the intervention and the intimacy of the therapeutic relationship, clients receiving psychotherapy services are at increased risk of harm from incompetent, unqualified or unfit practitioners. Changes to the Regulated Health Professions Act, 1991 (the "RHPA") reflect this heightened risk, and make psychotherapy one of fourteen controlled acts. A "**controlled act**" is an activity defined under the RHPA, the performance of which is restricted to members of certain professions, due to the risk of harm that it poses to the public. The **controlled act of psychotherapy** is defined in the RHPA as follows:

> 14. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning.[2]

As a result of these important legislative changes to the RHPA, a member of the Ontario College of Social Workers and Social Service Workers (the "College") is authorized to perform the controlled act of psychotherapy in compliance with the Social Work and Social Service Work Act, 1998 (the "SWSSWA"), its regulations and by-laws.[3] A College member may also supervise another College member in performing that controlled act, but may not delegate the performance of the controlled act.[4]

The College's Code of Ethics and Standards of Practice Handbook, 2nd Edition, contains a definition of **psychotherapy services** which is different from the controlled act of psychotherapy. **Psychotherapy services** are defined as "any form of treatment for psycho-social or emotional difficulties, behavioural maladaptations and/or other problems that are assumed to be of an emotional nature, in which a College member establishes a professional relationship with a client for the purposes of promoting positive personal growth and development."[5] **Counselling services** are defined as "services provided within the context of a professional relationship with the goal of assisting clients in addressing issues in their lives by such activities as helping clients to find solutions and make choices through exploration of options, identification of strengths and needs, locating information and providing resources, and promoting a variety of coping strategies, but do not include psychotherapy services."[6]

Distinguishing between the controlled act of psychotherapy and "psychotherapy services" as defined in the College's Handbook could prove to be challenging in practice. Ultimately, it is anticipated that the courts and College discipline committees will provide guidance on what is or is not included within the controlled act of psychotherapy. Although it is possible that not all psychotherapy would be found to fall under the definition of the controlled act, this cannot yet be determined with any precision or certainty. Members should therefore be very cautious when assessing their practice, and would be well-advised to assume that these Practice Guidelines apply to **all** psychotherapy practice.

Additionally, amendments to the SWSSWA provide that a member of the College who is authorized to perform the controlled act of psychotherapy may use the title "psychotherapist" if the member complies with the following conditions, as applicable:

1. When describing himself or herself orally as a psychotherapist, the member must also mention that he or she is a member of the Ontario College of Social Workers and Social Service Workers, or identify himself or herself using the title restricted to him or her as a member of the College.
2. When identifying himself or herself in writing as a psychotherapist on a name tag, business card or any document, the member must set out his or her full name, immediately followed by at least one of the following, followed in turn by "psychotherapist".

    i. Ontario College of Social Workers and Social Service Workers,

    ii. the title that the member may use under this Act.

3. The member may only use the title "psychotherapist" in compliance with this Act, the regulations and the by-laws.[7]

To sum up, members of the College may perform the controlled act of psychotherapy and use the title "psychotherapist", provided they do so in compliance with the SWSSWA, the regulations and the by-laws.

**FOOTNOTES**

1. Holman, Julieta B., William B. Jaffee and David H. Brendel "Introduction: The Complex Mosaic of Psychotherapy in the Twenty-First Century" in Harvard Review of Psychiatry, 15, 2007. Print. p. 265 and p. 267
2. Regulated Health Professions Act, 1991, section 27 (2)14 retrieved from http://www.e-laws.gov.on.ca
3. Regulated Health Professions Act, 1991, section 27 (4)
4. The Regulated Health Professions Act, 1991, section 27(1)(6) allows for the **delegation of controlled acts.** This formal process enables a regulated health professional who is authorized to perform a controlled act to delegate it to another person in accordance with any applicable regulations governing the regulated health professional's profession. The Regulated Health Professions Act, 1991 does not allow for the delegation of the controlled act of psychotherapy by OCSWSSW members who are authorized to perform the controlled act. (NOTE: Because of the central importance of the relationship in psychotherapy, and because of the risk of harm to clients posed by unfit, incompetent or unqualified practitioners, the regulated health professions authorized to perform the controlled act of psychotherapy have taken the position that the controlled act of psychotherapy cannot and should not be delegated).
5. Code of Ethics and Standards of Practice, Second Edition, 2008, p. 41
6. Code of Ethics and Standards of Practice, Second Edition, 2008, p. 40. The controlled act of psychotherapy, psychotherapy services and counselling may be practised with individuals, couples, families or groups, in a variety of settings.
7. Social Work and Social Service Work Act, 1998, section 47.2 retrieved from http://www.e-laws.gov.on.ca

# Purpose of the Guidelines

All members of the College are bound by the **Code of Ethics and Standards of Practice, 2nd Edition**, which sets out the minimum standards for professional practice and conduct. According to the Standards of Practice, members of the College must ensure that they are "aware of the extent and parameters of their competence and their professional scope of practice and limit their practice accordingly."[8] These **Practice Guidelines for Performing the Controlled Act of Psychotherapy** are intended to:

- address issues to be considered in the performance of the controlled act of psychotherapy about which members should be particularly informed;
- highlight the principles in the **Code of Ethics and Standards of Practice, 2nd Edition**, that have particular relevance to the performance of the controlled act of psychotherapy; and
- assist members in identifying what factors they should consider in order to determine if they are competent to perform the controlled act of psychotherapy.

After a careful review of these Guidelines, members are advised to consider completing the checklist in Section D to assess whether they have the necessary preparation to perform the controlled act of psychotherapy. It is important to note that these Practice Guidelines are intended primarily to help members assess their own situation in relation to the essential elements of competent psychotherapy practice. Members will need to use their professional judgment when considering the elements, as this self-assessment may not be a black and white process. Members should ensure that they could provide a sound rationale for their self-assessment based on the guidelines if they were required to do so.

Additionally, members should ensure that they are familiar with the **Code of Ethics and Standards of Practice Handbook, 2nd Edition** (which prevails over these guidelines), giving special attention to those standards with particular relevance to the performance of the controlled act of psychotherapy. To augment their self-assessment, they should also seek input/consultation from supervisors and/or others familiar with their practice.

**FOOTNOTES**

8. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle II, Competence and Integrity, interpretation 2.1.1

# Competence to Perform the Controlled Act of Psychotherapy: Essential Elements

This section addresses the essential elements which members should consider when assessing whether they are competent to perform the controlled act of psychotherapy: education and experience, supervision, and continuing competence.

## 1. EDUCATION AND EXPERIENCE

Performance of the controlled act of psychotherapy is not an entry-to-practice competency, and the necessary grounding in theory and practice goes beyond what would be attained through completion of a social work degree or a social service work diploma alone. Competent performance of the controlled act of psychotherapy is firmly rooted in an integrated and well-developed knowledge base which includes a comprehensive understanding of biopsychosocial theories and models of psychotherapy, as well as mastery of a range of intervention skills and therapeutic modalities.[9] Ideally, members should ensure that their diploma in social service work or degree in social work has a clinical focus. While this level of education might provide a sound base upon which to build the knowledge and skills required to perform the controlled act of psychotherapy competently, it is not in itself sufficient.[10] Members should engage in post diploma/degree training programs with a specific focus on psychotherapeutic theory, clinical modalities and techniques before performing the controlled act of psychotherapy. Optimally, such training should include an integrated program of study, an opportunity for clinical observation and demonstration of mastery of fundamental psychotherapeutic techniques. The training program should have an evaluative component and provide evidence of successful completion (e.g. certificate, diploma, or degree). In addition, members should obtain significant practice experience in a clinical setting in which they are engaged in clinical activities (in addition to supervision and ongoing post diploma/degree training, which will be covered in subsequent sections) before engaging in the performance of the controlled act of psychotherapy.

It should be noted that the Standards of Practice provide that members may represent themselves as specialists in certain areas of practice only if they can provide evidence of specialized training, extensive experience or education.[11]

Members are advised to consider the setting in which they obtained their practice experience when determining whether they are adequately prepared to perform the controlled act of psychotherapy. Agency settings (in which there may be more opportunities for supervision, consultation, informal support and a more varied caseload) rather than private practice (which may be more isolated with fewer supports, and may provide more limited exposure to a diverse caseload) are more likely to ensure an appropriate grounding in theory and practice. Members are not fully prepared to perform the controlled act of psychotherapy until they have completed two to three years (or 2000 to 3000 hours) of supervised experience.[12]

## 2. SUPERVISION

Competence in performing the controlled act of psychotherapy requires not only formal education and extensive experience, but also ongoing clinical supervision. Indeed, clinical supervision is the "central mode of learning psychotherapy."[13] The need for supervision does not end after a certain period in practice, but evolves and continues throughout a member's career. A distinction must be made between **clinical supervision**, which is associated with assessment, intervention and evaluation of client interventions as well as critical self-reflection, and **administrative supervision**, which is primarily concerned with the instrumental aspects of workers' roles in agencies. **Administrative supervision** typically focuses on record-keeping, accreditation, organizational policies, mandate and caseload.[14] While administrative supervision is important and necessary, it is not adequate or sufficient for members wishing to perform the controlled act of psychotherapy.

### Supervision — Members with less than 3 years' post-graduate experience

When assessing their competence to perform the controlled act of psychotherapy, members should consider whether they have adequately prepared themselves. Such preparation would include an extensive and more intensive period of clinical supervision upon completion of their degree or diploma. Ideally, this period of supervision should:

- take place individually and/or in a small group;
- occur regularly and with a frequency that is appropriate to the member's level of experience;
- provide opportunities to engage in case discussion and the learning of new skills and perspectives;
- include at least some direct observation of a member's practice (which may be in the form of audio or videotapes, one-way mirrors, co-therapy or reflecting teams);
- provide opportunities for in-depth experiential and didactic learning in an interactional and supportive environment; and
- enable members opportunity for critical self-reflection.[15]

### Supervision — Members with experience

As members gain experience, less frequent and more informal models of supervision may be appropriate. Members should seek supervision/consultation[16] with experienced colleagues throughout their careers, particularly in areas of practice in which they are less experienced, when they are aware of a strong reaction — positive or negative — to the client, and/or when the client could benefit from members gaining an additional perspective, outside expertise, and/or a new skill or approach. The Standards of Practice require that each member of the College ensures that "(as) part of maintaining competence and acquiring skills in social work or social service work practice ... (they) engage in the process of self review and evaluation of their practice and seek consultation when appropriate."[17] The supervision obtained by members with more experience:

- should occur regularly and with a frequency that is appropriate to the member's level of experience;
- may be less formal and structured;
- may use a group and/or peer consultation model, in addition or as an alternative to individual or small group supervision with an experienced supervisor;
- should be sufficiently accessible that members may obtain assistance in challenging or complex clinical work in a timely manner; and
- should be provided in an environment which enables members to examine their own reactions to their clinical work.

Regardless of their experience, members should be mindful of the supervision literature which suggests that rapport, trust and caring, in addition to clinical expertise and knowledge, are key aspects of all successful supervisory relationships.[18] Members using any model of supervision are personally accountable to bring forth challenging cases. Many find a structured format to be most effective, however at minimum, members should ensure that supervision is easily accessible. When face-to-face meetings are not possible, members may wish to consider on-line or teleconference options, though issues of security and confidentiality take on a heightened importance with these arrangements. Whatever the model chosen, members should ensure that the person or people who are providing supervision are competent clinicians who either practise or have experience in the relevant area. Members may be supervised by someone from outside the profession who has relevant expertise and experience in their area of practice and/or setting. In this case, they should consider whether the supervisor has an understanding of the profession's values, ethics and standards of practice, and determine whether additional input from other sources may be required to obtain the profession-specific supervision that they need. Whatever their profession, supervisors should be members in good standing with their respective regulatory body.

### Supervision and Confidentiality

Regardless of the extent of their experience or the model of supervision or consultation used, members should ensure that they "fully inform clients early in their relationship of the limits of confidentiality of information ... and explain to clients the needs for sharing pertinent information with supervisors."[19] Members should also be aware that Principle V: Confidentiality in the Standards of Practice distinguishes between consultation and supervision in the area of sharing client information, when it notes that "in consultation, clients are not identified."[20]

### Supervision — Providing Supervision

Clinical supervision requires specialized skills that do not evolve automatically from direct practice. Although the College does not define specific qualifications or experience required for members who provide clinical supervision, members are again reminded that Principle II: Competence and Integrity requires members to practice within their competence and their professional scope of practice.[21] Members who wish to provide clinical supervision should therefore explore opportunities to develop their supervisory skills, whether through additional

formalized training, supervision of their supervision, or mentorship. Members would also be wise to consider whether they have the cumulative experience in performing the controlled act of psychotherapy (which would include formal education, ongoing training, and supervised practice) as well as the specific experience and expertise in the setting in question, and with the client population served, to provide competent clinical supervision.

Supervisors affect the quality of psychotherapy services provided to clients through their influence on supervisees. They therefore share responsibility for the services provided and could be held accountable for inadequate supervision when a supervisee's conduct is in question.[22] In relation to such accountability, members should be aware that the Professional Misconduct Regulation, O. Reg. 384/00 made under the SWSSWA defines as an act of professional misconduct "failing to supervise adequately a person who is under the professional responsibility of the member and who is providing a social work service or a social service work service."[23] Thus, in addition to ensuring that they are competent to supervise members in the performance of the controlled act of psychotherapy, members should ensure that they make sound decisions about the amount of time and the structure required to provide adequate supervision to members with various levels of expertise and training.[24] When providing supervision in a group format, members should ensure that the size and duration of the group are conducive to participation by all supervisees.[25]

## 3. CONTINUING COMPETENCE

Formal education, experience and ongoing supervision are not the only factors which contribute to competent performance of the controlled act of psychotherapy. Members are required by the Registration Regulation, O. Reg. 383/00 made under the SWSSWA to provide evidence of their continuing competence to practise social work/social service work in accordance with the guidelines approved by Council and published and distributed to members.[26] All members of the College are required to participate in the Continuing Competence Program (CCP), a flexible, adult-education model which was launched by the College in 2009. Members must, at any time required by the College, provide evidence satisfactory to the College that they have completed the CCP. It is expected that members who perform the controlled act of psychotherapy ensure an appropriate emphasis on increasing their psychotherapy knowledge and skills in their CCP goals and learning activities.

While learning activities in the CCP could include reading or online learning, as well as brief workshops, members who perform the controlled act of psychotherapy are strongly encouraged to regularly include at least some more intensive, face-to-face training in their overall Professional Development Plan. While members might typically engage in numerous workshops in a given year, it is advisable for members to engage also in more intensive training, such as certificate programs (which would involve a series of courses or workshops), externships, and in-depth courses. A sound, psychotherapeutic knowledge base is made up of both theory and practice, and at least some of a member's learning activities should include opportunities for direct practice and/or direct observation of practice, or opportunities to observe interventions

conducted by others. Because technology has such a significant impact on practice, members should ensure that they are technologically competent. Their CCP self-assessment and learning goals should reflect this requirement.

Just as the need for supervision does not end, so, too, is lifelong learning through the CCP a requirement for experienced as well as less-seasoned members. Experienced members may tailor their learning activities to reflect their years of experience; however they have an ongoing professional obligation to ensure that they remain current in treatment modalities and approaches.

**FOOTNOTES**

9. American Board of Examiners in Clinical Social Work "Professional Development and Practice Competencies in Clinical Social Work: A Position Statement of the American Board of Examiners in Clinical Social Work" March, 2002, http://www.abecsw.org Web. April 30, 2012. p. 4
10. One example of this might be a member who completes a Masters of Education in counselling, as well as a diploma in social service work.
11. Code of Ethics and Standards of Practice, Second Edition, 2008, Principle VII, Advertising, interpretation 7.3.1
12. The first two to three years, or 2000–3000 hours of practice, are an essential training period, during which the member requires more intensive, close and frequent supervision. Similar standards are set for social workers in other jurisdictions, including, for example, the clinical specialty certificate, British Columbia College of Social Workers http://www.bccollegeofsocialworkers.ca.
13. Stovel, Laura and Paul Ian Steinberg "Learning Within Psychotherapy Supervision" in Smith College Studies in Social Work, Vol. 78(2-3), 2008. Print. p. 321
14. Dill, Katharine and Marion Bogo "Moving Beyond the Administrative: Supervisors' Perspectives on Clinical Supervision in Child Welfare" in Journal of Public Child Welfare, Vol. 3, 2009, Print. p. 88–89
15. Dill and Bogo, p. 88
16. Barker defines consultation as a problem-solving process which occurs on an ad hoc or temporary basis and has a specific goal and focus. The consultant has no special administrative authority over those to whom consultation is provided. Supervision, on the other hand, is relatively continuous and encompasses many areas of concern. It is both an administrative and educational process which focuses on enhancing skills, improving staff morale and providing quality assurance for clients. Barker, Robert L.: The Social Work Dictionary, 4th Edition, Washington: NASW Press, 1999.
17. Code of Ethics and Standards of Practice, Second Edition, 2008, Principle II, Competence and Integrity, interpretation 2.1.5
18. Shulman, L. The skills of helping individuals, families, groups and communities (5th edition), Belmont, CA: Thomson Brooks/Cole, 2006, cited in Mizrahi, Terry and Larry E. Davis, editors, The Encyclopedia of Social Work, Online Version, Oxford University Press, 2012
19. Code of Ethics and Standards of Practice, Second Edition, 2008, Principle V, Confidentiality, interpretation 5.4
20. Code of Ethics and Standards of Practice, Second Edition, 2008, Principle V, Confidentiality, interpretation 5.8
21. Code of Ethics and Standards of Practice, Second Edition, 2008, Principle II, Competence and Integrity, interpretation 2.1.1
22. National Association of Social Workers "Supervision and the Clinical Social Worker", Practice Update, Volume 3, Number 2, June 2003, Web. 10 January 2012
23. S. 2.4, O. Reg. 384/00 (Professional Misconduct) made under the Social Work and Social Service Work Act, 1998 www.e-laws.gov.on.ca Web
24. They should also obtain suitable professional liability insurance, a point that will be covered later in these Practice Guidelines.
25. New York State Office of the Professions, NYS Social Work, Practice Guidelines: Using and Providing Supervision www.op.nysed.gov/prof/sw/swsupervision.htm Online. May 11, 2012

26. S. 6.3, O. Reg. 383/00 (Registration) made under the Social Work and Social Service Work Act, 1998 www.e-laws.gov.on.ca Web

# Issues Requiring Special Consideration

Formal education, experience, supervision and continuing competence are essential elements in the competent performance of the controlled act of psychotherapy. However, this section addresses other themes and issues about which members who perform this controlled act should be aware. Members should be familiar with all eight principles in the Code of Ethics and Standards of Practice Handbook, 2nd Edition, as all are relevant to performing the controlled act of psychotherapy. This section of the Practice Guidelines for Performing the Controlled Act of Psychotherapy addresses issues of boundaries and sexual misconduct, termination, consent and confidentiality, professional liability insurance, and emphasizes some of the Standards of Practice that are of heightened relevance.

## 1. BOUNDARIES AND SEXUAL MISCONDUCT

Members are in a position of power and responsibility with clients.[27] All clients, including those receiving psychotherapy services, must be "protected from abuse of such power during and after the provision of professional services.[28] Therefore, members who perform the controlled act of psychotherapy must take great care to "establish and maintain clear and appropriate boundaries … for the protection of clients. Boundary violations include sexual misconduct and other misuse and abuse of the member's power. Non-sexual boundary violations may include emotional, physical, social and financial violations."[29]

While not all boundary issues pose a risk of harm, provided that they are appropriately handled, the high risk of boundary violations requires that members exercise great caution, and go through a careful process of decision-making, including consultation and reflection, when confronted with boundary issues of any kind.[30] The Standards of Practice require that members "do not engage in professional relationships that constitute a conflict of interest or … situations in which … (they) ought reasonably to have known that the client would be at risk in any way". They must not "provide a professional service to the client while … in a conflict of interest". This is achieved by "evaluating professional relationships and other situations involving clients or former clients for potential conflicts of interest and seeking consultation to assist in identifying and dealing with such potential conflicts of interest", "avoiding conflicts of interest and/or dual relationships with clients or former clients … that could impair members' professional judgement or increase the risk of exploitation or harm to clients" and "if a conflict of interest situation does arise, declaring the conflict of interest and taking appropriate steps to address it and to eliminate the conflict."[31]

Boundary crossings in the therapeutic relationship include but are not limited to dual relationships, self-disclosure, touch, location and timing of sessions, fees, and giving and receiving gifts.[32] Members' views about, and approaches to, some boundary issues will be influenced to some degree by their therapeutic orientation and by the client's culture.[33] At times, members' professional competence may be impaired by personal issues such as personal stress or burnout. This impairment could lead to blurred boundaries and boundary violations resulting from decreased objectivity and judgment, and gratification of their own needs (whether minor or more serious) at the expense of clients.[34]

It is the responsibility of members to be aware of when they are faced with a decision involving boundaries, to demonstrate that they have consulted appropriately, and to be able to articulate a sound rationale for how they have approached the situation. Any departure from accepted standards in the field should be approached with extreme caution. In some instances, in order to ensure that they are "distinguish(ing) their needs and interests from those of their clients" and ensuring that "clients' needs and interests remain paramount,"[35] members may decide to seek personal therapy, increase their self-care and/or obtain further supervision.

Members should engage in a process of ethical decision-making when considering how to approach any boundary issues. This process should include:

- identifying that a dilemma/difficulty exists;
- informing clients that there is a dilemma;
- consulting with colleagues and supervisors, a lawyer or risk manager, as appropriate, the Professional Practice Department at the College and possibly others;
- reviewing relevant professional literature, policies, and the standards;
- designing a plan of action that addresses the boundary issues and protects clients to the greatest extent possible;
- documenting their decision and its outcome; and
- monitoring and evaluating the impact of their strategy/approach.[36]

The **use of technology**, such as e-mail, text messages, Facebook and other social media, raises a number of boundary issues which should be carefully considered by members who perform the controlled act of psychotherapy. Texting clients (even if the intent is to restrict the contact to the administrative details of the treatment, for example) could imply an informality and immediacy which could blur boundaries for clients. Responding to clients via e-mail outside the boundaries of regular office hours could create expectations of an immediate response to client communication on the part of the member, and could also imply a familiarity and informality which could create ambiguity around the boundaries of the therapeutic relationship. Accepting a friend request from a client on Facebook immediately puts a member into a dual relationship with its inherent risks, and is therefore strongly discouraged. Failing to use privacy settings could lead to unintended self-disclosure, which may reveal inappropriate information,

and will certainly have implications for the therapeutic relationship. Members performing the controlled act of psychotherapy must therefore be alert to the particular boundary issues posed by the use of technology.

Poor handling of boundaries may have a significant and lasting negative impact on the psychotherapy process, relationship and outcomes.[37] Sexual misconduct is the most serious and harmful of all boundary violations. Members are solely responsible for ensuring that sexual misconduct does not occur, and must avoid sexual intercourse and any other form of physical sexual relations with clients. "Touching, of a sexual nature …", and "behaviour or remarks of a sexual nature… other than behaviour or remarks of a clinical nature appropriate to the service provided" are forbidden.[38] Members must not "provide clinical services to individuals with whom they have had a prior relationship of a sexual nature" and sexual relationships between members and clients are prohibited.[39] Additionally, "sexual relations between College members and clients to whom the members have provided psychotherapy and/or counselling services are prohibited at any time following termination of the professional relationship" and members must not "engage in sexual activities with clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to the client or when such activities would compromise the appropriate professional boundaries between the member and the client."[40] If a member "develops sexual feelings toward a client," it is the member's obligation to seek supervision and develop an appropriate plan to ensure that the client is not harmed.[41]

In short, the onus is on members who perform the controlled act of psychotherapy to ensure that they do not harm clients by violating boundaries, sexual or otherwise. It is members' professional responsibility to address these and other ethical issues by familiarizing themselves with current and relevant literature, obtaining appropriate supervision and consultation (not only when ethical and/or clinical issues arise, but on an ongoing basis), and ensuring that they are knowledgeable about the Standards of Practice. Clear roles when the controlled act of psychotherapy is performed are of pivotal importance in the psychotherapy process, and clear boundaries "provide a foundation for … (the therapy) relationship by fostering a sense of safety and the belief that the clinician will always act in the client's best interest."[42]

## 2. INFORMED CONSENT AND CONFIDENTIALITY

Members who perform the controlled act of psychotherapy must ensure that they "provide clients with accurate and complete information regarding the extent, nature, and limitations" of psychotherapy services, and "inform clients of foreseeable risks as well as rights, opportunities, and obligations associated with the provision of professional services."[43] **Informed consent** to psychotherapy services is a critical aspect of ethical practice, and the basis of a sound therapeutic relationship.[44] Informed consent ensures that clients and members participate together in setting and evaluating goals, and share a common purpose.[45] It also promotes clients' right to self-determination and autonomy,[46] and increases their ownership over the psychotherapy process.[47] While it is good practice for members to obtain written consent regarding the parameters of psychotherapy treatment, informed consent is not obtained solely through the use of a written form, nor is it a one-time, all-or-nothing event.[48] Rather, it is a process which

must take into account factors such as clients' capacity to consent, the timing of their consent, the nature of the psychotherapeutic approach, the anticipated course of the therapy, fees, and other administrative arrangements. Members should not assume that their clients have experience with psychotherapy. In addition to administrative details (including the parameters of the sessions), members should take care to explain their therapeutic orientation, the objectives of the approach that they are using, and the nature of their interventions. Informed consent is an ongoing requirement as the relationship and therapeutic process mature.

Members must be familiar with current legislation governing their practice,[49] in order to determine first whether formal consent is required to provide services, and secondly from whom such consent should be obtained. Members performing the controlled act of psychotherapy with children and youth should be familiar with the College's Practice Guidelines on Consent and Confidentiality with Children and Youth,[50] should consult with a colleague and/or supervisor, and should seek legal advice in any circumstances in which they are uncertain about their obligations. When practising with minors or with incompetent adults for whom a parent, legally appointed guardian, or substitute decision-maker must make treatment decisions, members should nevertheless ensure that clients are given an appropriate explanation of services, that their clients' preferences and best interests are considered, and that they seek agreement from clients regarding the treatment.[51]

**Confidentiality and consent to the disclosure of information** are also critical for the protection of clients seeking psychotherapy services. Members performing the controlled act of psychotherapy must "respect the privacy of clients by holding in strict confidence all information about clients and by complying with any applicable privacy and other legislation. (They may) …disclose such information only when required or allowed by law to do so or when clients have consented to disclosure.[52] The Standards of Practice also require that members "comply with any applicable privacy and other legislation… (and) obtain consent to the collection, use or disclosure of client information including personal information, unless otherwise permitted or required by law.[53] Members must also "inform clients early in their relationship of the limits of confidentiality of information … (and) respect their clients' right to withhold or withdraw consent to, or place conditions on, the disclosure of their information."[54] As with consent to psychotherapy services, members must make every effort to ensure that their clients understand the limits of confidentiality; a consent form, while necessary in most circumstances, is not necessarily sufficient on its own. When seeing legally-dependent clients or more than one client together (e.g. couples, families or groups) members should clarify how each individual's confidentiality will be maintained, and how, in fact, in some circumstances it cannot be maintained.[55]

By seeking clients' informed consent and ensuring that they understand the limits of confidentiality, members performing the controlled act of psychotherapy demonstrate not only their respect for clients' autonomy and self-determination, but also strengthen the therapeutic relationship and enhance clinical outcomes.[56]

## 3. PROFESSIONAL LIABILITY INSURANCE

Professional liability insurance protects both the public and members who perform the controlled act of psychotherapy. Unlike general liability insurance, professional liability insurance coverage focuses on an alleged failure by the member to perform to an acceptable standard in the service provided, or for actions taken or not taken that have resulted in harm or loss to the client, whether intentional or not. In the event of a successful civil suit, professional liability insurance may ensure that clients are able to recover the costs of litigation as well as monetary compensation for the harm they have suffered. Professional liability coverage may also be something that clients assume or expect members to have in place, as it is required for regulated professions under the RHPA.[57]

Professional liability insurance may protect members from bearing the full cost of legal expenses associated with defending against a claim made by a client, and damages awarded in a civil proceeding. Certain policies providing coverage for professional liability may also protect members from bearing the full cost of defending against a complaint made by a client to the College.

Given that performing the controlled act of psychotherapy poses a heightened risk to the public, it is strongly recommended that all members who perform the controlled act of psychotherapy obtain adequate professional liability insurance. As discussed earlier, members who provide supervision for members performing the controlled act of psychotherapy may be seen to bear professional responsibility for those performing the controlled act of psychotherapy under their supervision, and should therefore ensure that they are adequately covered for this activity as well. Because coverage can vary, members should carefully review their professional liability insurance coverage (whether provided through their employer or obtained independently) to ensure that they understand the nature and extent of the coverage.

### FOOTNOTES

27. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle II, Competence and Integrity, interpretation 2.2
28. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle II, Competence and Integrity, interpretation 2.2
29. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle II, Competence and Integrity, interpretation 2.2. Members may also wish to review Reamer, Frederic G. "Boundary Issues in Social Work: Managing Dual Relationships" in **Social Work,** Volume 48, Number 1, January 2003. Print. p. 121
30. Pope, Kenneth S and Patricia Keith-Spiegel "A Practical Approach to Boundaries in Psychotherapy: Making Decisions, Bypassing Blunders, and Mending Fences" in **Journal of Clinical Psychology: In Session,** Vol. 64 (5), 2008. Print. p. 642
31. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle II, Competence and Integrity, interpretation 2.2.1. Footnotes 6 and 7 in Principle II define "conflict of interest" and "dual relationship" respectively.
32. Barnett, Jeffrey E. "Psychotherapist Self-Disclosure: Ethical and Clinical Considerations" in **Psychotherapy** Vol. 48, 2011. Print. p. 320
33. Barnett, p. 316
34. Ibid, p. 320

35. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle I: Relationship with Clients, interpretation 1.6
36. Reamer, p. 130
37. Barnett, p. 316
38. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle VIII, Sexual Misconduct, interpretations 8.1 and 8.2 and Principle II, Competence and Integrity, interpretation 2.2.2
39. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle VIII, Sexual Misconduct, interpretations 8.5 and 8.6
40. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle VIII, Sexual Misconduct, interpretations 8.7 and 8.9
41. **Code of Ethics and Standards of Practice,** Second Edition 2008, Principle VIII, Sexual Misconduct, interpretation 8.3
42. Smith, D. and M. Fitzpatrick "Patient-centred boundary issues: An integrative review of theory and research" in **Professional Psychology: Research and Practice,** 26,1995, quoted in Barnett, p. 317
43. **Code of Ethics and Standards of Practice,** Second Edition 2008, Principle III, Responsibility to Clients, interpretations 3.1 and 3.6
44. Fisher, Celia B. and Matthew Oransky "Informed Consent to Psychotherapy: Protecting the Dignity and Respecting the Autonomy of Patients" in **Journal of Clinical Psychology: In Session,** Vol. 64 (5), 2008. Print. p. 576
45. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle I, Relationship with Clients, interpretation 1.1
46. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle I, Relationship with Clients, interpretation 1.3
47. Fisher and Oransky, p. 576
48. Ibid, p. 577
49. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle II, Competence and Integrity, interpretation 2.1.3
50. OCSWSSW, **Practice Guidelines on Consent and Confidentiality with Children and Youth,** Sept. 1, 2009
51. Fisher and Oransky, p. 578
52. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle V, Confidentiality
53. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle V, Confidentiality, interpretation 5.1
54. **Code of Ethics and Standards of Practice,** Second Edition, 2008, Principle V, Confidentiality, interpretation 5.4
55. New York State Office of the Professions, **Social Work Practice Guidelines: Maintaining Confidentiality** www.op.nysed.gov/prof/sw/swconfidential Online. May 13, 2012
56. Fisher and Oransky, p. 587
57. Amendments to the RHPA concerning liability insurance are not yet in force, however liability insurance is currently a registration requirement for members of many RHPA colleges.

# Conclusion

These Practice Guidelines have addressed critical elements in the competent and ethical practice of the controlled act of psychotherapy: education and experience; supervision; and continuing competence. They have also addressed boundaries and sexual misconduct, informed consent and confidentiality, and professional liability insurance. Members are advised to complete the checklist in Section D after reviewing the Practice Guidelines in their entirety, to ensure that they have made sound decisions regarding their readiness to perform the controlled act of psychotherapy competently.

# Checklist

## AM I PREPARED TO PERFORM THE CONTROLLED ACT OF PSYCHOTHERAPY?

In order to determine whether they are prepared to perform the Controlled Act of Psychotherapy, members are advised to seek input/consultation from supervisors and/or others familiar with their practice when completing the checklist below.

In addition to my degree in social work/ diploma in social service work, I have:

- a further degree or diploma with a clinical focus; and/or a certificate, or equivalent, from a program with a focus on performing the controlled act of psychotherapy; and
- post –degree/diploma experience in performing the controlled act of psychotherapy (2–3 years; 2000-3000 hours of supervised experience in performing the controlled act of psychotherapy).

My coursework and practica had a clinical focus.

I have engaged in a period of extensive clinical supervision with an experienced supervisor following the completion of my degree/diploma.

I continue to obtain regular supervision (individual, group, peer) appropriate to my level of experience related to performing the controlled act of psychotherapy.

My goals in the Continuing Competence Program are heavily weighted toward performing the controlled act of psychotherapy.

I am aware of confidentiality and boundary issues, including those raised by the use of technology, and have considered the impact of any technology I am using in my practice.

My learning activities include experiential learning and opportunities to practise and/or observe clinical interventions.

At least some of my ongoing training is more intensive (certificate programs, externships, in-depth courses).

I have reviewed, considered and understand the issues raised in the **Boundaries and Sexual Misconduct** section of the Practice Guidelines for Performing the Controlled Act of Psychotherapy.

I have reviewed, considered and understand the issues raised in the Informed Consent and Confidentiality section of the Practice Guidelines for Performing the Controlled Act of Psychotherapy.

I have reviewed the Standards of Practice in their entirety, and have considered the standards and interpretations relevant to performing the controlled act of psychotherapy.

I have taken steps to ensure that I am adequately covered by professional liability insurance.

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