Ontario College of Social Workers and Social Service Workers

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

Discipline Decision Summary

This summary of the Discipline Committee's Decision and Reason for Decision is published pursuant to the Discipline Committee's penalty order.

By publishing this summary, the College endeavours to:

- illustrate for social workers, social service workers and members of the public, what does or does not constitute professional misconduct;
- provide social workers and social service workers with direction about the College's standards of practice and professional behaviour, to be applied in future, should they find themselves in similar circumstances;
- implement the Discipline Committee's decision; and
- provide social workers, social service workers and members of the public with an understanding to the College's discipline process.

PROFESSIONAL MISCONDUCT
Member, RSW
August 4, 2011

Agreed Statement of Fact
The College and the Member submitted a written statement to the Discipline Committee in which the following facts were agreed:

1. The Member was employed as a community social worker in an intensive hospital program for individuals with serious mental illness, concurrent substance abuse issues, homelessness and other health issues. The Member's role included providing social work services to clients including home visits, coordinating services and liaising with the Member's team leader regarding client care.
2. The hospital terminated the Member's employment due to the following seven incidents which occurred over an approximate 6-month period of time:
    i. The Member arranged for a client's move from a homeless shelter to a boarding home on a Friday before a long weekend. The client was known to have serious mental illness, to require significant assistance with activities of daily living and had a history of homelessness. When the Member and the client arrived at the boarding home on the Friday afternoon, the keys to the client's room were not available. The boarding home staff let the client into the room and the Member and the client moved the client's belongings into the room. After communicating with the Housing Operator, the Member informed the client that a key would be

brought to the room and asked the client to wait for the key in the room. The Member left the boarding home before the client received the key. The Member did not follow up with the client to ensure the client received a key in the afternoon or over the long weekend. The client never received a key to the room. On the Sunday of the long weekend, the client was found sleeping in a park.

ii. The Member arranged for a "high risk client" to move from high support housing to low support housing but failed to organize adequate resources to prevent crisis after the move. Although the Member arranged for nursing visits over the weekend, those nursing visits never occurred. The client failed to take medications over the weekend, and was found in a dishevelled state, dehydrated and exhibiting signs of amplified psychosis. The client was subsequently admitted to the hospital.

iii. During a supervision session, the Member reported that the Member had not visited a client during the previous four month period, but had maintained weekly telephone contact with the client. The Member's clinical notes did not reflect any contact with the client in the previous four month period. The Member's explanation for not visiting the client was that another service provider, a nurse from another agency, had suggested that the Member not visit with the client for a while. The Member presumed that the other service provider was monitoring the client. The Member did not follow up with the other service provider, nor did the Member discuss concerns regarding the client with the Member's team leader, even though the Member was aware that during the preceding four months, the client had not been involved with the other agency. The client, at the clients' request, was ultimately discharged from the program.

Subsequently, in correspondence with the team leader, the client complained of feeling very dissatisfied with the Member and feeling anxious and upset after each visit. The client explained that the Member did not listen to the client, did not seem to know how to work with a person with a mental illness, and that the client was treated as if the client was not human. The client reported that after the Members visits, the client was sick for hours and the Member made the client upset and angry. The client added that even when the client told the Member how the client felt about the Member's conduct, the Member continued with the same attitude until the client told the Member not to come back. When the Member was confronted about the client's comments, the Member shifted the blame for the breakdown of the relationship to the client. According to the Member, the Member and the client had a very difficult relationship.

iv. A winter outing was planned at a park for program clients. Although the Member told his team leader he could not accompany his clients, the Member subsequently left the team leader a message stating that the Member planned to drop a client off at a specified time, believing that event staff would be there to supervise. The message concerned the team leader as it was a cold winter day, the client was elderly with severe mobility problems, the drop off time was prior to the arrival of the rest of the team and there would be no one there to supervise the client until the others arrived.

v. During a team meeting, the Member presented a service plan for a client. The client had informed the Member that the client did not want the Member to speak to the client's housing workers. Despite the client's request, the Member was adamant that it was necessary to speak to the housing workers, in the absence of the client, to keep them informed of the client's condition in case of crisis. When the team leader explored with the Member why the Member would pursue discussions with the housing worker without the client's consent, the Member explained that the client was not capable of giving consent as the client heard voices. As there was no evidence that a capacity assessment had been performed, the team leader inquired about the Member's rationale for speaking to the housing workers. The Member explained that the client had given him permission to speak with housing staff before, notwithstanding the client's right to revoke consent pursuant to privacy legislation. The team leader subsequently questioned the Member regarding his understanding of issues surrounding capacity at which time the Member became angry and raised his voice, displaying defensive and argumentative behaviour and making it difficult to provide the necessary teaching and supervision.

vi. The team leader accompanied the Member on a visit with a client as the Member had previously reported that the client was not engaging well with service. During the visit, the client expressed distress regarding auditory hallucinations affecting the client's mood and ability to function on a daily basis. The Member appeared not to listen accurately to the client's words and responded with a question about where the client's child sleeps when the child visits the client. The client appeared surprised by the sudden change in topic.

The team leader observed that the client appeared down and expressed disappointment about the client's current life. Despite these observations, the Member did not explore the client's feelings, coping skills, or strengths, and failed to provide any form of supportive counselling. The Member did not complete a mental status assessment or risk assessment when the client began to describe signs of psychosis, low mood and disappointment with the client's life. When the team leader asked the Member why the Member did not pursue these matters with the client, the Member responded that when the Member asked the client how the client was doing, the client said "OK".

Documentary evidence indicated that the Member did not make an entry into the client file for the visit.

vii. The Member had a history of meeting with a client about three times each week, during which time the Member identified that the client had self-harm issues and had developed a crisis plan to address the concern.

The team leader accompanied the Member on a visit with the client. During the visit, the client appeared distressed, stating the client had been experiencing flashbacks of past sexual abuse, and that the client had called several crisis numbers and had visited the ER of the client's local hospital several times in recent days. The client added that the client had recently moved and had lost some

of the client's supports, and discussed a past history of substance abuse. The Member did not complete a mental status assessment of the client, did not ask about suicidal thoughts, or about triggers/temptations to use substances. The Member did not offer any counselling regarding the client's experience with flashbacks, nor did the Member explore how the client was coping with changes and stressors.

The team leader observed the Member interrupt the client several times and did not appear to listen to the client's statements, nor did the Member follow through on the client's comments. When the Member was asked why the Member did not perform a more in depth assessment of the client's mental status, the Member responded that the client has "a tendency to be needy and manipulative and to act like [the client] doesn't know how to do things, but [the client] does."

When the Member was asked why the Member did not ask the client about thoughts of self-harm when the client exhibited several risk factors, the Member stated that the client is not actively suicidal since the client does not have a plan. When the team leader asked how the Member could know this, as the Member had not performed an assessment, the Member replied that the client was not suicidal the other day.

Documentary evidence indicates that the Member did not make an entry into the client's file for that visit.

3. The Member acknowledged that, following the termination of his employment, while clearing his workspace, the hospital discovered in a personal locked cupboard a large volume of disorganized and damaged client consent forms that were signed, completed referral forms, income tax forms and receipts, as well as a variety of other client documents dating back over three years. Those client records were inaccessible to other members of the clinical team and mixed in with the Member's personal belongings. The damage consisted of wrinkled forms, very frayed or torn edges, stains, and actual pieces of torn off documents. The volume of practice related documents was large enough to fill a banker's box.

   Review of the damaged documents revealed that the Member had clients sign blank consent forms without specifying to whom the forms would be sent or for what use they would be put.

Allegations and Plea

The Discipline Committee accepted the Member's plea, admitting the truth of the facts set out in the Agreed Statement of Fact and that the Member was guilty of professional misconduct within the meaning of subsections 26(2) (a) and (c) of the SWSSWA, in that the Member violated section 2.2 of Ontario Regulation 384/00 (Professional Misconduct) and the following Principles and Interpretations of the First Edition of the College's Standards of Practice:

(i) Principle I (commented on in Interpretations 1.2, 1.4, 1.5 and 1.7), by failing to observe, clarify and inquire about information presented to the Member by clients, failing to demonstrate an acceptance of each client's uniqueness, failing to maintain an awareness of the Member's values, attitudes and needs as well as the purpose, mandate and function of the Member's employer and how those impact on and limit the Member's professional relationships with clients;

(ii) Principle II (commented on in Interpretations 2.1.5 and 2.2.8) by failing to engage in the process of self review and evaluation of the Member's practice, failing to seek consultation when appropriate, and by engaging in conduct which could reasonably be perceived as reflecting negatively on the professions of social work or social service work.

(iii) Principle III (commented on in Interpretation 3.2) by failing to deliver client services and respond to client queries, concerns or complaints in a timely and reasonable manner; and

(iv) Principle IV (commented on in Interpretations 4.1.1, 4.2.1, and 4.2.2) by failing to record information relevant to the services provided and in conformance with accepted service or intervention standards and protocols, failing to record information in a format that facilitates the monitoring and evaluation of the effects of the service/intervention, failing to comply with the requirements regarding record retention, storage, preservation and security set out in applicable privacy and other legislation, failing to acquire and maintain a thorough understanding of the Member's employer's policies with regard to the retention, storage, preservation and security of records and failing to take necessary steps to protect the confidentiality and security of paper records, faxes, electronic records and other communications.

Penalty Order

The panel of the Discipline Committee accepted the Joint Submission as to Penalty submitted by the College and the Member and made an order in accordance with the terms of the Joint Submission as to Penalty. The panel concluded that the proposed penalty was reasonable, in the public interest, addresses the circumstances of the serious acts of professional misconduct engaged in by the Member, and sends an appropriate message to the Member, the membership and the public that the profession will not tolerate this type of conduct. The Committee noted that the proposed penalty also reflects that the Member cooperated with the College and that by agreeing to the facts and proposed penalty, the Member has accepted responsibility for the Member's actions. The Committee found the Member to be very remorseful for the Member's conduct and willing to continue with counselling and continuing education.

The panel ordered that:

1. The Member be reprimanded and the reprimand be recorded on the Register.
2. The Registrar is directed to suspend the Member's Certificate of Registration for a period of 24 months, which suspension shall be suspended and shall not be imposed if the Member provides evidence, satisfactory to the Registrar of the College, of compliance with the terms and conditions imposed on the Member's Certificate of Registration, pursuant to paragraph 3 hereafter.

3. The Registrar is directed to impose a term, condition and limitation on the Member's Certificate of Registration, to be recorded on the Register.
    a. Requiring the Member to receive supervision of the Member's social work practice (including the Member's practice as an employee, if any, and the Member's private practice, if any) for a period of 2 years from the date of the Discipline Committee's Order herein from such person or persons as may be approved, in advance, by the Registrar of the College (hereinafter referred to as "supervisor(s)"). If the Member is employed during the 2 year period, the supervisor must be employed within the same organization and be a health care professional approved by the Registrar of the College. The Member is not to practice social work until obtaining approval from the College of' one or more named supervisor(s). The Member shall provide to the supervisor(s) complete access to all of the Member's files for review. The supervisor(s) shall make quarterly written reports to the Registrar of the College (or reports at such lesser frequency as the Registrar may from time to time determine) as to the substance of that supervision and the progress of the Member. Any fees associated with the Member's supervision shall be paid at the expense of the Member;
    b. Requiring the Member, at the Member's own expense, to participate in and successfully complete social work training and/or continuing education with respect to (1) ethical decision making, (2) interviewing, assessment and goal setting, and (3) clinical documentation and file management as prescribed by and acceptable to the College and provide proof of such completion to the Registrar within two (2) years from the date of the Order. The approved training shall be reviewed by the Member's Supervisor to ensure that the Member integrates the training into his practice. The progress of the Member with respect to the training will be reported to the College in the Supervisor reports; and
    c. Requiring the Member, for a period of two years following the Member's receipt of the Discipline Committee's Decision and Reasons in this matter, should the Member currently be employed (or should the Member obtain any future or other employment) in a position in which the Member's duties include the provision of social work services, to immediately provide the Member's current, future and/or other employer(s) with a copy of the Decision and Reasons, and to forthwith thereafter deliver any such employer's written confirmation of receipt of a copy of the Decisions and Reasons to the Registrar of the College;
    d. Requiring the Member, for a period of two years following receipt of the Discipline Committee's Decision and Reasons in this matter to alert the Registrar of any change to employment status where the Member's duties include the provision of social work services. This notice requirement also applies should the Member become self-employed. The notice must be received by the Registrar prior to commencing with any new employment;
    e. Prohibiting the Member from applying under Section 29 of the Social Work and Social Service Work Act, 1998, S.O. 1998, Ch. 31, as amended, for the removal or modification of the terms, conditions or limitations imposed on the Member's Certificate of Registration for a period of two (2) years from the date on which those terms, conditions and limitations are recorded on the Register.

4. The Discipline Committee's finding and Order (or a summary thereof) be published, with identifying information removed, in the College's official publication on the College's website, and the results of the hearing be recorded on the Register.