Clinical Psychologist, Ms B

A District Health Board

A Report by the

Health and Disability Commissioner

(Case 05HDC16909)

Parties involved

Mr A	Consumer
Ms B	Provider/Clinical psychologist
Ms C	Clinical psychologist
Ms D	Clinical psychologist
Mr E	Senior clinical psychologist
Dr F	Psychiatry registrar
District Health Board 1	Provider/District Health Board
District Health Board 2	Complainant/District Health Board

Complaint

On 18 November 2005, the Commissioner received a complaint from a District Health Board (DHB2), about the services provided by clinical psychologist Ms B to her ex-client Mr A. The issues identified for investigation were:

- *The appropriateness of the care and treatment Ms B provided to Mr A from January through May 2005.*

- *The appropriateness of Ms B's relationship with Mr A from January 2005 to the present date.*

- *The appropriateness of the care and treatment provided by District Health Board 1 (DHB1) to Mr A from January through May 2005.*

An investigation was commenced on 12 April 2006.

Information reviewed

Information from:

- Mr A
- Ms B
- DHB1
- Mr A's clinical records from DHB2
- Mr A's clinical records from DHB1

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The following responses to my provisional opinion were received:

- Mr A, on 31 October, 3 and 6 November 2006
- Ms B, on 2 November 2006
- Ms C and Ms D, mental health services at DHB2, on 9 November 2006.

Information gathered during investigation

Care in City 1
On 10 December 2004, Mr A, aged 23, was admitted to the psychiatric inpatient unit at DHB1. The medical admission record states:

> "23 year old man [with] first presentation of mania. Recently started work [at] his 'dream job' in [city 1]. Staff became concerned — seen by [mental health services in City 2] … had bloods taken. … Overall assessment = Mania."

The nursing admission record describes Mr A as being very agitated and an "immediate risk of harm to self or others". Mr A was prescribed sedation (olanzapine) and placed in seclusion.

Over the next few days, Mr A became more settled, and on 15 December was described as "drowsy and sedated", and a "low safety risk". Eventually, it was decided that Mr A could go home overnight on a regular basis. This plan worked well and, on 29 December, Mr A went home to his parents with the intention of returning to the ward on 7 January 2005. However, Mr A became increasingly agitated, and was readmitted on 4 January with a recurrence of mania.

Over the next two weeks, Mr A remained an inpatient, under regular observation, as he was considered a potential risk of harm to himself and to others.

On 17 January 2005, Mr A was first reviewed by clinical psychologist Ms B. She summarised her first assessment:

> "[Mr A] appeared slightly pressured, neat in appearance, very tearful, quite childlike at times, very emotional."

From 18 January to 8 February, Ms B assessed Mr A in person 10 times. During this time, she became attracted to Mr A. She discussed this matter with her clinical supervisor, senior clinical psychologist Mr E. He stated:

> "The question of maintaining boundaries, focusing on the patient's needs, seeking personal support to address her own issues, and keeping herself safe, was frankly discussed within supervision. [Ms B] demonstrated openness and maturity in these

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matters, being very aware of the need to act professionally and in the best interest of her patient.

…

Given [Ms B's] candour and insight into the complexities of the professional and personal matters raised at the time, I considered she was thinking and acting thoughtfully and sensibly. From the information provided to me, at no time throughout this period of supervision, did I consider she was acting unethically, or was putting herself or her patient at risk."

Mr A, meanwhile, was not aware of any attraction that Ms B felt towards him, and thought of her purely as his psychologist during this time. He added that he was so sedated at this stage of his treatment that he would not have been interested in an intimate relationship.

On 10 February, a meeting was held between Mr A, his parents, and members of his clinical team. A decision was made to discharge him home under the care of mental health services at DHB1.

From 16 February to 4 May, Mr A attended 10 reviews as an outpatient. Ms B remained involved in Mr A's care and attended consultations between Mr A and a consultant psychiatrist on 21 February 2005, 2 March 2005 and 21 April 2005. During the last appointment on 4 May 2005, the consultant psychiatrist noted that Mr A was "having regular input from [Ms B] (Clinical Psychologist)" and recorded:

"I saw [Mr A] today. … His mood, sleep and appetite are normal. There is no indication of any affective symptoms. He is ready to return back to [City 2] on Saturday 7th May and start work on Monday 9th May. There are no safety issues. He is looking positive towards the future. He is realistic about his illness and the need for medication. He is accepting of further support and follow-up from [the mental health services at DHB2]. ... We have wished him well for the future and formally discharged him from the service."

Relocation to City 2
Ms B stated:

"One week after [Mr A] moved to [City 2], I phoned him at his work to find out if he was coping. I rationalised this to myself by thinking that supporting him was not unethical. He reported that he was struggling to adjust to work and his new accommodation. I started phoning him at least 3 times a week at his home. The focus of these calls was on supporting him. I did not report this to my supervisor but continued [to] rationalise my actions as 'only supportive' and therefore ethical."

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On 10 May 2005, Ms C, a clinical psychologist at DHB2, telephoned Ms B to discuss the therapy Mr A received in City 1. Ms B informed Ms C that she saw Mr A at least once a week between 17 January and 8 February 2005, and a cognitive behavioural approach was primarily used during the sessions. In addition to follow-up care, Ms B recommended that DHB2 provide psychotherapy to Mr A.

In July 2005, for personal and professional reasons, Ms B moved to the City 2 and commenced a job as a senior psychologist. On 9 July, she moved to a boarding house. Ms B stated:

> "I secured my accommodation five weeks prior to my relocation to [City 2]. [Mr A] was aware of this move. He initially planned to continue his current living arrangements with family friends. However, pressure was put on him to seek other accommodation due to their impending overseas holiday. Moreover he became increasingly frustrated with the physical distance of his … living place from work. When an advertisement appeared in the local paper for a room at my boarding house, we decided that moving in to the same boarding house would be supportive (for both of us) and physically convenient for him. He physically took possession of the room one week after I moved in."

On 22 August 2005, during a cognitive behaviour therapy (CBT) session, psychiatry registrar Dr F noted:

> "[Mr A's father] spoke with [Ms B, Mr A's flatmate]."

Ms B stated:

> "Our relationship remained 'supportive and friendly' until approximately [the] beginning of September when the nature of the relationship evolved into a sexual relationship. I did not discuss my concerns in supervision due to the frequent change of clinical supervisors (3 supervisors in 6 months) and my shame of what I had done."

On 3 October, Mr A spoke with Dr F, who noted:

> "[Mr A] discussed job and relationship with [Ms B] in some detail today."

On 17 October, at a further CBT session, Dr F noted:

> "[Mr A] brought in a travel itinerary for a [3 week trip overseas at] Xmas with [Ms B] and wanted advice on precautions/planning."

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On 25 October, Dr F noted:

> "[Mr A] questioned [about] relationship [with Ms B] after I noticed name on travel itinerary = same as that of his therapist last week and he confirmed [Ms B] was his therapist in [City 1].
>
> Session taken up [with] discussing potential boundary violation that we are bound to report by protocol and likely outcomes of a tribunal/committee review.
>
> …
>
> [Mr A's] parents know about relationship but no one else does."

On 15 November, Dr F, Ms C and Ms D co-signed a letter to the New Zealand's Psychologists' Board. The letter stated:

> "We have recently become aware of an ethical dilemma involving a clinical psychologist who is now in an intimate relationship with a former client (who now receives follow-up from our service). We are sufficiently concerned about the conduct of this psychologist to make a complaint to the New Zealand Psychologists' Board.
>
> …
>
> As part of [Mr A's] follow-up here at [DHB2], our client agreed to work with [Dr F] in a cognitive behavioural framework. [Dr F's] supervisor for this case is [Ms C] … During [Dr F's] work with our client, we gradually became aware that our client's new intimate relationship was with his former psychologist, [Ms B]. They live in separate flats in the same house, but the relationship is sexual. It has been reported that [Ms B's] former partner has also considered laying a complaint with the Board as well."

In accordance with section 64(1) of the Health Practitioners Competence Assurance Act 2003, the complaint was forwarded to the Commissioner.

Response to complaint

On 12 April 2006, Ms B was notified of this Office's investigation of her care of Mr A. In both her formal response to the complaint on 2 June 2006, and a subsequent interview on 11 August 2006, Ms B asserted that she had not contacted Mr A after his discharge from DHB1, and that his move into the same boarding house was "entirely coincidental". This was supported by Mr A in a separate interview. Thereafter, Mr A and Ms B were advised that copies of their telephone records for the period May to July 2005 might be formally requested in order to check whether there had been any contact between them. However, before this request could be formalised, Ms B wrote to this Office on 23 August 2006, stating:

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> "[In] the … interview dated 11 August 2006 and in my correspondence with [the HDC Investigator], I failed to tell the truth regarding my phone contact with [Mr A] after psychological treatment with him concluded. The sole reason for this was fear. I have been unable to access legal help via NZCCP[1] due to terminating my active registration with the Psychology Board and could not afford any other legal advice. [Mr A] was put in an untenable position by my distress and pleadings and was in a sense coerced to support my lies.
>
> …
>
> I apologise for my deceitful actions and want to reiterate that undue pressure was put on [Mr A] to do the same."

Other events
On 16 January 2006, Ms B advised the New Zealand Psychologists Board (the Board) that she intended to stop practising as a clinical psychologist from 1 February 2006, and requested that her name be removed from the register. In light of DHB2's complaint to the Board in November 2005 and the commencement of an investigation by this Office in April 2006, the Board advised Ms B that she would remain on the register as an "inactive" practitioner until the complaint was resolved.

Mr A continues to receive regular follow-up care from the mental health services at DHB2. Both he and Ms B have confirmed that they are still together in a personal relationship.

DHB1's guidelines
DHB1's guidelines on *Professional Boundaries* for mental health and intellectual disability services staff (in place at the time Ms B provided care to Mr A) state:

> "…
>
> - Staff have an ethical obligation to consumers, their family/whanau/carers and to their colleagues, and are to practise within their professional codes of practice within the [DHB] Code of Conduct.
>
> …
>
> - If it is necessary for staff to have a therapeutic relationship with an individual with whom there is a prior personal relationship, staff will discuss this in clinical supervision. In other instances where there is any concern or uncertainty with regard to professional boundaries, staff will use clinical supervision to discuss the issues.

[1] New Zealand College of Clinical Psychologists.

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- Developing friendships between staff and consumers is discouraged as this will compromise the therapeutic relationship.
- Sexual behaviour or sexual contact between staff and consumers … under their professional care is prohibited."

Responses to provisional opinion

Ms B
In response to my provisional opinion Ms B stated:

> "…
>
> I have not practised as a clinical psychologist since January 2006, and requested to be removed from the register as of the beginning of February 2006.
>
> I have no intention of practising as a clinical psychologist again, and am pursuing a new career.
>
> I have practised in an ethical manner since registering as a clinical psychologist in 1999. I commenced (and currently still receive) professional counselling in September 2006 to help me understand this uncharacteristic, unethical behaviour.
>
> On reflection, I feel that the term 'coerced' overstated my behaviour regarding [Mr A]. I was very distressed, and this distress influenced him.[2]
>
> I received no legal advice due to my financial situation."

Mr A and mental health services at DHB2
Both Mr A and the mental health service at DHB2 confirmed that the information gathered in my provisional opinion was accurate, and no amendments were necessary.

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[2] Ms B was contacted for clarification following receipt of her response. On 14 November 2006, Ms B clarified that she did not threaten Mr A to support her lies. Instead, her crying and emotional distress "influenced [Mr A] a lot", and "drove [Mr A] and her to take the wrong route" in relation to the information they provided this Office.

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Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

Right 2
Right to Freedom from Discrimination, Coercion, Harassment, and Exploitation

Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.

Right 4
Right to Services of an Appropriate Standard

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

Other relevant standards

The Code of Ethics for Psychologists Working In Aotearoa/New Zealand (2002):[3]

"**Principle 2**

Responsible caring
The practice of psychology promotes well-being. In pursuing this goal, psychologists demonstrate an active concern for the welfare of those with whom they work and acknowledge the social and institutional power that structures their role as psychologists. Psychologists have a primary responsibility to protect the welfare of those with whom they work.

…

[3] Prepared by the Code of Ethics Review Group, a joint working party of the New Zealand Psychological Society, the New Zealand College of Clinical Psychologists and the New Zealand Psychologists' Board.

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2.1.10. Sexual relationships with clients, supervisees and/or students are unethical. Psychologists do not encourage or engage in sexual intimacy, either during the time of that professional relationship, or for that period of time following during which the power relationship could be expected to influence personal decision making.

…

Principle 3

Integrity in Relationships
The relationships formed by psychologists in the course of their work embody explicit and mutual expectations of integrity that are vital to the advancement of social justice, scientific knowledge, and to the maintenance of public confidence in the discipline of psychology. Expectations of professional practice include: respect, accuracy and honesty; openness, maintenance of appropriate boundaries, and avoidance of conflicts of interest. Psychologists will seek to do right in their relations with others.

…

3.1 Honesty:
Psychologists recognise that integrity implies honesty in relationships. Honesty requires psychologists to be accurate, complete and comprehensible in all aspects of their work.

…

3.3.2 Psychologists maintain appropriate boundaries with those with whom they work and carefully consider their actions in order to maintain their role."

Opinion: Breach — Ms B

This report is the opinion of Rae Lamb, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

January to May 2005
Ms B provided clinical psychology services to Mr A between January and May 2005. When Ms B realised that she was developing an attraction to Mr A, she acted appropriately by raising the matter at clinical supervision in February 2006, and amended her care according to the advice from her supervisor. There is no evidence to

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suggest that the clinical care Ms B provided to Mr A from January to May 2005 was inappropriate or inadequate.

May 2005 to April 2006: Professional boundaries
As a client of Ms B, Mr A had the right to services that complied with legal, professional, ethical and other relevant standards in accordance with Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code). The standards applicable to this complaint are that of Principles 2 and 3 of the Code of Ethics for Psychologists Working In Aotearoa (2002) (the Code of Ethics).

In the context of a psychologist–client relationship, there is an inherent power imbalance between the psychologist and the client, as the client's emotional vulnerability is exposed during therapy. Accordingly, principle 3.3.2 of the Code of Ethics requires psychologists to "maintain appropriate boundaries with those with whom they work and carefully consider their actions in order to maintain their role". Principle 2.1.10 of the Code of Ethics also states:

> "Psychologists do not encourage or engage in sexual intimacy, either during the time of that professional relationship, or for that period of time following during which the power relationship could be expected to influence personal decision making."

Contrary to the provisions in the Code of Ethics, Ms B exceeded the boundaries of professional practice. Initially she took appropriate measures by discussing her attraction to Mr A during supervision. Thereafter, despite being cautioned to maintain professional boundaries by her supervisor, Mr E, Ms B acted on her feelings by pursuing a personal relationship with Mr A. Following her initial telephone call a week after his discharge from DHB1 in May 2005, Ms B contacted Mr A at least three times a week. When Ms B relocated in July 2005, she encouraged Mr A to move to the same boarding house as it would be supportive for them both. Both Ms B and Mr A confirmed that a sexual relationship commenced some time around September 2005.

In another case in 2003 (03HDC06499), the Commissioner considered a sexual relationship that developed between a counsellor and a client and noted:

> "The maintenance of professional boundaries is an integral part of counselling, a process that involves an intense therapeutic relationship where the client confides fears, feelings, emotional responses and vulnerabilities. The importance of maintaining professional boundaries in the counsellor/client relationship cannot be overemphasised. [Mr A], as a counsellor aware of the relevant ethical codes, could reasonably be expected to have recognised the need to maintain professional boundaries, and to be alert to situations where they were under threat and becoming blurred."

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Similar principles apply in the context of a professional relationship between a psychologist and a client. It is incumbent on the psychologist to set and maintain boundaries, both during the relationship and after.

Ms B was clearly aware of her professional responsibility to monitor boundaries because she had responded appropriately when feelings of attraction developed at an early stage in the relationship. Mr E confirmed that "the question of maintaining boundaries, focusing on patient's needs, seeking personal support to address her own issues, and keeping herself safe, was frankly discussed within supervision".

Having recognised the potential for such issues to arise in her relationship with Mr A, Ms B should then, in my view, have been vigilant in monitoring ongoing boundaries and either sought support or withdrawn from the relationship if she was unable to do so. Instead, Ms B pursued a personal relationship with Mr A immediately after he had been discharged from her care, at a time when the "power relationship could be expected to influence personal decision making". In my view, Ms B's decision to pursue a personal relationship with Mr A at that time was in breach of her professional and ethical obligations as a psychologist, and Right 4(2) of the Code.

Ms B has acknowledged that continuing to contact Mr A following his discharge was unethical.

Freedom from exploitation

Under Right 2 of the Code, every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation. Exploitation is defined in clause 4 of the Code as "any abuse of a position of trust, breach of a fiduciary duty, or exercise of undue influence".

Exploitation occurs when a person in power (such as a clinical psychologist) takes advantage of the trust that has developed during a therapeutic relationship and uses it for his or her own ends. It is irrelevant to the finding of exploitation whether the other person is a willing participant in the relationship.

When Ms B initiated telephone contact with Mr A in May 2005, Mr A was a vulnerable ex-patient who had been discharged from her care only the week before. Although Ms B rationalised her actions as providing support to Mr A, she acted on her underlying attraction to him, and pursued a personal relationship by contacting Mr A regularly for several weeks. Subsequently, Ms B encouraged Mr A to move into the same boarding house, which he did, and the relationship became sexual in early September 2005.

It was inappropriate for Ms B to enter into any kind of personal relationship with Mr A when he had only recently been discharged from her care. Mr A had shared personal information and developed trust in Ms B at a time when he was inherently vulnerable and relying on Ms B to treat his condition. When he relocated to City 2, Mr A was again placed in a vulnerable position and it is not surprising that he was receptive to

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Ms B's support. Ms B should have been aware of the risk that Mr A would readily transfer trust from the professional relationship to a personal context, and known that it was inappropriate to exploit the situation for her own benefit. Ms B has since acknowledged that her distress from issues she was facing in her personal and professional life had a significant influence on Mr A.

In my view, Ms B abused Mr A's trust by placing her own interests and welfare above his. Ms B's actions were exploitative and unprofessional, and cannot be excused by her attempts to provide Mr A with emotional support, and the problems she was facing in her personal life. It is irrelevant that Mr A was a willing participant in their relationship.

Taking into account all these factors, I conclude that Ms B breached Right 2 of the Code by exploiting Mr A.

Summary

Ms B has acted unethically by pursuing a relationship with a vulnerable ex-client a week after his discharge from her care. Subsequently, she maintained communication with Mr A on a regular basis, and encouraged his move to her boarding house. An intimate relationship subsequently ensued. All these acts are contrary to the Psychologists Board's Code of Ethics.

By failing to maintain professional boundaries with an ex-client and by exploiting the trust that had been established in the clinical context, Ms B failed to comply with professional and ethical standards. She therefore breached Right 2 and Right 4(2) of the Code.

Opinion: No Breach — DHB1

DHB1 has guidelines that discourage "developing friendships between staff and consumers", and prohibit "sexual behaviour or sexual contact between staff and consumers". The guidelines also set out the requirement for staff to utilise the forum of clinical supervision "where there is any concern or uncertainty with regard to professional boundaries".

Ms B was aware of her professional responsibilities to maintain boundaries, and underwent clinical supervision. There has been no complaint made about the care provided by DHB1, and from a review of the information provided, there is no evidence that DHB1 breached the Code.

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Other comments

This investigation was commenced on 12 April 2006. For much of this investigation, Ms B claimed that she had no contact with Mr A from his discharge in May 2005, to his "coincidental" move to the same boarding house in July 2005.

In August 2006, Ms B admitted that she made intentionally misleading statements during the investigation. She also admitted that there was ongoing contact between Mr A and her a week after his discharge from her care, and that his move into the same boarding house was pre-arranged and agreed between them. In addition, Ms B also acknowledged that she put undue pressure on Mr A to support her earlier misleading statements in dealings with this Office.

Principle 3 of the Code of Ethics states:

> "The relationships formed by psychologists in the course of their work embody explicit and mutual expectations of integrity that are vital to the advancement of social justice, scientific knowledge, and to the maintenance of public confidence in the discipline of psychology. Expectations of professional practice include: respect, accuracy and honesty; openness, maintenance of appropriate boundaries, and avoidance of conflicts of interest. Psychologists will seek to do right in their relations with others."

Ms B's admission that she had deliberately misled this investigation came three months after her initial statements. In the interim, considerable effort was expended on investigating the complaint, including conducting interviews with Ms B and Mr A. It was only after requests were made for the telephone records of Mr A and Ms B that Ms B came forward and admitted that she pursued a relationship with Mr A.

Ms B effectively coerced Mr A by placing him under undue pressure to mislead this Office in its investigation.

I note that in the recent *Director of Proceedings v Dr N* (58/Med05/15D) the Health Practitioners Disciplinary Tribunal considered the conduct of a doctor who deliberately hindered an investigation by this Office and stated:

> "Doctor N's conduct was plainly misleading. She knew she had made alterations to the notes and deliberately misled the Commissioner about those additions for almost a year. Doctor N only admitted the additions to her records when she realised the Commissioner was proposing to have the original notes examined.
>
> The Tribunal is very concerned by this aspect of the case. The Tribunal believes that misleading the Commissioner was Dr N's most culpable misconduct. No health professional should mislead the Commissioner or any other person about their records.

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> The Tribunal is in no doubt Dr N's actions in misleading the Commissioner were likely to bring discredit to the medical profession. Furthermore Dr N's behaviour justifies a disciplinary sanction for the purposes of protecting the public and maintaining professional standards and to punish Dr N."

Dr N was fined $10,000 in relation to the finding of professional misconduct for obstructing the investigation.

By deliberately making misleading statements and encouraging Mr A to corroborate the false information she provided, Ms B has hindered this investigation. In my view, this conduct reflects very poorly on Ms B's professional integrity.

Follow-up actions

- Ms B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- A copy of this report will be sent to the New Zealand Psychologists Board, the New Zealand College of Clinical Psychologists, and the New Zealand Psychological Society.
- A copy of this report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes on completion of the Director of Proceedings' processes.

Addendum

The Director of Proceedings laid a disciplinary charge before the Health Practitioners Disciplinary Tribunal alleging that Ms B had commenced a sexual relationship with her former client in a period of time during which the power relationship could be expected to influence personal decision-making, and further that she had misled the Commissioner during the investigation. Ms B admitted that her conduct amounted to professional misconduct and on 7 May 2007 the Tribunal upheld the charge, imposing the following penalty:

1. cancellation of registration.
2. conditions to be satisfied before any application for re-registration can be made:
   (a) Psychological examination is to be undertaken by two independent

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psychologists working collaboratively, not more than 12 months before the application is made. A written report of the examination is to be provided to the Psychologists Board. Specific consideration is to be given by the independent psychologists as to whether counselling or therapy is needed at the time of the examination. Evidence is to be provided to the board that any such counselling or therapy has been carried out and of any other recommendations which the psychologists may have made.

(b) At the time of re-application evidence is to be given that Ms B has disclosed to all employers at the time of her employment in any role where she is providing counselling and related professional services of the fact of these proceedings and their outcome. It is a further aspect of this condition that her current employer be informed of these matters as soon as possible.

(c) Ms B is to provide satisfactory evidence to the Psychologists Board at the time of the application that her personal circumstances are stable.

3. a fine of $5,000 and costs in the total sum of $5,000 to be apportioned 50% as to the HDC costs and 50% as to the Tribunal costs.

Name suppression was granted because publication of name would lead to identification of the consumer.

Ms B appealed the decision in relation to the last sentence of condition 2(b). The Director of Proceedings supported the appeal because compliance with the condition would lead to identification of the consumer. On 3 October 2007 the High Court upheld the appeal.

A copy of the Tribunal's decision may be found at www.hpdt.org.nz Psy07/58D.

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