Counsellor, Ms C

A Report by the

Acting Health and Disability Commissioner

(Case 09HDC01409)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

Mr A (aged 18), was depressed, at times very distressed, and eating and sleeping poorly. His mother, Mrs B, was concerned and, in early 2009, arranged for Mr A to see Dr D, a private psychotherapist, who urgently referred him to a DHB Child and Youth Mental Health Team (the Clinic).

Three days later, Mr A saw a private counsellor, Ms C. After his appointment, Mr A told his mother that he didn't need to take any medication. He also said that Ms C would not see him again unless his mother had counselling.

Ms C saw Mr A only once. Subsequently, she offered him several appointments, each of which he cancelled by text.

Four days later, Mr A was assessed by the mental health team and diagnosed with early psychosis. He was prescribed an anti-psychotic medication. He was then referred to the Early Psychosis Intervention team at the DHB, which became his primary mental health care provider. Mr A did not take the medication as prescribed.

Six days later, Mr A contacted Ms C by text. In one message he asked for her views as he was reluctant to take medication. Ms C's reply supported Mr A's decision not to take medication, but only if he had excellent support.

Mr A committed suicide about two weeks later.

Complaint and investigation

On 30 June 2009 the Commissioner received a complaint from Mrs B about the services provided by counsellor Ms C to her son, Mr A. The following issues were identified for investigation:

- *Whether counsellor Ms C provided Mr A with reasonable care in early 2009, including:*
    1. *diagnosis*
    2. *treatment*
    3. *documentation*
    4. *communication with Mr A and with other providers.*

An investigation was commenced on 1 September 2009.

The parties directly involved in the investigation were:

Mr A	Consumer
Mrs B	Complainant/consumer's mother
Ms C	Provider/counsellor

Also mentioned in this report:

Dr D	Counsellor/psychotherapist
Dr E	Child and Adolescent Psychiatrist
Ms F	Social worker
Ms G	Registered nurse
Dr H	Consultant psychiatrist

Information was reviewed from the above listed parties and also:

- counsellor and psychotherapist Dr D
- a general practitioner
- the Coroner
- the DHB.

Independent expert advice was obtained from counsellor and psychotherapist Eric Medcalf (Appendix A).

This report is the opinion of Rae Lamb, Acting Commissioner.

Information gathered during investigation

Background
In early 2009, Mrs B had become concerned that her 18-year-old son, Mr A, was distressed and eating and sleeping poorly. He had been using cannabis and other drugs and had had recent relationship difficulties with his girlfriend.

Mr A's general practitioner told the Coroner that Mr A had:

> "mentioned that he was having emotional problems and feeling depressed, in passing whilst consulting for other urgent matters and we had urged him to come in for a proper consultation about the issues, but he had not done so. I was not altogether surprised (as a GP of 20 plus years and a police surgeon) when I heard of his suicide. I had no idea he had reached that stage however."

Appointment with Dr D
On Day 1, Mrs B arranged for Mr A to see psychotherapist Dr D. Mrs B recalls that the appointment was split into three sessions:

> "the first of which was with [Mr A], [Dr D] and myself. [Dr D] asked questions to establish our family situation, details of our extended family and how we both felt [Mr A] had been feeling and acting lately. [Mr A] was open, communicative and appeared comfortable discussing his feelings and concerns with [Dr D]. The second session of the appointment was with [Mr A] alone with [Dr D] for approximately 30 minutes. The last session was with the three of us wherein [Dr

> D] recommended [Mr A] attend an appointment at [the Clinic] and in response to my questioning suggested that psychotherapy could be useful after time spent in care at [the Clinic] but not prior to this treatment. [Mr A] expressed disappointment to me immediately after the meeting with [Dr D]; he had attended the appointment with [Dr D] hopeful that his problems could have been dealt [with] solely by [Dr D] and that treatment from [Dr D] would have resulted in his quickly getting over what [Mr A] and I perceived to be his depression."

Dr D diagnosed Mr A as schizophrenic/psychotic and urgently referred him to the Clinic at the DHB. Dr D described Mr A as withdrawn, hearing voices and believing that people on television and the internet were talking about his thoughts. Dr D had not discussed medication with Mr A as he considered he needed a team approach urgently.

Mrs B recalls that her son was optimistic just prior to his appointment with Dr D, and "not as upbeat" afterwards.

Appointment with Ms C

Ms C is a member of the New Zealand Association of Counsellors.[1] On Day 4, Mrs B took her son to see Ms C, whom a friend had recommended as a good psychotherapist. Mrs B recalls that her son was optimistic just prior to the appointment. She stated that her son "felt that [Ms C's] spiritual approach would be more suited to his condition".

Ms C advised that she is not a spiritualist and has never called herself one.

Ms C recalls that at the time of the appointment she was not aware that Mr A had seen Dr D.

Ms C stated that she saw Mr A for an hour. Mrs B did not attend the appointment. Ms C recorded a single page of notes for the session, which included a brief history. She recalls that Mr A was "concentrated, even intense, but able to focus and explain himself clearly". Mr A discussed past and recent traumas. Ms C did not record any discussion of alcohol or drug use, or of Mr A hearing voices or having delusions.

Ms C explored suicidal ideation with Mr A. She asked him to rate his risk of suicide from 1 to 10, with 10 being the most suicidal. She recorded: "Only a 1 out of 10 today, but fluctuates."

Ms C then wrote an "Alive & Safe" contract for Mr A to sign and return at their next appointment four days later. Ms C explained:

> "Although I assessed [Mr A] as not at risk at the time of our one appointment, given the issues he raised, … I considered the No suicide contract a useful precaution in our potential future work.

[1] Counsellors are not currently registered health practitioners under the Health Practitioners Competence Assurance Act 2003 (the Act). The profession has expressed an interest in being covered by the Act.

- My understanding of the use of a No suicide contract is that a counsellor would so use if they assessed that a client was at any potential risk of harming themselves.
- I have had perhaps 18–20 clients in my 34 years of counselling under No suicide contract. All are presently alive.

The contract I use, and wrote out for [Mr A], is worded as follows:

I, (client's full name), agree to keep myself safe while I am working with [Ms C].

Signed: (client's full name signature)
(My full name signature)
Date:"

Ms C later explained that she gave the contract to Mr A to take away because her photocopier wasn't working. Mrs B does not recall her son bringing anything from his appointment except a note with Ms C's colleague's phone number on it (see below). She did not find the contract amongst her son's possessions.

Ms C recorded in the notes that Mr A was to "get a new journal & continue writing (very articulate)".

Ms C stated that "[Mr A] wanted to work in counselling on the many issues that were weighing him down, and I encouraged him in this". She recorded "Treat: Depression/Grief and Identity issues" in the notes.

Mrs B recalls that:

> "[d]irectly after the appointment with [Ms C] [Mr A] was quite elated, he said he felt there was some solution to his problems, that it was emotional issues and further counselling with [Ms C] would have him back on track.
>
> …
>
> [Mr A] got out of the meeting very upbeat and said if [the Clinic] said he would need to take medication he would not need to as his problems were 'emotional' and he wanted to meet with [Ms C] again a.s.a.p."

Ms C told HDC that the issue of medication was not discussed at the appointment. There was nothing in her notes about medication.

Mr A told his mother that Ms C would not see him again unless Mrs B also had counselling. He said that Ms C had provided him with the name and telephone number of her colleague who could provide this. Mrs B recalls that she was "angry and said to [Mr A] it was not I who is depressed and recommended by [Dr D] to see [the mental health team] and I said how unprofessional I thought [Ms C] to be".

Ms C later explained that "given the nature of what [Mr A] had shared with me regarding his mother's history and the degree of enmeshment between them, I did not feel that it would be productive to work with the son unless the mother was also receiving counselling".

When asked why she did not speak directly to Mrs B about her also undergoing counselling, Ms C replied:

> "I am accustomed to making arrangements directly with my clients. Because of [Mr A's] age and because he presented to me in a responsible manner, I treated him as a responsible though young adult. The referral was for individual work with [Mr A]. Neither [Mr A] nor [Mrs B] suggested a wish for her to be included in the appointment.
>
> In an initial session with a client it is important to establish trust and build a therapeutic relationship. In this sole contact with [Mr A] I was not ethically in a position to speak to [Mrs B] without the express permission of [Mr A]."

In response to my provisional opinion, Ms C advised:

> "I did ask [Mr A] to convey to his mother that my condition for ongoing counselling with him, was that his mother also have counselling. I gave the name and contact number of a professional colleague. However, I did not specify that [Mrs B's] counselling be with that particular counsellor. I considered that this would provide support for both [Mr A] and his mother."

Ms C stated that she did not ask Mr A who his general practitioner was, as he did not present in a manner indicating the need to contact his general practitioner.

A week to 10 days after the appointment, Mrs B telephoned Ms C and said that her son was now under the care of the mental health team. She expressed her concern that Ms C had told her son that she should have counselling.

Ms C recalls that she offered Mr A several appointments, each of which Mr A cancelled by text. On Day 7, Ms C sent a text to Mr A at 10.42pm: "Just got msg, can't tues, yes wed, 9am? Blessings, [Ms C]."

On Day 8, Mr A replied at 10.09am: "Sory fel asleep las nite. Cnt do wensday as hv anutha apointment at hospital at 9 tht hv 2 go 2. Wil thursday 9.0o work? Shes going 2 call [your colleague] so0n." Mr A then sent: "I feel very guilty."

Ms C replied at 10.20am: "Forget guilt, it's useless n sick making. No thurs or fri, yes Sat 3pm or Sun 10am if u cld get 2 nr […] where I'll b (nr […])..[Ms C]"

Mental health team appointment

On Day 8 an assessment of Mr A was carried out at the Clinic by Dr E, Child and Adolescent Psychiatrist, and Ms F, social worker. Dr E recorded:

> "?Resinol. To date, taken four tablets. Last night had been the first night that the voices were dull and he was able to feel relaxed, however, he does not want to take medication at this stage as he feels it doesn't fix the problem, it only 'dulls' them."

Mr A reported delusions of reference (that the television and newspaper were referring directly to him), visual hallucinations ("faces roaring") and auditory hallucinations ("lots of voices screaming"). Dr E noted thought disorder (disorganisation in the way that Mr A connected his thoughts, as observed by disorganisation in his speech — a symptom of psychosis) with loosening of associations and loss of goal in the conversation. Dr E described Mr A's mood as "perplexed". The clinical notes record his mood as "flat and unmotivated" and state that there were periods when he burst into tears for no reason.

Dr E diagnosed Mr A as having early psychosis, and prescribed risperidone (an anti-psychotic). Dr E recorded:

> "He demonstrated a reasonable degree in insight in asking for help on one hand: on the other he was clear that he did not want to take medication although he agreed to consider it. Although there were no clear cut signs of imminent risk to himself or others, we were clear today that the risk to himself and others were at least moderate and needed ongoing engagement with mental health services as well as his mothers input."

Dr E noted that Mr A was at least of moderate risk of suicide because he told him that he had considered suicide two months ago, although he denied any current suicidal thoughts. Mr A was referred to the Early Psychosis Intervention (EPI) team at the DHB. Dr E noted that Mr A had also been seeing a therapist, and the Clinic was happy to work alongside any such person, noting that "it seemed that [Ms C] was working from a spiritual basis".

Mrs B recalls that she spoke privately with the team at the Clinic and told them of Ms C's request that she also undergo therapy. Mrs B stated that the Clinic also thought it unprofessional and unusual. She recalls: "They said [Mr A] seemed very keen on her and so not to alienate her they suggested to [Mr A] they would 'work with her with the team'."

However, the Clinic did not contact Ms C. Ms F reported that she did not consider contacting Ms C as her plan was to transfer Mr A to the EPI team.

Ms C stated that several days after Mr A's appointment with her:

> "[Mrs B] phoned me asking about my reasons for requiring her to be in counselling. I explained that it was not a requirement at all, unless she felt it was useful for her son to continue seeing me. … At that stage she explained that they were both now under [the Clinic's] care, and I responded that if she and he wanted me to continue to support [Mr A] in personal counselling, adjunctive to [the Clinic's] interventions, I would be happy to do so. I was not told any of the parameters of [the Clinic's] interventions. … I assumed [Mr A] was in expert hands, with competent, closely monitored interventions."

First EPI appointment

On Day 12, Mr A had his first appointment at EPI with RN Ms G, and Ms F. The object of the meeting was to review Mr A's mental state and to formally transfer his

care to EPI. Mrs B was present for part of the interview. She reported that she had been giving Mr A his medication, but after she left the meeting he advised that he had not taken any of the medication his mother had given him.

During the interview, Mr A discussed his previous substance abuse. He admitted taking LSD ("acid") six times in the previous six months, and that he had also taken ecstasy. He stated that his last use of acid in mid-January 2009 had been frightening for him and had resulted in paranoia. He also described hearing distressing voices from 2007 onwards.

Mrs B and Mr A were both given written and verbal information on risperidone. Ms F noted: "No changes with fleeting suicidal thoughts but has no intent or plan." Ms G's impression was that Mr A was experiencing psychosis and met the EPI entry criteria. Ms F does not recall Mr A discussing Ms C's view on medication. The clinical notes state: "[Mr A] and [Mrs B] appear to now be contemplative about using anti-psychotic medication."

Text messages
On Day 14 Mr A contacted Ms C a few times by text. Ms C contacted Mr A at 10.48pm:

> "I am assuming we r not mtg 2moro at 2, right? Contact me if u want 2 make another appt. Cheers, [Ms C]"

Mr A replied at 11.04pm:

> "Im realy sory iv ben so useless and nt txtd u bk and screwed u rwnd. Iv jst had a realy hectic last fw days. txtng has ben last thng on my mind. Wnt hapen agen. alot ov ppl thnk I shud go on medicati0n. Bt I thnk thts going 2 supress a lot ov important em0tions tht r crucial 2 find and feel. Wat do u thnk? Sory 2 txt u and ask u ths kind ov stuf as i n0 i shud b paying 4 ur time. and im sory didnt cancel 2m0ro. Id like 2 c u as so0n as posible bt I gta find sum muny and fix my car so i can gt in."

Ms C replied at 11.14pm:

> "I agree, no meds, but only if u have xlent support, at leart 2x wk, with therapist that r not afraid of emotional xpreshun. Txt me 2 make nxt appt when it wks 4 u. Blessings, [Ms C]"

Ms C later told HDC:

> "As my one experience of [Mr A] had been of a person who was depressed but not actively suicidal, and because I had been told he was under [the Clinic's] care, I texted him that I supported his stance in not taking medication, but only if he was in fact receiving counselling … I supported his right to choose what he felt was right for himself, though I added the caveat suggestion regarding the importance of continuing to access strong therapeutic support."

Ms C had no further contact with Mr A. She stated that she was "upset and sorry to hear of his death".

When asked whether she had considered it necessary to make any changes to relevant aspects of her practice or service since the complaint, Ms C responded:

> "I would seek clarification of other services being utilized and liaison with the appropriate personnel, as I have done in the past. Unfortunately by the time of the text messages in question, my role with [Mr A] had become tangential, at best. I doubted whether I would have any further appointments with Mr A, as he seemed to be choosing another avenue of therapeutic support with [the Clinic]. I felt that he had a right to this choice, and that no matter what I said, he would be working out the interventions with his primary caregivers that felt best to him. I now consider it advisable to keep a detailed log of the content of phone and text messaging."

Further EPI contacts
On Day 15, the EPI team agreed that Mr A was an appropriate referral, and Ms G was allocated as his Key Worker.

On Day 16, Ms G saw Mr A and Mrs B. Mrs B was concerned that Mr A had not yet accepted the recommendation to take risperidone. Mr A wanted to heighten his feelings and considered taking ecstasy to assist with this. Ms G advised him against this.

On Day 18, Mr A was seen by Dr H, a consultant psychiatrist (EPI), and Ms G. The review was limited because Mr A indicated that he was very tired, having hardly slept the previous night. He only wanted to discuss medication options and to save more extensive assessment for future appointments. He indicated that he was now willing to try medication.

Mr A presented at the interview as flat in affect and admitted that his mood was low, but he had had no recent thoughts of self-harm or harm to others. Ms G noted that his mood was significantly different from two days before.

Mr A had been distressed the night before, believing he had wronged his friends, and had slept for only half an hour. Dr H recorded in the notes that Mr A had previously been reluctant to consider antipsychotic medication but, due to his distress the night before, was now motivated to try medication. Mr A was prescribed 1mg of risperidone.

On 28 September 2009, the DHB provided the following information:

> "[Dr H] recalls [Mr A] stating that he did not want to take medication because he felt that he deserved to suffer and feel horrible. [Mr A] told [Dr H] that he wanted to heighten his feelings and that he considered taking illegal substances to assist this. [Dr H] wondered if [Mr A] found his distressing state of heightened emotions cathartic and whether he thought taking medication would stop him reaching this state and working through his feelings."

It was agreed that Ms G would contact Mr A by phone the following day and would review him in person in a week's time. Dr H would review him in one to two weeks' time. Mr A and Mrs B were advised that they could contact EPI or the after-hours crisis team at any time.

Dr H stated that he and Ms G were under the impression that Mr A had ceased seeing Ms C, so they did not consider contacting her.

Later, on Day 18, Mrs B contacted Ms G as she was concerned for Mr A, who was again very distressed. Ms G visited Mr A and provided him with 1mg of lorazepam.[2] Ms G noted that he was settled by the end of the visit and was practising breathing exercises and distraction. Ms G left him with five further tablets of lorazepam and organised for Mr A and Mrs B to visit a respite facility (as an alternative to hospital admission) the following day.

On Day 19, Mr A cancelled the visit to the respite facility, preferring to remain with friends.

On Day 22, Ms G contacted Mr A by phone to discuss his condition. He said he had been up and down, but was planning to return to work that day.

On Day 25, Mr A and Mrs B were seen by Dr H and Ms G. Mrs B was concerned that Mr A had not improved despite taking his medication. Mr A admitted that he hadn't been taking his medication. He explained that he wanted to experience negative emotions and felt that medication would limit his capacity for this. He was assessed as being increasingly thought disordered. Dr H and Ms G advised Mr A that taking the medication would probably help with his thinking. He agreed to take the risperidone.

Mr A denied any suicidal thoughts, although he did express a belief that he deserved to be punished. This arose from the context of Dr H trying to persuade him to take his medication. Mr A admitted ongoing cannabis and alcohol use.

Mrs B stated that she was leaving for a three-day trip overseas. EPI repeated the offer of respite care while Mrs B was away, which Mr A declined. Mrs B had organised for a friend of hers to stay whilst she was away, and Mr A's father was due to arrive from overseas on Day 27. Mr A agreed to try medication and abstain from substance abuse.

Suicide
On Day 27, two hours after his father arrived, Mr A left home and committed suicide.

Mrs B made a complaint to the Police, who referred her to HDC.

Follow-up actions
In response to my provisional opinion, Ms C advised that she fully accepts the recommendations of the independent advisor and is changing her practice in light of his recommendations.

[2] Lorazepam is a benzodiazepine used in the management of anxiety disorders, and the short-term treatment of relief of symptoms of anxiety or anxiety associated with depression.

She accepts that she should have contacted Mrs B directly about her requirement that she obtain counselling while Ms C counselled Mr A.

Ms C advised that she would be limiting the scope of text messages. With regard to the content of the text message she stated:

> "I accept that I needed more knowledge about the reason for medication being prescribed, and the actual medication and its effects. I could have approached the [Clinic] to obtain this. Again, I was uncertain of my role in relation to the family and to the [Clinic]."

Ms C advised that she has a schedule of checkpoints for assessing depression and drug use, which she will use consistently in the future. She has

> "looked at semi-structured protocols and note taking relating to these and will make clearer notes about assessment and treatment decisions. This includes details of other support people (like the GP)."

Ms C has also undertaken extra supervision sessions, during which she has reviewed her use of "no suicide" contracts, and would now approach their use in a more comprehensive way.

Ms C provided a written apology for Mrs B.

Opinion: Breach — Ms C

Mr A was a distressed young man who was willing to seek help but reluctant to take prescribed medication that would affect his ability to explore his emotions. He was supported by his mother and friends, but was regularly drinking alcohol and using drugs.

Ms C, as a health care provider subject to the Code of Health and Disability Services Consumers' Rights (the Code), was required to provide Mr A with services with reasonable care and skill. In my view, Ms C did not provide Mr A with appropriate care in the following areas:

Assessment
Ms C knew that Mr A was depressed, but there is no evidence that she undertook a formal assessment of his depression. My expert advisor, psychotherapist and counsellor Eric Medcalf, was surprised that she did not do this, as Mr A was referred to her with depression.

In July 2008, the New Zealand Guidelines Group published *Identification of Common Mental Disorders and Management of Depression in Primary Care.*[3] The guidelines recommend using the HEEADSSS acronym,[4] developed by Goldenring et al, to structure a psychosocial assessment of young people. Had Ms C conducted a formal assessment she may have diagnosed Mr A with severe depression and realised he needed to be referred to secondary mental health care.

There is also no indication of how Ms C assessed Mr A's risk of suicide, beyond taking a brief history and asking him directly.

Mr Medcalf compared the clinical notes from Mr A's consultations with Dr D and Ms C. In his opinion, Mr A presented quite differently to each of them, which could explain the differences in diagnosis. Mr Medcalf noted that Ms C does not appear to have assessed Mr A's drug and alcohol use, which can impact on whether a person can benefit from psychological interventions, and was a significant factor in this case.

Ms C did not ask Mr A whether he would agree to her speaking to his mother during or following her appointment with him. Mrs B may have provided useful information, as Mr A did not inform Ms C that he had seen Dr D or had been referred to the Clinic.

In previous HDC cases involving suicide, lack of consultation with family members has been consistently identified as a missed opportunity to gather further important information to assist diagnosis and treatment.[5]

As Mr A was still living at home, his mother would have been a reliable source of information about his behaviour. Ms C considered that she was "not ethically in a position to speak to Mrs B without the express permission of Mr A". However, she has provided no evidence that she sought that permission. I note that Mr A agreed that his mother could participate in his consultations with Dr D, the Clinic, and the EPI team. In a recent opinion, the Commissioner stated:[6]

> "Common sense suggests what research confirms: that good working relationships between mental health staff and families/whānau usually help the recovery of people with mental illness.[7] Standard 10 of the *National Mental Health Sector Standard 2001* (NZS 8143:2001) strongly encourages family involvement and recognises their important contribution, including their role in risk management, particularly when they are involved in supporting the family member with a mental illness."

I accept that Ms C's diagnosis of Mr A as having "depression/grief and identity issues" may have been acceptable given his "optimistic" presentation on the day she

[3] The guidelines are intended for use by all health care practitioners practising in a primary care setting, including general practitioners, practice nurses, midwives, counsellors, nurse practitioners, psychologists, psychotherapists, social workers and school nurses.
[4] Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide and depression, Safety.
[5] Opinions 02HDC01804, 04HDC00671, 05HDC13239, 07HDC14286, 08HDC08140.
[6] Opinion 08HDC08140 pages 9–10.
[7] Research shows the significant clinical, social, and economic advantages in providing mental health services in a family-inclusive way (World Schizophrenia Fellowship, 1998).

saw him. However, I believe that she should have done a more thorough assessment, including using a formal depression assessment tool that incorporated questions about drug use. It was unfortunate that Ms C did not seek Mr A's consent to speak to Mrs B during or directly after Mr A's appointment, a matter I will discuss in relation to his treatment.

Treatment
Ms C had only one appointment with Mr A. The appointment was primarily for assessment. Ms C wrote out a "no suicide" contract, offered a follow-up appointment, and requested that Mrs B also undergo counselling. Mr Medcalf considers that the subsequent text messages should also be regarded as treatment.

I am not able, from the evidence provided, to determine whether or not Ms C discussed medication during Mr A's appointment with her. Mrs B blames Ms C for her son's reluctance to take medication. However, I note that Mr A was not prescribed any medication until after his appointment with Ms C, and no members of the Clinic and EPI team recorded or could recall that his rationale for not taking medication was related to his appointment with Ms C.

"No suicide" contracts
Published literature suggests a lack of evidence that "no suicide" contracts reduce suicide attempts, and that their use may induce a false sense of security in the therapist. The reasoning behind them is considered to be flawed, as it assumes that the patient's mental state, which is often ever changing, is such that he or she can be influenced by such agreements, which may increase pressure and produce a sense of guilt.[8]

Mr Medcalf commented that while the use of these contracts is disputed, they can be a useful assessment tool, reduce clinician and patient anxiety, and provide alternative behaviours to suicide. However, to be used in these ways the contract needs to be significantly more detailed than that used by Ms C. Mr Medcalf was also critical of Ms C allowing Mr A to take away his contract, thus allowing him to have control over its existence.

In 1999, the New Zealand Guidelines Group recommended:

> "An action plan should be written for the young person outlining steps to take if suicidal ideation increases. … An important part of the plan is back-up support that is available 24 hours a day with names and contact numbers… From time to time the use of a written contract in which young people agree not to harm themselves is raised ('no suicide' contracts). These have not been shown to be effective and mental health professionals working in this area do not support their use."[9]

[8] See Beautrais et al, "Effective strategies for suicide prevention in New Zealand: a review of the evidence". *New Zealand Medical Journal*, 23 March 2007 (www.nzma.org.nz/journal/120–1251/2459/).
[9] New Zealand Guidelines Group, 1999. *Suicide Guidelines.* Royal New Zealand College of General Practitioners.

In my opinion, Ms C's use of the "no suicide" contract for Mr A was ill advised. Clearly these contracts are controversial and their value is disputed. Great care is needed if they are even to be used at all. Such care was not apparent here. Mr Medcalf has recommended that Ms C review her use of "no suicide" contracts and consider that, if she intends to use one, the content of the contract should be negotiated with the client and include much greater detail, including contingency actions.

Further appointments
Given Ms C's diagnosis of Mr A as having "depression/grief and identity issues", it was appropriate for Ms C to offer Mr A a further appointment in the near future, as at that stage she was unaware that he had been referred to the Clinic. In Mr Medcalf's opinion, Ms C had achieved a good rapport with Mr A, which is important for successful treatment.

Counselling for Mrs B
Ms C had correctly identified that Mr A and his mother had complementary issues. However, Mr Medcalf advised that it was not appropriate to require Mr A to tell his mother that she should also undergo counselling, and to make her counselling a condition of his receiving ongoing treatment. I do not accept that Ms C "was not ethically in a position to speak to [Mrs B]". Ms C should have asked Mr A for his consent to speak to his mother, if it involved discussion about his health and treatment. If the contact related to counselling for Mrs B, Ms C should have contacted her directly.

Text messages
Mr Medcalf regards Ms C's use of text messages to provide advice as a form of counselling treatment. While text messaging can be used appropriately when communicating with young people, there are recognised risks. These risks include lack of confidentiality, misinterpretation, and being "too available". Mr Medcalf recommends that text messages be limited to simple topics, such as making appointments or for support and encouragement at times of crisis.

Medication advice
It was not appropriate for Ms C to provide advice to Mr A on medication, particularly by way of a text message. Before providing advice, Ms C needed to have contacted the Clinic, found out what the medication was, what care Mr A was receiving, and explored Mr A's rationale for not taking his medication. As Ms C considered that she was only tangentially involved in Mr A's care, it was not appropriate to advise him on his treatment, particularly without a further consultation and appropriate follow-up. Ms C advised HDC that she was "over-confident that [Mr A] was now being treated by a specialist Mental Health Service". That confidence reinforces the need to consult with the mental health team before giving any advice on medication.

In 2008, the New Zealand Guidelines Group's advice was: "Specialist advice should also be sought before changing or stopping antidepressant therapy in this

population."[10] While this advice is directed at the care of younger people, my expert considers this is appropriate guidance for good practice in Mr A's circumstances.

I do not accept that Ms C was appropriately supporting Mr A's right to refuse treatment. Although she qualified her advice, I agree with Mr Medcalf that:

> "[Ms C's] provision of advice about medication prescribed by the primary clinical team fell short of what I would expect of a qualified and ethical counsellor and [to] do so without discussion with that team breached her professional duty to collaborate with other health providers and uphold the values of responsible caring, as well as breaching the principles of promoting safety and avoiding harm. I consider this would provoke severe professional disapproval."

Documentation
Ms C's clinical notes, while described as minimal by Mr Medcalf, do provide an adequate summary of her contact with Mr A. I recommend that Ms C review her note-taking, especially in regard to recording the bases for diagnostic and treatment decisions.

Communication
Ms C clearly established a good rapport with Mr A. In 2008, the New Zealand Guidelines Group recommended that "if another health practitioner delivers psychotherapy to a young person with depression in primary care, there should also be regular communication between practitioners about the young person's progress". Ms C did not consider that Mr A's presentation necessitated contacting his general practitioner. However, my adviser suggests that Ms C could have considered contacting Mr A's general practitioner given his complex history.

In addition, Ms C did not attempt to contact the Clinic once she became aware that Mr A had been referred there. Ms C told HDC that following Mrs B's call, which informed her that Mr A was under the Clinic's care, she assumed he was in expert hands, with competent, closely monitored interventions.

I am of the view that Ms C should have contacted the Clinic before giving advice to Mr A about medication. She had not seen him for 10 days, and her only communication had been by text. She did not have sufficient information to provide advice. Mr Medcalf advised: "[On] balance I feel that Ms C could have taken initiative in making contact with [the Clinic] and consider that her failure to do so this would meet with moderate professional disapproval."

Summary
Ms C saw Mr A for one session, during which she took a brief history, but did not explore key issues, such as substance abuse, or complete a formal depression assessment. Ms C entered into a pro forma "no suicide" contract with him, rather than negotiating an agreement containing strategies, such as who to contact if suicidal ideation arose. By allowing him to take the contract away, he then had control over its existence, rather than Ms C retaining his "promise" not to commit suicide.

[10] *Identification of Common Mental Disorders and Management of Depression in Primary Care.*

Ms C used text messages to give advice concerning medication, without seeing Mr A and consulting with other providers. She failed to provide care with reasonable care and skill, and therefore breached Right 4(1) of the Code.[11] Her failure to consult with others regarding Mr A's care was a breach of Right 4(5) of the Code.[12]

Recommendation

Ms C has apologised to Mr A's family and reviewed her practice, particularly the use of "no suicide" contracts.

I recommend that Ms C:

- report back to me by **16 June 2010** with details of how she will approach the use of "no suicide" contracts and text messages, and of how she has changed her practice in line with the expert advice.

Follow-up actions

- A copy of this report will be sent to the Coroner and the DHB.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the New Zealand Association of Counsellors, which will be advised of Ms C's name.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[11] Right 4(1): *Every consumer has the right to have services provided with reasonable care and skill.*
[12] Right 4(5): *Every consumer has the right to co-operation among providers to ensure quality and continuity of services.*

Appendix A: Independent Advisor's Report to the Health and Disability Commissioner

28th November 2009

I, Eric Medcalf, of Wellington, Counsellor and Psychotherapist, Member of the New Zealand Association of Counsellors and of the New Zealand Association of Psychotherapists; have been asked to provide an opinion to the Health and Disability Commissioner on Case Number 09/01409.

I have read the Commissioner's Guidelines for Independent Advisors and agree to follow them.

I have a BA Honours degree, a post graduate Social Work Qualification and a post graduate qualification in Psychotherapy. I am registered as a psychotherapist with the Psychotherapists Board of Aotearoa New Zealand. My work experience, over 30 years, includes work as a Social Worker and Family therapist in a Child and Adolescent Psychiatry service, a University Student Counsellor, trainer of Social Workers, Advisor to the Sensitive Claims Unit of the ACC and as a Counsellor and Psychotherapist in private practice. I currently hold the position of Convenor of the National Ethics Committee of the New Zealand Association of Counsellors and, as part of that role, take responsibility for the processing of complaints to the NZAC for alleged breaches of its Code of Ethics. I also sit on the Council of the New Zealand Association of Psychotherapists.

The Commissioner has provided the following documents:

- Letter of complaint to the Commissioner from [Mrs B], dated 30 June 2009, marked with an "A".(pages 1 to 2)
- Letter from [Mrs B] dated 31 July 2009, including note given to [Mr A] and [Mr A's] text messages, marked with a "B". (Pages 3 to 8)
- Letter from [Mrs B] dated 18 October, marked with a "C". (Pages 9 to 11)
- Response from [the] Coroner dated 28 July 2009, including autopsy report, report from [Dr H] and letter from [the general practitioner] marked with a "D" (Pages 12 to 61)
- Response from [Dr D] dated 30 July 2009, marked with an "E". (Pages 62 to 64)
- Notes of a phone conversation with [Dr D] on 4th August 2009, marked with an "F".(Page 65)
- Response from [the] DHB dated 28 September, marked with a "G". (Pages 66 to 72)
- Response from [Ms C] dated 14 August 2009, marked with an "H". (Pages 73 to 76)
- Response from [Ms C] dated 16 October 2009, marked with an "I" (Pages 77 to 79).

Using these documents I have been asked to provide an opinion as to whether [Ms C], Counsellor, provided services to [Mr A] of an appropriate standard and answer the following questions:

1. Were the services provided to [Mr A] appropriate?
2. What standards apply in this case?
3. Were those standards complied with?

In particular, and in addition I have been asked to comment on the following:

1. Did [Ms C] provide an appropriate standard of assessment and treatment to [Mr A]? Specifically referring to:
    a. Diagnosis
    b. Treatment
    c. Documentation
    d. Communication with [Mr A] and with other providers
2. Was it appropriate for [Ms C] to request [Mrs B] to also undergo counselling?
3. Was it appropriate for [Ms C] to sign a "no suicide" contract?
4. Was it appropriate for [Ms C] to provide advice by text?
5. Was it appropriate for [Ms C] to advise [Mr A] to not take his medication?

Standards:

In reviewing this case I will use both Ethical and practice standards.

As a member of the New Zealand Association of Counsellors (NZAC), [Ms C] is bound by the NZAC Code of Ethics. [Ms C] has been trained as a Counsellor to Masters Degree level. The minimum academic level for membership of the NZAC is a Diploma. I would therefore expect a high level of skill and knowledge.

In this situation the following sections of the latest edition NZAC Code of Ethics (2002) are relevant. I shall refer back to these in answering the Commissioner's specific questions.

> **3. CORE VALUES OF COUNSELLING**
> The practices of counselling involve the expression of particular core values. This Association expects counsellors to embrace these core values as essential and integral to their work.
>
> The core values particular to this situation are:
>
> 3.2. Partnership
> 3.3. Autonomy
> 3.4. Responsible caring
>
> **4. ETHICAL PRINCIPLES OF COUNSELLING**
> These principles are expressions of core values in action and form the foundation for ethical practice. Relevant principles here are:

Counsellors shall:

4.2. Avoid doing harm in all their professional work.
4.5. Promote the safety and well-being of individuals, families, communities, whanau, hapu and iwi.
4.6. Seek to increase the range of choices and opportunities for clients.
4.7. Be honest and trustworthy in all their professional relationships.
4.8. Practice within the scope of their competence.
4.9. Treat colleagues and other professionals with respect.

5.1. Safety
(a) Counsellors shall take all reasonable steps to protect clients from harm.

5.7. Documentation of Counselling

"Documentation" in this code refers to all material about the client or about the counselling, recorded in any form (electronic, audio, visual and text). Documentation includes material collected for the purposes of: enhancing counselling practice; and meeting the requirements of research, accountability, appraisal, audit and evaluation.

(a) Counsellors shall maintain records in sufficient detail to track the sequence and nature of professional services provided. Such records shall be maintained in a manner consistent with ethical practice taking into account statutory, regulatory, agency or institutional requirements.

5.9. Maintaining Competent Practice
(c) Counsellors shall work within the limits of their knowledge, training and experience.

5.14. Referral
(b) Counsellors shall obtain clients' consent before making referrals to colleagues and other services and before disclosing information to accompany such referrals.

7.1. Responsibility to Colleagues
(a) Counsellors should treat colleagues with respect, fairness and honesty.

7.4. Collaboration with Counselling Colleagues and Other Professions
(a) Counsellors should endeavour to achieve good working relationships and communication with other professionals in order to enhance services to clients.
(b) Counsellors should be respectful and mindful of confidentiality in all communications with other professionals about clients.
(c) Counsellors should negotiate to work collaboratively with other professionals working with the same client.
(d) Counsellors working in a team with other professionals should seek respect for counselling ethics from the team.

13. COUNSELLING AND ELECTRONIC COMMUNICATION

This section refers to any counselling practices that occur when clients and counsellors are in separate or remote locations and utilise electronic means to communicate, such as email, fax, telephone, voicemail, video conferences, web messages and instant messages.

13.1. Confidentiality

(a) Counsellors shall take all reasonable precautions to ensure the privacy of electronic communications, for example, by using passwords, encryption and secure sites.
(b) Counsellors shall provide clients with a full explanation of the limits of confidentiality with regard to electronic communication.

13.2. Anonymity

(a) While clients have a right to preserve their anonymity through electronic communication, counsellors should make open disclosure of their identity, professional membership, qualifications, training, work context and the country worked from.
(b) Counsellors should take all reasonable steps to verify whether or not a client is a minor.

13.3. Information

Counsellors should provide clear and sufficient information about the limitations and risks of online counselling in order for clients to make informed decisions about using this service.

13.4. Counselling Contracts

Counsellors should, when engaging in online counselling, establish agreements with clients on the following issues:

- Online availability,
- Response time,
- Alternative contact methods,
- Relevant legal context in which the counselling takes

Question 1. Did [Ms C] provide an appropriate standard of assessment and treatment to [Mr A]? Specifically referring to diagnosis, treatment documentation and communication with [Mr A] and with other providers.

a) Diagnosis:

[Ms C's] notes and written submissions state that [Mr A] was referred to her by his mother as being "a depressed 18 year old". The written submission stated "19 year old" (p77). She states that she assessed [Mr A] for suicide risk and that he reported that he was at a very low level of current risk: "1 out of 10" in the written casenote, (p 76) and initial submission, (p74) and "2 out of 10" in the later submission, (p 77). There is nothing in the notes to say how she assessed the risk, other than asking [Mr A]. There is also nothing in the notes to indicate that she assessed his depression. However, that she sought a "no-suicide" contract indicates that she had some concerns in spite of [Mr A's] low estimate of risk.

Considering that the referral was of a depressed 18 year old I am surprised that [Ms C] does not record an assessment of his level of depression. 18 year olds straddle the boundary between being a "Young Person" and an "Adult", although technically an adult. The New Zealand Guidelines (NZGG 2008)) stress the importance of proper assessment at initial presentation and that, "the young person's presenting complaint should be addressed as a priority" (p 27). Whilst this may not technically refer to [Mr A] as an adult I feel that it would be good practice in this situation.

If not assessed as requiring immediate referral the guidelines state that:

> *Initial management should include active listening, problem identification, advice about simple self management strategies and active follow-up (2-weekly monitoring by face to face/phone/text/email).* (p. xvi, note 1)

Generally, I have no reason to doubt that [Ms C] kept to these.

The Guidelines also recommend the use of structured assessment tools, but also state that these should not replace clinical judgement, which will be informed by experience. Even if she does not ordinarily use formal instruments such as those described in the Guidelines there are simple screening questions that can be asked (see Guidelines p 60, Box 5.2). She does, however, go on to say in her handwritten casenote (p 76) that her treatment would focus on depression, along with grief and anxiety. However, in her later submissions the depression is not mentioned and (on p 77) she only talks about "loss, grief and anxiety".

[Ms C's] notes and submissions indicate that she formed a useful perspective on the range of [Mr A's] issues. His was clearly a complex background, with past and recent trauma, drugs and serious family problems. These would place him at risk of a psychiatric illness. From the comments of the hospital in their notes, she also appears to have established good rapport, an important indicator of potentially successful treatment, and (from her own notes) had an expectation of an early follow-up appointment.

There is no indication that she was aware that [Mr A] had seen, two days previously, [Dr D] and that he had made an urgent referral to the [Clinic]; even though it would seem that his mother had accompanied him to both appointments. From the notes of both it is apparent that [Mr A] presented quite differently to the two counsellors and that his psychosis was much more apparent to [Dr D]. However, it is not clear from [Dr D's] notes whether he saw [Mr A] by himself or with his mother. [Ms C], it appears, did not see [Mrs B]. I do not think that this necessarily reflected a different level of skill, nor of negligence on [Ms C's] part, more a difference in [Mr A's] presentation, as perhaps evidenced by him not mentioning [Dr D] or the [Clinic] referral himself.

I consider that [Ms C] might have concentrated more on the reported depression in this first, and only, interview. She did however, obtain complex and relevant historical data as well as make an attempt to assess his potential for suicide. **Her apparent**

failure to assess for depression in a more thorough way would meet with mild to moderate professional disapproval.

I note that [Ms C] does not refer anywhere in her notes to any assessment of drug or alcohol use. In my opinion this should be standard practice in work with young people, it is also strongly indicated in the "Guidelines". Apart from any potential long term damage, drug use will also influence the ability of a person to benefit from psychological interventions.

I consider that her failure to do this would meet with mild to moderate professional disapproval.

I recommend that **[Ms C] review her note-taking, especially in regard to recording the bases for diagnostic and treatment decisions.**

b) Treatment

[Ms C] had only one session with [Mr A]. From her notes this was primarily an assessment. She responded to this by appropriately offering an appointment in the near future. Her treatment goals were relevant, given the history she had received and her assessment of [Mr A's] presentation on the day. She clearly did not gain any sense of [Mr A's] psychosis in this first interview.

However, her use of text messaging to provide advice can be seen as a form of treatment, this is discussed below.

c) Documentation

[Ms C's] handwritten casenotes (p76) of her first, and only, face to face consultation with [Mr A], although minimal, show some structured interviewing, history taking and formulation. These are expanded by her two written submissions (pp74, and pp77–79). There are some clumsy inconsistencies across all three documents which do not reflect well on [Ms C's] attention to detail. These do not detract from the notes which, in total, give an adequate summary of her contact with [Mr A]. In itself the original casenote is brief and I would like to have seen a record of her enquiries about mood, especially around depression.

I imagine that [Ms C] must have other paperwork as the sheet provided does not carry any basic details (address, phone, date of birth, GP). I would be particularly interested to know whether she had details of [Mr A's] GP, as a GP will be useful contact, especially where there is a complex history, where other services may be involved and medication an issue.

d) Communication with [Mr A] and with other providers

[Ms C's] communication with [Mr A] was appropriate to his age and the context of their relationship. I discuss the issue of text messaging later.

[Ms C] does not seem to have been aware of the consultation with [Dr D] previous to her session with [Mr A].

[Ms C] states that she became aware of [Mr A's] referral to, and assessment at, [the Clinic] via a telephone call from [Mrs B] "a number of days" after the initial appointment [on Day 4]. It is not clear whether this was before or after [Day 8], on which [Mr A] had referred to "another appointment at the hospital" (p6). There is no doubt from her continued efforts to make appointments that she still considered herself clinically involved with [Mr A]. It is surprising, therefore, that she made no efforts to contact [the Clinic] in order to work collaboratively according to section 7.4 of the NZAC Code of Ethics. However, there are also no signs that [the Clinic] tried to contact her, even though (as [Mrs B] reports) they suggested that "they would work with her as a team" (p9).

In balance I feel that [Ms C] could have taken initiative in making contact with [the Clinic] and consider **that her failure to do so would meet with moderate professional disapproval.**

Note:
[Ms C] is referred to as a "Spiritualist" in the clinical notes from the EPI (7/4/09, p 24; p 47, p 67) and as "working from a spiritual basis" p 42). I also note that, in her communications with the Commissioner, she does not refer to herself in this way. Whilst this would ordinarily be pertinent to my examination of [Ms C's] conduct in this case I do not propose to consider it as relevant in view of the fact that there is nothing in the documents provided to indicate that she advertised herself in this way, or purported to be a spiritualist. It appears that these terms were used by [Mr A] and his mother.

Question 2. Was it appropriate for [Ms C] to request [Mrs B] to also undergo counselling?

In a situation where the emotional health of a client is clearly influenced by the behaviour of a close family member it would be wrong for the counsellor to ignore the other party. In this case there were clearly complementary issues between [Mrs B] and her son. She was concerned and upset by his mental state and [Ms C] was concerned at the degree of "enmeshment" between mother and son, especially in the context of the history of [Mrs B's] suicide attempt and [Mr A's] role in its discovery.

It is my opinion that it was professionally responsible to consider [Mrs B's] needs and how they might interlock with those of her son. However I am surprised that [Ms C's] assessment that [Mrs B] needed to be seen by a counsellor appears to have been transmitted to her by [Mr A], verbally and via a slip of paper (p4).

I am also concerned that both [Mrs B's] letters and [Ms C's] notes and submissions state that her continuing to see [Mr A] was conditional on [Mrs B] receiving counselling. A strong stance such as this can sometimes be useful to enable a more complete treatment plan to be carried out. However, that this message was meant to be delivered by [Mr A], and not communicated directly was highly inappropriate. [Ms C] should have spoken to [Mrs B] directly about this. If [Mrs B] proved reluctant (which seems to be the case) this placed [Mr A] in a difficult position of being a go-between again in having to convey that back to [Ms C]. The stress of this would add to his already unsettled state of mind.

I note that (p75) [Ms C] goes on to say that she informed [Mrs B], when [Mrs B] telephoned her to ask about the referral she states that "I explained that it was not a requirement at all", in direct contradiction of the message she had passed through [Mr A].

I consider that [Ms C's] actions in communicating her wish for [Mrs B] to see a counsellor would meet with moderate professional disapproval.

Question 3. Was it appropriate for [Ms C] to sign a "no suicide" contract?

From [Mr A's] history and presentation [Ms C] was right to make an assessment of suicide risk. The use of suicide contracts as such is the subject of some debate within the mental health professions. **It cannot be equivocally stated that they either should, or should not, be used.** It is more the way they are used, the purpose of using them and whether they are effective in preventing suicide attempts.

Marcia Goin, in referring to their use by psychiatrists ("The "Suicide-Prevention Contract": A Dangerous Myth", ***Psychiatric News July 18, 2003*** **vol. 38** ***no. 14 3-38,)*** states that:

"It would be wonderful if contracts truly prevented such tragedies, but there are no reliable or valid data to confirm their effectiveness. Indeed, the use of such contracts flies in the face of clinical common sense and may in fact increase danger by providing psychiatrists with a false sense of security, thus decreasing their clinical vigilance".

Lee, J. B., Bartlett, M. L. (2005) state that: "Despite its entrenchment as a standard of practice, no-suicide contracts fail to achieve their purpose as an effective part of treatment or as an effective method of inoculating counsellors against potential lawsuits should a client commit suicide."

However, the US Centre for Suicide Prevention (www.suicideinfo.ca/csp/assets/alert49.pdf) state that research on the use of contracts highlights the usefulness of negotiating the contract as an assessment tool; a means of assessing current suicidality; of reducing clinician and patient anxiety; and a way of providing alternative behaviours to suicide. It is quite common for counsellors to use these contracts and it would seem that [Ms C] has done so in the past, and sees them as having been successful.

It is noticeable that neither the NZGG Guidelines, nor the National Suicide Prevention Action Plan (NZSAP 2008) refer to the use of suicide contracts, neither to promote or discourage their use.

[Ms C] describes her contract in her submission (p78), and shows that she has a simple and very short pro-forma contract rather than one which is negotiated and which described alternative actions (e.g. who to contact, situations to avoid, disposal of dangerous objects, medications etc). Also in this situation it appears that, once signed [Mr A] took the contract away, an error in my opinion as psychologically he then had control over its existence and had not left his "promise" with [Ms C].

Although flawed I consider that [Ms C's] actions in this would only meet with mild professional disapproval.

I recommend that [Ms C] review her use of suicide contracts and consider that, if she still intends to use one, that it is negotiated and includes contingency actions.

Question 4. Was it appropriate **for [Ms C] to provide advice by text?**

For most young people text communication is commonplace and a preferred use of a cellphone over direct voice contact and voice messaging. The reasons for this are largely financial, with 1000s of texts per month being part of some pay-as-you-go cellphone plans.

Some counsellors will use texts as a means of communicating with their clients, especially younger clients. The NZAC Code of Ethics has a specific section for electronic communication, see above. Electronic communication has risks. Apart from confidentiality there are also risks of misinterpretation due to an absence of gesture, tone of voice, eye contact etc. Counsellors would be wise, therefore, to limit text messaging to simple topics, like appointments. However, it is fairly common for texts to be used as for the provision of support and encouragement at times of crisis, especially with young people. There are risks to the counsellor, of being "too available", which is why clear contracts on the use of texts are important.

Following the consultation on [Day 4] [Ms C] had several communications with [Mr A] via text messaging which involved appointments and the provision of support and encouragement.

I consider that it was appropriate for [Ms C] to use texting as a means of communicating. However, a shift from negotiating appointments and offering encouragement to providing advice on medication is inappropriate.

This specific action would meet with moderate professional disapproval.

Question 5. Was it appropriate for [Ms C] to advise [Mr A] to not take his medication?

[Mr A's] texts of [Day 14] indicate that he had been advised to take medication and that he was asking for [Ms C's] opinion. This appears to be the first time that medication had been discussed between them both.

[Mr A's] message was: " *…a lot ov ppl thnk I shud go on medicati0n. bt I thnk thts going 2 supress a lot ov important em0tions tht r crucial 2 find and feel. Wat do u thnk?...*"

[Ms C's] reply was: "*I agree, no meds, but only if you have xlent support, at least 2x wk, with therapist that is not afraid of emotional xpreshun. Txt me 2 make nxt appt when it wks 4 u. Blessings, [Ms C]*."

(I note that in her submission (p75) [Ms C] states that her recommendation was that the counselling should be "3 times per week").

In her submission (p77) [Ms C] states that "This support of his position was based on my assessment of his state at the one appointment we had earlier in the month, wherein he did not present as at risk". Yet she knew that he was a patient at [the Clinic] and made this recommendation without any communication with the team that had the main clinical responsibility for [Mr A's] mental health. She says in her submission that she had told [Mrs B] that she was "willing to do adjunctive counselling for emotional support".

[Ms C] states in her submission (p78) that she was supporting [Mr A's] right to choose and quotes Right 7 of the Code of Health and Disability Services Consumers Rights. This would also be consistent with Counselling Ethics, the value of Autonomy (3.3); and the principle of increasing the range of choices (4.6).

However, Codes of Rights and Ethics do not contain absolute or exclusive clauses and may often evoke conflicts from which the clinician must decide the most appropriate course of action. It is not my role in this report to comment on [Ms C's] adherence to the Health and Disability Code, only in consideration of Counselling Ethics and accepted practice.

In this situation it is my opinion that we must also consider the value (in the NZAC Code of Ethics) of responsible caring (3.4), as well as the principles of promotion of safety (4.5), and avoidance of harm (4.2). There is also the question of whether [Ms C] was advising outside her competence (4.8); and her collaboration with other health providers (7.4 (a)).

There is no indication that [Ms C] enquired as to the specific medication prescribed, yet she was still able to say in her text "no meds"; even with the condition that he have frequent counselling. She admits to having had no communication with the [Clinic] team and that she felt that her relationship with [Mr A] had "become tangential" (p.79), yet she still felt able to offer an opinion on the medication under the umbrella of "supporting" [Mr A's] autonomy.

From the information provided it would seem that [Mr A] might have already been ambivalent about medication. This is confirmed in the notes provided by the [Clinic] team ([Day 12], p 35–37). However, in the notes for [Day 16] (pp31–32), two days after the text advice from [Ms C]) he has decided that he "doesn't think he will take the Respiridone". In spite of the Early Intervention Team's (EPI) attempts to persuade him otherwise he continued to resist taking the Respiridone. On [Day 25] the EPI notes state that "his main objection to taking Respiridone is his fear that it will not allow him to express negative emotions" (p28), a repeat of the arguments he used with [Ms C], and which she did not attempt to debate (even though this would have been inappropriate using texts).

It is my opinion that [Ms C's] provision of advice about medication prescribed by the primary clinical team fell short of what I would expect of a qualified and ethical counsellor **and that to do so without discussion with that team breached her professional duty to collaborate with other health providers and uphold the**

values of responsible caring, as well as breaching the principles of promoting safety and avoiding harm.

I consider that this **would provoke severe professional disapproval.**

Summary
This has been a tragic story where a young man has sought help from a range of treatment providers, encouraged and supported by his mother. He had a traumatic history and was in the early stages of a psychotic illness. He was also a frequent user of cannabis and other illicit drugs. It seems that he was able to hide his psychosis from [Ms C] and she responded to him as a very troubled young man who was depressed and anxious. From the hospital notes it appears that she established good rapport with him; a relationship that might well have proved helpful in the context of a wider team approach, including medication.

The support of [Mr A's] stand on medication was highly inappropriate. Whether it was a pivotal point in his stance not to use the anti-psychotic I cannot judge.

References:

"Identification of Common Mental Disorders and Management of Depression in Primary Care," New Zealand Guidelines Group July 2008

Lee, J. B., Bartlett, M. L. (2005). Suicide prevention: critical elements for managing suicidal clients and counselor liability without the use of a no-suicide contract. Death studies, 29, 847-865.

National Suicide Prevention Action Plan 2008–2012, NZ Ministry of Health 2008.

Code of Ethics (2002); New Zealand Association of Counsellors, Hamilton

Signed
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