A Residential Facility

Counsellor, Mr A

A Report by the

Deputy Health and Disability Commissioner

(Case 12HDC01582)

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Executive summary

1. In July 2012, Mr B, suffering from alcohol addiction issues and depression, entered a residential facility (the facility) for treatment. The facility is a medium to long-term residential programme intended to assist the recovery and healing of people affected by addictions, dependency or co-dependency, and/or other mental health issues, and to provide counselling assistance to residents. Mr A is the programme director of the facility.

2. Mr B was resident in the programme from 23 July 2012 until 22 November 2012. During this time, he had no written individual recovery plan and received only three one-to-one counselling sessions with Mr A. Mr A retained no clinical records of the counselling he provided to Mr B. The counselling sessions stopped because Mr A was double booked, but Mr B continued paying for counselling. Mr B was taking prescribed antidepressants, and Mr A encouraged him to stop taking his medication.

3. Following payment for the programme from his WINZ benefit, Mr B was left with only $7.00 per week. Mr A arranged work for Mr B doing jobs for people from Mr A's church, and charged Mr B out at $21.00 per hour but gave him only $15.00 per hour. Mr A also assisted Mr B to incorporate a company to avoid ramifications with regard to his benefit from being paid. The facility paid for the incorporation of the company, which resulted in Mr B owing a debt to the facility in excess of $300. He was expected to repay or work off the debt.

4. In addition, Mr A provided residents with knives, and they had access to air rifles.

Findings

5. The facility failed to provide criteria for entry to or exclusion from the facility, and did not provide a treatment programme or a plan that was generally adhered to. Accordingly, the facility failed to provide services to Mr B consistent with his needs and breached Right 4(3) of the Code of Health and Disability Services Consumers' Rights 1996 (the Code).[1]

6. Mr A failed to provide the agreed individual counselling services to Mr B that he required to assist with his recovery. Accordingly, Mr A failed to provide services to Mr B with reasonable care and skill and breached Right 4(1) of the Code. [2]

7. Mr A kept no records of any treatment or counselling sessions with Mr B during the 16 weeks he was a resident. Accordingly, Mr A also failed to provide services in accordance with professional standards and breached Right 4(2) of the Code.[3]

8. Mr A abused his position of trust and exploited Mr B's vulnerabilities for the financial gain of the facility and himself and, accordingly, breached Right 2 of the Code.[4]

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[1] Right 4(3) states: "Every consumer has the right to have services provided in a manner consistent with his or her needs."

[2] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

[3] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

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9. Mr A failed to maintain appropriate professional boundaries and breached Right 4(2) of the Code.

10. By providing access to knives and air rifles, Mr A failed to provide addiction treatment services to Mr B with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

11. Mr A 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.

Complaint and investigation

12. The Commissioner received a complaint from Mr B about the services provided to him by the facility and Mr A. The following issues were identified for investigation:

- *Whether the care provided to Mr B by the facility was of an appropriate standard.*
- *Whether the care provided to Mr B by Mr A was of an appropriate standard.*

13. This report is the provisional opinion of Ms Theo Baker, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

14. The parties directly involved in the investigation were:

Mr A	Provider
Mr B	Complainant
The facility	Provider

15. Information was also reviewed from:

Work and Income New Zealand
District Health Board
Mr C

16. Independent expert advice was obtained from addictions clinician Vanessa Caldwell (**Appendix A**).

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[4] Right 2 states: "Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation."

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Information gathered during investigation

Mr B

17. In 2012, Mr B was suffering from alcohol addiction issues and depression. He was living in a hostel and decided he needed to seek assistance with his alcohol addiction issues.

18. Mr B's Community Alcohol and Drug Services case manager referred him to the facility, a medium to long-term residential programme intended to assist the recovery and healing of people affected by addictions, dependency or co-dependency, and/or other mental health issues. Mr B said he understood he would get counselling, and help with his addiction issues and his grief from his personal issues. He resided at the facility from 23 July 2012 until 22 November 2012, when he was asked to leave following an argument with the director of the programme, Mr A.

Complaint to HDC

19. Mr B later complained to HDC about the availability of knives and air rifles at the facility, the lack of counselling, and the payment regimen. He also described the living arrangements, saying that during his time at the facility Mr A and his wife, Mrs A, lived in a house on the property, and that he lived in one of four small individual units. The ablutions unit (outhouse) was a shed that contained a toilet and a shower, and was 30–40 metres from his unit. The shower was operated by way of an LPG bottle, and the toilet consisted of a bucket, which the residents had to empty. There was no access to a flush toilet. Mr B told HDC that residents could use the flush toilet in Mr and Mrs A's house, which was about 50-60 metres from his unit, but that he did not feel comfortable doing so.

Individual recovery plan

20. Mr B said that he did not have a written plan, and the only plan was that he was to attend Alcoholics Anonymous (AA) meetings, join the other residents and Mr and Mrs A for dinner at night, and have weekly counselling sessions. Mr B said that any notes that Mr A made were not shown to him.

Counselling

21. Mr B stated that on Mondays at 10am there would be a two-hour group session, and each Tuesday at 10am he would have one-on-one counselling with Mr A. The group sessions involved group counselling with a number of outside people present, and took place on each of the 16 weeks that Mr B was at the facility.

22. Mr B elaborated that he received only three one-to-one counselling sessions with Mr A, one in each of the first three weeks he was at the facility. The counselling sessions then stopped because Mr A was double-booked. Mr B said that Mr A rescheduled one session from the Tuesday to the Thursday of that week, but the counselling did not take place on the Thursday either. Mr B raised the matter with Mr A, who said, "You are right; we will do it next week." However, the counselling never recommenced. Mr B told HDC that he thought that counselling was necessary to assist him to retain sobriety, and expressed to Mr A his concerns about the lack of counselling.

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23. Mr B stated that during the three counselling sessions that did occur, Mr A wrote down what Mr B said, then Mr A talked about his own experiences of anxiety, separation from his children, his intravenous drug use, and how he became separated from his family. Mr A also talked about his brother's family and Mr A's experiences with his father's ill health.

24. Mr B said that he gained strength from what Mr A was saying, as it indicated that your faith gets stronger through troubled times. He felt that he and Mr A had similar stories about addiction causing the end of their family as they knew it, and their need to face up to their mistakes. Mr B said that from listening to Mr A, he realised that "there is light at the end of the tunnel".

Payment for counselling

25. Mr B advised that his benefit from Work and Income New Zealand (WINZ) was $333.00 per week, and the arrangement was that $326.00 per week was paid directly to the facility, leaving him with only $7.00 per week. Of the $326.00, $61.00 was paid for weekly counselling.

26. Mr B said that in July 2012, Mr A took him to a consultation with a general practitioner (GP) at a medical centre to get a form signed to authorise 10 counselling sessions. The form was signed by both Mr A and the GP, and then Mr B took the form to WINZ. WINZ then paid the facility $610.00 for ten weeks' counselling.

27. Mr B said he again consulted the GP in October 2012 to get a further ten weeks' counselling signed off, because Mr A wanted the money.

Medication

28. Mr B stated that during his stay at the facility he was taking prescribed antidepressants. Mr A encouraged him to stop taking his medication and said that true sobriety means being off all medications. Mr B stated that he told Mr A that he wanted to get off the medication, but the antidepressants helped him to sleep at night. Mr A replied that he was not a fan of taking antidepressants because they may be blocking a channel with Mr B's higher power.

29. Mr B said that he responded that the doctor was prescribing the antidepressants, and Mr A said, "Yeah, he is prescribing them to you but you are swallowing them." Mr B stated that he was very hurt by that because he wanted to get clean and wanted the spiritual aspect, but he was scared not to have his medication, so he did not stop it.

Work arrangements

30. Mr B stated that he enjoyed working in the garden and assisting Mr A. However, he had only $7 per week and needed some money to buy items for himself and to pay for the arrangements to see his daughter.

31. Mr B was concerned about whether working would affect his benefit. He discussed the matter with Mr A, who said that he could perhaps find some work for Mr B, as he had done for other clients. They agreed that Mr B would work and receive $15.00 cash per hour. Mr B stated that Mr A found him work doing jobs for people from Mr

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A's church, and was charging him out at $21.00 per hour but giving him only $15.00 per hour.

Access to knives

32. On one occasion shortly before he left the facility, Mr B ran a fund-raising stall at the local Saturday market to raise funds for the facility, and also to enable him to make some extra money. He sold knives, garden tools and equipment, seedling plants, children's toys, bric-a-brac, jewellery and other miscellaneous items. Mr A supplied Mr B with a number of knives to sell. The knives, which Mr A had imported from overseas, were new and still in plastic bags. Mr B said that they were hunting knives, with approximately 10cm long blades. Mr B said that each resident was given one of the knives as a gift. He felt that the knives were not a good thing to have available in a place where emotions were seesawing as people were coming off alcohol or drugs. He stated, as an example, that one resident had been on amphetamines and had been in prison for firearms offences. Mr B said that he split the money he made with Mr A.

Access to air rifles

33. Mr B also stated that Mr A kept high powered hunting rifles in a shed at the back of his house in a 1.5 metre high gun safe bolted to brackets on the wall. The shed also contained weed-eaters and weed spray. Mr B stated that there were also air rifles available for general use. He said that a couple of air rifles were in the garage and one was in his (Mr B's) room.

34. Mr B stated that, one night, he went out with Mr A to shoot possums, and that he also went to shoot possums on three other occasions by himself.

The facility

35. The facility was established in 2010. The trustees are Mr A, his wife, Mrs A, and a counsellor, Mr C. The objectives as set out in the trust deed include fostering the recovery and healing of individuals affected by addiction, dependency or co-dependency, and/or other mental health issues that can be worked with competently … Providing counselling assistance to those in need whatever reason presented.

36. Mr A advised HDC that he and Mrs A established the facility to fill a gap between large residential A&D (alcohol and drug) Treatment Centres and the community.[5] Mr A said that the facility is a small facility staffed by himself, Mrs A, and one part-time unpaid counsellor.[6]

37. Mr A told HDC that the facility assists people to recover from addictions and other mental health issues, and that they are treated as family members. He said that the facility requires clients to make "a weekly payment of $326 or more which covers full board plus counselling and programme. This money is accessed via WINZ Sickness Benefit or by private means depending on the person's circumstances."

[5] The District Health Board advised HDC that it has no contractual arrangements with the facility or Mr A.

[6] The counsellor stated that when required she provides individual counselling. Mr B told HDC that she was training to be a counsellor at the time of these events and did not provide individual counselling.

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38. Mr A stated that, prior to entry, clients must sign a "Personal contract", which includes agreeing to these financial arrangements. The facility's informational material states that it is a charitable trust. It advertises itself as providing an environment where individuals with addictions to harmful substances and behaviour can be treated, which is not only safe culturally, but also caring and prayerful.

39. The facility states that the programme is for people seeking recovery from addictions to alcohol, drugs and other types of addictive behaviour. It is also advertised it as being a place where individuals with other mental health issues, or who just require somewhere to retreat and get well, can go to be treated. The environment is described as being a "family setting", where meals and social times are shared among residents, and it is stated that it is within this setting that the individual's recovery programme is decided upon and operates.

40. The informational material describes the recovery programme as self-directed, where individuals will take ownership of their own programme; and states that they are required to drive their own individual recovery process. However, it is noted that each plan is created and maintained in cooperation with the Programme Director.

41. The informational material states that each recovery plan includes details about activities such as taking part in training and education; maintaining personal hygiene; exercising regularly; attending Alcoholics Anonymous (AA) meetings; taking responsibility for various duties on the property; and participating actively in both one on one and group counselling sessions, which are done on a regular basis.

42. The informational material further advertises that the programme is personalised to meet each individual resident's needs, with a focus on his or her own personal recovery. Therefore, the informational material states that a resident's programme does not have a strict time frame, and is focused on the resident's safety, support, and connections from which a routine and structure is encouraged to emerge. The personal contract states that residents must agree to be open to regular review of their treatment plans according to what is thought necessary or useful for their personal well-being and recovery.

Mr and Mrs A

43. Mr A is the programme director of the facility. He has qualifications in A&D Counselling, and a bachelor's degree majoring in psychology. He is a member of the New Zealand Christian Counsellors Association (NZCCA) and the Addiction Practitioners Association Aotearoa (Dapaanz). Mr A said that he offers formal, weekly, one-to-one counselling to residents.

44. The facility's informational material states that relaxation and therapeutic massage are provided to the residents by Mrs A.[7]

45. The informational material states that the programme is operated within a family setting, and that each resident is expected to share the day-to-day practical duties relating to the property, which include helping in the garden.

[7] Mrs A has many years' experience in reflexology and relaxation massage.

HDC

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Mr C

46. Mr C stated that he has served on the board of the facility since its inception as a charitable trust, and has also provided counselling supervision services for Mr A for over 18 months.

Work and Income New Zealand

47. Mr A stated that residents are usually funded by Work and Income New Zealand (WINZ) sickness benefit payments, in which case the resident's GP and Mr A sign an Application for Special Needs Benefit for Counselling. This gives the residents access to Temporary Additional Support which, together with the accommodation allowance, covers the costs of staying at the facility.

48. WINZ advised HDC that it has no contractual arrangements with the facility or Mr A, but it has received redirection forms from clients requesting payment for their treatment to be redirected from their benefits to Mr A or to the facility.

49. WINZ stated that Mr A had recently queried WINZ clients' ability to stop redirections, as he was concerned that WINZ was making payments to clients for treatment they were not receiving, and that the facility was providing treatment and not being paid. WINZ advised Mr A that clients have the right to cease redirections, but they are obligated to advise WINZ should their personal circumstances change, such as having ceased treatment.

Care provided to Mr B

Individual recovery plan

50. The facility's informational material refers to individual recovery programmes and plans and recovery plans. It is unclear whether these are different documents or different expressions for the same document. In any event, Mr A provided no written planning or programme documentation for Mr B.

51. When asked about Mr B's individual recovery plan, Mr A said that Mr B was "offered weekly 1x1 counselling, weekly the facility therapy and education group" plus various groups held at a counselling centre, supported attendance at AA meetings, work opportunities, and ongoing therapeutic and financial support with his involvement with other organisations. Mr A said: "These engagements were all part of an holistic individuated approach toward promoting [Mr B's] ongoing sobriety."

52. Mr B told HDC that usually he went to AA meetings by himself and that Mr A lent him his car to drive there. Mr B said that he never saw any individual recovery plan for himself.

Counselling

53. Mr A provided no clinical records of the counselling he provided to Mr B. Mr A stated that the counselling sessions were fluid and relational, and could occur in the garden or at the kitchen table rather than in a formal setting in his office. He stated that the counselling services he provided to the facility clients are different from the services he provides to private clients, and said, "I treat them less formally in terms of taking notes", as the one-on-one counselling sessions could occur anywhere on the property where it is not appropriate to write notes, or notepaper may not be available.

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Payment for counselling

54. Mr A told HDC that the facility charges $61 per week for counselling services, but if the client chooses not to receive the services, or time does not allow the counselling to be provided because there are too many other commitments that week, the money is not refunded. He agreed that the payment related to the provision of one-to-one counselling sessions.

55. On occasion, the facility transfers a lump sum to Mr A for payment of wages and services, but the payments are not defined in the trust account, and there is no clear process for payment to him for counselling services. Mr A stated that much of the time the counselling services he provides one-on-one are provided without payment directly to him. He said: "[A company under my name] provides my personal counselling services to the facility. Payment for such services provided is piecemeal and depends entirely on the financial status of the Trust at any particular time."

56. Mr A provided an unsigned copy of a "Weekly payment contract", which he said had been signed by Mr B. Mr A said: "Clients must sign a client contract part of which is agreeing to the financial side prior to entry." He did not supply a copy signed by Mr B, who stated that he did not sign a personal contract.

57. The unsigned contract provided by Mr A states that clients will pay a total of $326 a week, comprised of:

- $200 for board
- $65.00 for food
- $61.00 for therapy

Medication

58. Mr A told HDC that the facility has an abstinence approach to recovery, which means that, over time, antidepressant medication is ceased because it can hinder the recovery process. Mr A said that he would not require or recommend that anyone cease their medication but that, when a client is ready, he would encourage him or her to consider "looking at" his or her medication with involvement from a GP.

Work arrangements

59. Mr A stated that the arrangement that residents be given an opportunity to work while getting paid was a "recovery pathway for certain residents", and was never intended as a money-making tool for the facility. Mr A agreed that the payment rate was a problem for Mr B. Mr A said he was "absolutely open" with Mr B as to what he was being paid and the rate at which he was being charged out. Mr A stated that the difference between the amount Mr B was paid ($15.00) and what the facility charged per hour ($21.00) was to cover expenses incurred by the facility, for tools, equipment repairs and the like. However, the facility provided HDC with copies of invoices for the customers on the facility letterhead, which state that the invoices were for "Fund raising gardening work" and included payments for labour, plus equipment and vehicle costs.

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60. Mr A stated: "[Mr B] was unwell and could not understand the reasons for this $6.00 difference. At the time it was problematic to the extent that I stopped offering work to him." Mr A stated that the facility runs at a loss on such activities. However, he also stated that "[a] little money from odd jobs adds slightly to income as well".

61. Mr B said that he considers it hurtful and manipulative for Mr A to have said that Mr B did not understand the situation due to being "unwell".

62. Mr A assisted Mr B to incorporate a company to avoid ramifications with regard to his benefit, from being paid. Mr A agreed that he suggested Mr B start a company so that any legalities and regulatory requirements regarding the facility paying Mr B for services rendered would be resolved. The facility paid for the incorporation of the company, which resulted in Mr B owing a debt to the facility in excess of $300. He was expected to repay or work off the debt.

Access to knives

63. In response to the issue of knives, Mr A agreed that knives are sometimes gifted to residents, and he told HDC that the knives were easy-opening lock-blade pocket-knives. He saw no risk from the knives being in the possession of residents as, in his view, a pocket-knife is a handy tool and valuable for many practical tasks.

Access to air rifles

64. Mr A told HDC that rifles are used at the facility to shoot possums. He stated that the rifles are 22 single shot spring-loaded slug rifles, legal for anyone over the age of 18 to use, and that the facility residents are "welcome to exercise this aspect of rural living" under supervision.

Departure from the facility

65. On 20 November 2012, Mr B had an altercation with Mr A regarding the various issues that had arisen. Mr B was intoxicated at the time. Mr B told HDC that he was out of line in the way he behaved, and accepts that no one should be spoken to in the manner that he spoke to Mr A.

66. Mr B stated that two days after the argument, on 22 November, Mr A "kicked [him] out". Mr B believes that the delay was in order for Mr A to collect a further $343.50 from Mr B's benefit for that week. Mr B said that he was very upset on 22 November when he received a letter ejecting him. He said that the letter claimed he owed Mr A $305.19. Mr B provided HDC with an invoice from the facility for that amount. Mr B told HDC that he disputes that he owed Mr A $305.19.

67. Mr A said that clients are often in deficit when they leave the programme, and that "[w]hen this is the case the moneys owed [to] the facility are not pursued but rather forgiven. These may be recovered if the person re-enters the Programme at a later date … At best a person leaves the facility with nil balance owing."

68. Mr B stated that he was put out on the street with nowhere to go. He said: "I had no money and nowhere to go, only the clothes on me. I was suicidal and felt so trapped." On 23 November he returned to his cabin at the facility to sleep, so Mr A called the Police, who removed Mr B and served him with a trespass order. He then managed to

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find a place to stay in a motel and, subsequently, his personal possessions were packed and delivered to the motel.

Subsequent events

69. Mr B said that he is now sober and living peacefully. He said he "found the facility anything but a safe haven and that distressed [him]". He wants each counselling session to be signed off by both the client and Mr A, and a copy of the document sent to WINZ as evidence that the counselling actually happened.

Response to provisional decision

70. Mr B was given the opportunity to comment on the "Information gathered during investigation" section of the provisional decision, and his comments have been incorporated above as appropriate.

71. Mr A and the facility were given the opportunity to comment on the provisional decision and made no comment about the proposed findings. Mr A said that he was willing to comply with the proposed recommendations.

Relevant standards

72. The New Zealand Christian Counsellors Association (NZCCA) *Code of Practice and Ethics* 2008 states:

> "1.5 Counsellors recognise the power differential implicit within every counsellor/client relationship, and seek to minimise the potential negative impact of that differential. …
>
> 1.7 Counsellors recognise the potential for multiple relationships to exist, in that 'counsellor' and 'client' may relate to each other in different roles in other environments. Counsellors seek to recognise when such circumstances exist and to establish clear boundaries for the conduct of differing roles. …
>
> 1.10 Counsellors keep sufficient records of their activities, in a secure manner:
>
> 1.10.1 for their own reference.
>
> 1.10.2 to ensure that at some future date the client, or other relevant professional(s) responsible for the client, can be informed of the process undertaken.
>
> 1.10.3 to enable the information to be presented clearly if necessary."

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73. The Dapaanz Code of Ethics provides:

> "[I]t is a responsibility of practitioners to avoid dual or multiple relationships and other conflicts of interest when appropriate and possible. When such situations cannot be avoided or are inappropriate to avoid practitioners have a responsibility to declare they have a conflict of interest, to seek advice, and to establish safeguards to ensure that the best interest of members of the public are protected."

Opinion: Introduction

74. During the course of investigating this complaint, I have found it difficult to separate the roles and responsibilities of the facility from those of Mr A. Mr A stated that he and the facility "are (currently) somewhat synonymous". It is clear that he intermingled the facility's role with his role as an addictions clinician and counsellor.

75. Small organisations such as the facility that have fewer than five residents are not required to be certified under the Health and Disability Services (Safety) Act 2001. They are also not regulated as boarding houses under the Residential Tenancies Act. However, the facility and Mr A, as healthcare providers[8] providing health services,[9] are subject to the obligations set out in the Code. Equally, consumers treated by the facility and/or Mr A have rights as set out in the Code. The consumers treated by the facility are vulnerable and at risk of harm. I am concerned about the facility's lack of structure, lack of a documented programme, and the failure to provide counselling when this was specifically paid for.

Opinion: The facility

Programme — Breach

76. The facility has provided me with no documentation to support any minimum criteria for entry or exclusion into its programme. My expert advisor, addiction clinician Vanessa Caldwell, advised that without criteria for entry it is difficult for people to make an informed choice as to their suitability for the programme, or for Mr A to ascertain whether he has the training and expertise to treat the residents.

77. The facility's informational material refers to the structure of the programme and states that each resident will have an individual programme plan, and that issues such as actively participating in regular therapy sessions (both one-on-one and group sessions), taking part in the programmes, and participating in the facility's routines will be included within the detail of each recovery plan.

[8] Section 3(k) of the Health and Disability Commissioner Act 1994 (the Act).
[9] Section 2 of the Act.

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78. Mr B was a resident at the facility for 16 weeks, but neither the facility nor Mr A has produced any evidence of a recovery plan or individual programme plan prepared for him. I find it more likely than not that no written plan was prepared detailing Mr B's intended and agreed activities.

79. Ms Caldwell advised me that individual treatment planning, as described in the facility's informational material, is ideal but, at the very least, there should have been a documented assessment of the issues presented by Mr B on entering the programme, and an appropriate plan of activities to address the issues, in the form of a treatment plan.

80. Ms Caldwell advised that it would be standard practice for the plan to be presented in a format that would have allowed Mr B to structure his week in a programme of activities. She noted that although some activities might have been deferred in any given week, generally, the programme the facility was being paid by Mr B to provide should have been provided.

81. Ms Caldwell advised that "self-directed and consumer ownership of a programme, in my opinion, does not devolve the responsibility of the service to provide a regular programme of activities that can be clearly linked to assessed needs". Ms Caldwell considered that the lack of structure indicated that the programme was not operating as an addiction treatment programme as it was held out to be. Rather, Mr B was being supported to attend activities if and when he wished in an unplanned manner, which, in her opinion, was more akin to what would be expected in a supported accommodation service, which was not what Mr B required or expected.

82. Mr B was a vulnerable consumer who required an addiction treatment programme that was suitable to meet his needs. The facility failed to provide Mr B with consistently documented criteria for entry or exclusion to the facility or a treatment programme or a plan that was generally adhered to.

83. I find that by failing to provide criteria for entry or exclusion to the facility, and not providing a treatment programme or plan that was generally adhered to, the facility failed to provide services to Mr B consistent with his needs and, accordingly, breached Right 4(3) of the Code.

Accommodation — Other comment

84. Mr B advised that he resided in a small unit with no ablution facilities, and that in order to shower or use the toilet he had to go to a building some distance from his unit. The ablution unit did not have a flush toilet, and the shower was operated from a gas bottle. The residents were required to use a bucket as a toilet, which they were then required to empty. In my view, the nature of the accommodation should be made clear in the facility's informational material. This is information that prospective residents should be aware of.

85. In my view, the facility should ensure that the accommodation provided is of a suitable standard to facilitate the recovery of clients.

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Opinion: Mr A

Counselling — Breach

86. Mr B had three one-on-one counselling sessions with Mr A. Mr B attempted to arrange further counselling, but Mr A failed to provide any more counselling sessions. Mr A stated that the formal one-on-one counselling sessions did not always occur because of difficulties around timing, conflict with other activities, and Mr B's resistance to the process.

87. Mr A stated that the counselling sessions were fluid and relational and might occur in the garden or at the kitchen table rather than in a formal setting in his office. He said that he kept no records of the counselling because the one-on-one counselling sessions could occur anywhere on the property where it was not appropriate to write notes, or notepaper might not be available.

88. Ms Caldwell advised that informal discussions can have therapeutic benefits, and any discussion outside a structured counselling session can involve recovery related information or issues. However, she noted that such informal conversations do not constitute an adequate proxy for counselling sessions with a qualified counsellor. Ms Caldwell advised:

> "[I]n essence counselling could be considered a distinctive, professional, contracted activity that is undertaken by people who agree to occupy the roles of counsellor and client. In my opinion, an informal conversation without the explicit agreement by both parties and which has no contract, is not documented and shows no evidence of use of therapeutic intervention towards an agreed end, falls well short of this definition of professional counselling which would be expected from someone of [Mr A's] training and professional identity."

89. In my view, informal conversations do not amount to counselling sessions. Mr B considered that counselling was necessary to assist him to retain sobriety, and expressed to Mr A his concerns about the lack of counselling. In my view, it was unacceptable for Mr A to fail to provide the agreed individual counselling services to Mr B that he required to assist with his recovery. Accordingly, I find that Mr A failed to provide services to Mr B with reasonable care and skill and breached Right 4(1) of the Code.

90. Futhermore, Mr A kept no records of any treatment or counselling sessions with Mr B during the 16 weeks he was a resident and, instead, referred to the relational approach taken by the facility. In my view, this is a clear breach of the NZCCA Code of Ethics 1.10, which states: "Counsellors keep sufficient records of their activities, in a secure manner." I find that Mr A failed to provide services in accordance with professional standards and, accordingly, also breached Right 4(2) of the Code.

Financial exploitation — Breach

91. Right 2 of the Code provides that every consumer has the right to be free from financial or other exploitation. Clause 4 of the Code states that exploitation "includes

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any abuse of a position of trust, breach of a fiduciary duty, or exercise of undue influence”.

92. This Office has previously stated:[10]

> “Any relationship between a patient and a health professional, whether the health professional is registered or not, involves trust, even more so when the patient is vulnerable.”

93. Mr B was a vulnerable consumer who was reliant on Mr A to provide his accommodation and necessaries of life, as well as the treatment he required to maintain sobriety. He had very limited means and, after payment of $326.00 per week to the facility, he was left with $7.00 per week to pay for any items not provided by the facility. This was of concern to him, in particular because he needed to pay for supervised contact with his daughter. In my view, Mr A held a position of trust in respect of Mr B, and there was a substantial power imbalance in their relationship. Mr A abused this position of trust when he took advantage of Mr B for his own ends — to provide financial advantage for the facility and, ultimately, for himself. For the reasons given below, I consider that Mr B was financially exploited by Mr A.

94. Mr B paid $61.00 per week for counselling services via WINZ. The payment was made to the facility, and then payment for counselling services was made to Mr A via the facility. Neither the facility nor Mr A provided itemised detailed invoices for the counselling.

95. Mr A said that the payment of $326.00 per week was for board and programme costs; however, the unsigned contract provided by Mr A to HDC specifies:

- $200 for board
- $65.00 for food
- $61.00 for therapy

96. Mr A arranged for Mr B to obtain authorisation from WINZ for 10 counselling sessions in July 2012, but provided Mr B with only three one-on-one counselling sessions. Despite his not receiving the entire initial 10 sessions, in October 2012 Mr A encouraged Mr B to again obtain authorisation for a further 10 weeks of counselling. In my view, it was exploitative for Mr A to undertake to provide the counselling that Mr B needed, require Mr B to pay for the counselling, but fail to provide it.

97. In my opinion, Mr A abused his position of trust and exploited Mr B’s vulnerabilities for the financial gain of the facility and himself. Accordingly, Mr A breached Right 2 of the Code.

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[10] Opinion 09HDC01375, 17 March 2010, available at www.hdc.org.nz.

Boundary issues — Breach

98. Ms Caldwell advised that Mr A's arrangement for Mr B to be engaged as a subcontractor of the facility to provide services to customers for which he invoiced the facility was a clear breach of the Dapaanz Code of Ethics, which states:

> "[I]t is a responsibility of practitioners to avoid dual or multiple relationships and other conflicts of interest when appropriate and possible. When such situations cannot be avoided or are inappropriate to avoid practitioners have a responsibility to declare they have a conflict of interest, to seek advice, and to establish safeguards to ensure that the best interest of members of the public are protected."

99. Ms Caldwell advised that those arrangements exacerbated the power differential in the relationship that Mr A had with Mr B, and fell outside the generally accepted nature of a therapeutic relationship. In her view, that was a breach of the NZCCA Code of Ethics 1.5, which states: "Counsellors recognise the power differential implicit within every counsellor/client relationship, and seek to minimise the potential negative effect of that differential."

100. It is apparent that Mr B did not understand the basis for the subcontracting relationship, which had a destructive effect on his relationship with Mr A.

101. Furthermore, Mr A advised Mr B to form a company to process the payments associated with his work, which resulted in Mr B becoming indebted to the facility for over $300.00. Ms Caldwell advised that it was of concern that Mr A believed it was within his scope of practice to give business advice to Mr B to form a company. Ms Caldwell advised that "even if [Mr A] was fully qualified to offer this advice, to offer it without a clear agreement that [Mr B] was engaging him for the expressed service would constitute a breach of an existing relationship as a counsellor of [Mr B]".

102. Mr B told HDC that Mr A encouraged him to stop taking his prescribed medication. Mr A stated that he would not require or recommend that anyone cease their medication, but said that the facility has an abstinence approach to recovery which means that, over time, antidepressant medication is ceased because it can hinder the recovery process. He also said that, when a client is ready, he would encourage him or her to consider "looking at" his or her medication with involvement from a general practitioner.

103. Having considered these facts, I am of the view that it is more likely than not that Mr A did encourage Mr B to stop taking his prescribed medication. In my view, it was inappropriate for Mr A to discuss medication with Mr B. If a client has any questions about medication, he or she should be referred to the prescriber. Had Mr B taken the advice that he cease taking his medication, he may have been at risk of becoming unwell.

104. Ms Caldwell noted that it was a breach of the NZCCA Code of Ethics 1.7 for Mr A to engage in multiple roles as counsellor/client, contractor/subcontractor, and programme director (with financial control)/treatment.

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105. Ms Caldwell also noted that Mr A referred to residents as family members. She advised that there is a conflict between establishing professional relationships as a counsellor/addiction treatment practitioner and developing more intimate family-like relationships. She stated: "The notion that 'genuine relationship building' could be 'mandated' as described in [the facility's] material does not fit with any generally accepted treatment modality that I am aware of." Ms Caldwell noted that many of the issues in this situation occurred as a result of Mr A's lack of clear boundaries and professional roles.

106. In my view, Mr A failed to maintain appropriate professional boundaries and, accordingly, breached Right 4(2) of the Code.

Knives and air rifles — Breach

107. Mr A acknowledged that he supplied knives to residents, including Mr B. Mr A said that the knives were gifted to residents, and he saw no risks in doing so. He also stated that he took residents hunting for possums. Mr B stated that there were also air rifles available for general use, which were kept in the garage, and he also had an air rifle in his room. Mr A agreed that .22 single-shot spring-loaded slug rifles were available at the facility for residents to use to shoot possums.

108. Ms Caldwell noted that the facility clearly promoted and provided services for people who are in the early stages of recovery from addiction. She advised that residents may have chronic problems and, as a result, may be experiencing cognitive difficulties, which are commonly manifested through difficulties with impulse control, anger management, stress management and depression. Ms Caldwell advised:

> "[T]herefore, to suggest that knives of any type and guns (and associated activities such as hunting) are provided for as part of treatment is incredulous. The fact that one could hurt themselves or someone else aside, the potential intimidation to others of some residents having these weapons (which [Mr A] refers to as handy tools) appears to be something that [Mr A] has not considered."

109. Ms Caldwell advised that Mr A's actions would be met with severe disapproval from other treatment providers. In my view, by providing access to knives and guns Mr A failed to provide addiction treatment services to Mr B with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Recommendations

110. In accordance with the recommendation made in the provisional decision, Mr A provided an apology on behalf of himself and the facility, which has been forwarded to Mr B.

111. I recommend that the facility :

a) Obtain certification under the Health and Disability Services (Safety) Act 2001.

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b) Amend its informational material to ensure that the information provided accurately reflects the services available.
c) Develop documentation that consistently sets out the minimum criteria for entry into, or exclusion from, the programme.
d) Ensure that an individual programme plan for each individual resident at the facility, as at the date of this report, is drafted, implemented and reviewed by an independent addiction clinician, and provide a report from that clinician to HDC.
e) Ensure that all services advertised and/or charged for are provided and recorded.
f) Ensure that appropriate Trust accounts that meet expected accounting standards are maintained.
g) Ensure that residents are aware of the actual costs of the programme before they enter the programme.
h) Obtain an independent audit of the programme and provide the audit report to HDC.

112. I recommend that the facility comply with the above recommendations and provide evidence of compliance to HDC within **six months** of the date of this report.

113. I recommend that Mr A:

a) Undertake training on professional boundaries, dual and multiple relationships, and conflicts of interest.
b) Arrange for his supervisor to assess whether boundaries are appropriately maintained by Mr A at the facility and, every six months until June 2016, report to Dapaanz about the steps taken to clarify boundaries and professional roles with Mr A.
c) Arrange for an independent audit of his records and report to HDC on the outcome of the audit.

114. Mr A is to provide HDC with evidence of compliance with these recommendations within **six months** of the date of this report.

Follow-up actions

115.
- Mr A 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 with details identifying the parties removed, except the expert who advised on this case, will be provided to Dapaanz, NZCCA, the District Health Board, and WINZ, and they will be advised of the facility and Mr A'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.

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Addendum

The Director of Proceedings filed a claim at the Human Rights Review Tribunal which proceeded by agreement. The Human Rights Review Tribunal made a declaration that the providers had breached Rights 4(1) and (2) of the Code.

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Appendix A — Independent expert advice to the Commissioner

The following expert advice was obtained from Vanessa Caldwell, addictions clinician:

"I Vanessa Caldwell have been asked to provide an opinion to the Commissioner on Case Number 12HDC01582 and I have read and agreed to follow the Commissioner's Guidelines for Independent Advisors.

QUALIFICATIONS AND RELEVANT WORK EXPERIENCE
My current role is national manager of Matua Raki, national addictions workforce development and I have worked in the addictions field as a clinician and service manager for both residential and outpatient addiction treatment services over the past 20 years. Previous roles have included Programme director of the Wellington Bridge programme and Director of Hanmer Clinic Wellington at its set up. I was general manager and executive director of a behavioural healthcare company that specialises in assisting organisations to manage alcohol and drug issues in their workplaces for 7 years prior to working with Matua Raki. I am a registered psychologist although have not renewed a practising certificate this year due to demands in my current work role. I have an MBA and am in the final year of completing doctoral studies. I am currently an elected member of the Dapaanz executive and co-chair of the national committee of addiction treatment (NCAT).

Sources of information reviewed

Below is a list of the material supplied to me by the Commissioner. I have read all the documents carefully.

Supporting Information

- Copy of e-mail complaint [to HDC] outlining concerns about the services provided by [the facility] and [Mr A]
- Call log on 05-12-12 from HDC to [Mr B] to confirm concerns raised by [Mr D]
- Call log on 17-12-12 from HDC to [the] Police to confirm discussion with [Mr D] as outlined in e-mail.
- Letter of response from [Mr A] to complaint from [Mr D] dated 21-12-12.
- Letter of complaint from [Mr B] and summary of his concerns dated 08-01-13 (refers to letter from HDC dated 17-12-12 not included in materials)
- Letter to [Mr B] from HDC dated 18-01-13 (also refers to previous letter dated 17-12-12) indicating information will be sought from [Mr A]
- Letter to [Mr B] from HDC dated 18-04-13 indicating decision to investigate complaint
- Letter to [Mr A] from HDC dated 18-01-13 seeking clarification on issues relating to complaint from [Mr B]

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- Letter of response from [Mr A] to HDC dated 23-01-13 with supporting documents as requested:
  - Trust Deed for [the facility],
  - copy of consent to Release information form
  - copies of pages (13) from [the facility's informational material]
  - copy of personal contract template
  - copy of information sheet titled [the facility] Residential Programme
  - entry for [Mr A] as counsellor on NZCCA website
- Letter from HDC to Trustees of [the facility] dated 18-04-13 outlining complaint and inviting response to areas of investigation
- Letter of response to HDC from Trustees of [the facility] dated 07-05-13 with supporting documents including:
  - Overview summary of [the facility]
  - Mission, Vision statements
  - E-mail from [Social worker]
  - Letter of support from [Mr C] the supervisor for [Mr A]
  - Letter of support from [Ms A] a counsellor (when required) at [the facility]
  - Payment contract template
  - 3 letters of support from clients of [the facility] (2 current, 1 left the service April 2012 after 16 months)
  - 1 card of thanks to [the facility] from client
  - Letter of thanks to [Mr A] from [a tertiary institution] for Year 1 student experience placement
  - Two letters of support from counselling clients of [Mr A] not residents of [the facility]
  - Copy of letter to [Mr B] from [a community organisation] regarding cost of supervised visitation
  - Copy of invoice from [Mr B] to [the facility] dated 22-08-12 for gardening work
  - Copy of receipt from [the community organisation] to [the facility] for [Mr B] dated 26-08-12 — does not state on receipt what this money is for.
  - Copy of handwritten workings dated 25-08-12 for monies paid on behalf of [Mr B] to [the community organisation] — Note that no invoice supplied from [the community organisation] included
  - Copy of invoice (although not stated as such) for gardening work from [the facility] to (name withheld) dated 25-08-12

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- Copy of quote for gardening work from [the facility] to (name withheld) dated 25-08-12
- Copy of invoice from [Mr B] to [the facility] for work undertaken dated 05-09-12
- Copy of bank record indicating payment on 07-09-12 to [Mr B] from [the facility] in the amount invoiced on 05-09-12
- Copies of two invoices (although not stated as such) from [the facility] to (names withheld) for gardening work dated 06-09-12
- Copy of two receipts of payment from [a] Medical centre to [Mr B] dated 03-10-12 and 10-10-12
- Copy of receipt from [a retail outlet] dated 01-10-12 noted as mobile phone for [Mr B]
- Documents relating to the formation of a company for [Mr B] including the confirmation and invoice from [a company specialising in the formation of companies] and confirmation of payment made for this invoice by [the facility's] Trust Account VISA.
- Spreadsheet of account details (deposits and debits) recorded for [Mr B] while residing at [the facility] from 31-07-12 to 23-11-12
- Copy of bank statement for account: [Mr A], [the facility] dated 21-04-13 detailing transactions from 02-04-12 to 28-03-13.
- Letter of endorsement for [the facility] from […] dated 07-05-13.

Standards applied

- The Code of Health and Disability Services Consumers' Rights (1996) which extends to any person or organisation providing, or holding themselves out as providing, a health service to the public or to a section of the public — whether that service is paid for or not
- The Dapaanz (Addiction Practitioners Association of Aotearoa, NZ) Code of Ethics 2005. [Mr A] is a registered Dapaanz practitioner.
- The NZCCA (NZ Christian Counsellors Association) Code of Practice and Ethics 2008. [Mr A] is a full member of NZCCA.

FACTUAL SUMMARY

Background

[Mr B] was a resident at [the facility] for 16 weeks from 22 July 2012 until 22 November 2012. [Mr B] was asked to leave because he was found to have consumed alcohol on more than one occasion while resident at [the facility]. [Mr B] complained that during his residence at [the facility] his needs were not met. A summary of the key points of [Mr A's] complaint is as follows:

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- [Mr B] paid through his WINZ benefit for services, specifically counselling services that were not provided as stated on [the facility's informational material]
- Pocket knives were handed out to residents as gifts or rewards
- Residents were invited to go hunting with [Mr A] as part of therapy and were provided with guns to do so
- [Mr B] paid more for visits to his GP than he was entitled to pay
- [Mr B] was charged out at more than he was being paid for work such as gardening and painting
- There was no compulsory requirement to attend AA or other parts of the programme that were offered
- There were no set rules that applied universally but rather different rules for different residents
- [The facility] did not have a zero tolerance policy regarding alcohol and drug use
- Residents were encouraged to cease their anti-depressant medication.

REFERRAL INSTRUCTIONS

Expert Advice Required

I have been asked to provide an opinion to the Commissioner on whether the services provided at [the facility] were of an appropriate standard and make comment on the following:

- Do not limit your comments to the points raised in the complaint but consider the service provided as a whole.
- Comment on the lack of structure in the programme that is offered. In particular the counselling sessions offered which are informal and not documented on a regular basis, and the programme which is voluntary and does not appear to have minimum requirements.
- Please comment on the payment scheme offered by the Trust and review the Trust accounts.
- Please comment on the provision of knives and guns to the residents.
- In commenting on the services provided please refer where applicable to relevant standards that apply to the provision of drug and alcohol services. Please also comment on requirements generally for providers of drug and alcohol addiction services such as [the facility].
- If in answering the questions you believe that [the facility] did not provide an appropriate standard of care, please indicate the severity of its departure from that standard. To assist you on this point we note that some experts approach this question by considering whether the provider's peers would view the conduct with mild, moderate, or severe disapproval.

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Assumptions

'[The facility]' or the 'Trust' will be referred to in respect to issues relating to the service as a whole which can be distinguished from services provided by [Mr A].

'[Mr A]' will be referred to in respect to services provided by [Mr A] that are distinct from the service as a whole.

The following opinion is offered acknowledging that several references provided in writing by [Mr A] attest to the passion and commitment that [Mr A] has to this area of work and which the addiction treatment field has typically relied on. His level of commitment is not in question, however, the provision of addiction treatment services such as that offered by [Mr A] and [the facility] must meet certain standards of care and as a registered, practising member of both Dapaanz and NZCCA [Mr A] must comply with the practices and ethics set out by those organisations.

It is noted that the people [Mr A] provides services for are seeking addiction treatment so would not be considered stable in abstinence or recovery and it is further noted that a distinction is clearly made [in the facility's informational material] between the provision of a residential addiction treatment programme and respite care (home page). Therefore the complaint will be viewed from the perspective that [the facility] was undertaking to provide a residential addiction treatment programme for [Mr B] rather than supported accommodation or respite care.

Opinion

1. Comment on the lack of structure in the programme that is offered. In particular the counselling sessions offered which are informal and not documented on a regular basis, and the programme which is voluntary and does not appear to have minimum requirements

I will comment on the structure of the programme and the provision of counselling separately.

1(a) Programme Structure

In regards to the requirements of entry and structure of the programme, [the facility] offers no documentation to support any minimum criteria for entry or exclusion into the programme and the only criteria for dismissal indicated in the [informational] material […] is the use of alcohol and or drugs.

In regards to the dismissal criteria the information sheet provided by [Mr A] titled '[The facility's] Residential programme' states that 'any breaking of the no alcohol/drug rule may result in immediate dismissal from the property'. [Mr B] was concerned that the 'no alcohol/drug rule' was not applied universally and it appears that it wasn't in his situation as there were prior incidences of his drinking where he remained in residence after consultation with his referrer. On this issue, I agree with [Mr A] that with the client group concerned, it is desirable to have discretion as to dismissal, as indicated in the document noted above, to take into consideration circumstances and support and decide on a case by case basis where alcohol or drug use is concerned. I do note however, that the clause stated above is

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not consistent in the materials relating to the [the facility] programme and would recommend this is corrected in order to avoid confusion.

Without any minimum criteria for entry into this programme, it is difficult for people to make an informed choice about their suitability for this programme. [Mr A], as programme director, has no criteria by which to assess this programme's suitability against people's needs. [Mr A] puts himself at risk of working with people who have conditions that are outside his area of training and expertise to manage and for whom this programme may not be suitable.

As regards to the structure of the programme itself, the following excerpt details the information provided to the public and residents about the programme:

[…each individual plan is created and maintained in cooperation with the Programme Director. Each recovery plan includes details about activities such as taking part in training and education; maintaining personal hygiene; exercising regularly; attending Alcoholics Anonymous (AA) meetings; taking responsibility for various duties on the property, being involved in the facility's daily and weekly agenda; and actively participating in regular therapy sessions (both one-on-one and group sessions), which are done on a regular basis.] [Paraphrased for privacy.]'Because of this focus on individual recovery any programme is not overly structured to a regimented timeframe.' (*[The facility's informational material] …*)

[Mr B] was a resident in this treatment programme for a period of 16 weeks having being referred by [CADS]. [Mr A] has not produced any evidence of a recovery plan or individual programme plan that has been drafted, implemented or reviewed in any way by himself as the Programme Director. [Mr A] instead deferred the question of a treatment plan to the referring agent who he describes as [Mr A's] case worker and who is not able to supply any records of communication. It would be considered unusual practice for a referring agent to dictate an individual's proposed treatment plan to another service or have copy of a recovery plan that the treating organisation does not have. It would appear that a written programme plan detailing [Mr A's] intended and agreed activities that would contribute to his recovery does not exist.

Individual treatment planning as described by the information relating to [the facility's] programme is ideal, however, the standard level of addiction treatment, at the least, would involve a documented assessment of the issues presented by [Mr B] on entering the programme (either from his referrer or [Mr A]) and an appropriate plan of activities to address these issues in the form of a treatment plan. It would be standard practice that this plan is presented in a format that allows [Mr B] to structure his week in a 'programme' of activities. It is accepted that for various reasons during any given week some of these may be deferred, generally this programme would constitute the treatment that is being provided and for which [the facility] is being paid for via the WINZ benefit. Self-directed and consumer ownership of a programme, in my opinion, does not devolve the responsibility of a service to provide a regular programme of activities that can be clearly linked to assessed needs. In my opinion the lack of any structure or regular occurrence of any activities including the group therapy, education classes or 1x1 counselling that [Mr A] refers to in his responses indicates that [Mr B] was not

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involved in an addiction treatment programme but rather was being supported to attend activities as and when he wished in an unplanned manner which cannot be clearly tied to contributing to his recovery. This is more akin to what one might expect of a supported accommodation service and as such the promotional material for [the facility] could be seen as misleading and a breach of NZCCA Code of Ethics 2.3 (*Professional qualification and description of services help the public to make informed choices about the quality and type of service provided. Accordingly counsellors seek to accurately and honestly represent their qualifications, experience or services*).

1(b) In respect to the counselling sessions there are two main issues of concern which although related will be addressed separately: the informal nature of counselling and payment of counselling services.

Informal nature of counselling

References: Response to HDC from [the facility] dated 07-05-13 (page 4) Call log HDC dated 10-05-13

I agree that informal discussions can have therapeutic benefits and any discussion outside a structured counselling session can involve recovery related information or issues. These conversations however do not constitute or would be considered in any way an adequate proxy for counselling sessions with a qualified counsellor such as [Mr A]. As a definition of counselling is not provided on the NZAC or NZCCA website, I looked to the Psychotherapy and Counselling Federation of Australia (www.pacfa.org.nz) to find the following definition of counselling:

> 'Psychotherapy and Counselling are professional activities that utilise an interpersonal relationship to enable people to develop self understanding and to make changes in their lives. Professional counsellors and psychotherapists work within a clearly contracted, principled relationship that enables individuals to obtain assistance in exploring and resolving issues of an interpersonal, intrapsychic, or personal nature. Professional Counselling and Psychotherapy are explicitly contracted and require in-depth training to utilise a range of therapeutic interventions, and should be differentiated from the use of counselling skills by other professionals.'

In essence counselling could be considered a distinctive, professional, contracted activity that is undertaken by people who agree to occupy the roles of counsellor and client. In my opinion, an informal conversation without this explicit agreement by both parties and which has no contract, is not documented and shows no evidence of use of therapeutic intervention towards an agreed end, falls well short of this definition of professional counselling which would be expected from someone of [Mr B's] training and professional identity.

[Mr A] states, in his response dated 07-05-13 that 'formal 1x1 counselling sessions were offered [Mr B] weekly. These were not always actioned because of the difficulty around timing, conflicts with other activities and resistance to that very process by residents (including [Mr B])'. [Mr A] has not supplied any evidence of any formal counselling sessions with [Mr B] throughout the 16 weeks he was resident and instead refers to the 'relational approach' taken at the centre where 'matters are not always formalised or structured into a specific timeframe'.

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No records of dates are provided for which counselling was offered or rescheduled or specific reasons for [Mr B] not undertaking this counselling as part of his programme. Again, this suggests that no clear treatment programme of scheduled activities including counselling was provided by the service to [Mr B]. In my opinion, the lack of any records of activities relating to the treatment of [Mr B] constitutes a breach of NZCCA Code of Ethics (1.10) which states:

1.10. Counsellors keep sufficient records of their activities, in a secure manner

1(c) Payment of counselling sessions

[Mr A] states in his response dated 07-05-13 (page 6) that payment for counselling services to [Mr A] via the Trust is done 'piecemeal and depends on the financial status of the Trust at any particular time. The focus is not on reimbursement of services rendered so much as on service provision for those residing at [the facility]'. Indeed, the bank statement for the previous year for the Trust showed one payment of $2,000 for 'reimbursement of counselling' but the recipient is not identified. It is standard practice that this payment would relate to an itemised, detailed invoice for this counselling activity. [Mr A] confirmed that WINZ payments for residents included $61 per week to cover counselling sessions and that this payment was made irrespective of the activity occurring. The account record for [Mr B] shows on 25 September 2012 a summary of income from WINZ which details board and nine counselling sessions have been paid for on behalf of [Mr B].

Although [Mr A] was not charging for informal counselling sessions on the basis that it was not financially viable for the Trust, he was correct in my opinion not to charge for informal sessions such as have been described as occurring at [the facility]. These discussions have not been documented, there is no evidence of having applied counselling skills or models in the course of those discussions to any specific end that was agreed by the other party in the discussion. Therefore in my opinion these do not constitute a counselling session and should not be chargeable as such.

I think it is reasonable to assume that WINZ payments of a set fee of $61 per week specifically noted as payment for counselling sessions would be payment for professional counselling services that involve counselling as described above.

Further I think it is reasonable to assume that these WINZ payments are made on the basis that weekly counselling is a standard part of the programme as advertised [in the informational material]. Although [Mr A] may not always be charging the Trust for these activities, the Trust is clearly collecting payment for these activities as noted above and it appears these payments are subsidising the programme overall.

2 Provision of knives and guns to the residents

[Mr A] (response dated 23-01-13) admits that he supplied pocket knives to residents including [Mr B], who at the time of the original complaint had 6 in his possession. [Mr A] states that knives are sometimes 'gifted to family member's [residents] and that he sees no risk in any of these knives being in the possession

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of “family members”’. [Mr A] also admits that he takes residents hunting for possums and .22 rifles are supplied to ‘family members’ for this purpose.

Several of the references [Mr A] supplied in favour of his service explained that he provided care and treatment for clients who would not be eligible for treatment in other places or who ‘were characterised as difficult in the best of circumstances’ (letter from [Mr C] 01-05-13). This facility is clearly promoted for and provides service for people who are in early stages of recovery from addiction, who may have chronic problems and as a result may be experiencing cognitive difficulties which are commonly manifested through difficulties with impulse control, anger management, stress management and depression. These aspects of people experiencing the long term effects of alcohol and drug dependence are well known and an expected part of the recovery process. Therefore, to suggest that knives of any type and guns (and associated activities such as hunting) are provided for as part of treatment is incredulous. The fact that one could hurt themselves or someone else aside, the potential intimidation to others of some residents having these weapons (which [Mr A] refers to as handy tools) appears to be something [Mr A] has not considered.

In my opinion, the provision of knives and guns to residents of an addiction treatment facility could breach the Code of Health & Disability Services Consumers’ Rights #4 ‘Right to services of an appropriate standard’ whereby consumers have the right to have services provided in a manner consistent with their needs and in a manner that minimises potential harm. These actions would be met with severe disapproval from other treatment providers.

3. Trust accounts and payment scheme

It is noted that on request of the Trust to supply a set of accounts, a copy of the Trust’s bank statement was provided which covers the period to April 2012 to April 2013. While a number of inferences can be made from this information, this is not a set of Trust accounts in the generally accepted accounting standard. I note that there are several deposits and payments that have no identifiers.

The lack of a set of accounts is of concern given this business has been in operation for a number of years, a set of accounts should be kept and readily available. There are a number of free or low cost programmes available for small businesses in NZ to facilitate this process. This is recommended as an immediate remedy.

It is noted that in several places in his responses to the HDC, [Mr A] indicates that payment via WINZ is made for board AND programme costs. However, the weekly payment contract which is signed by residents (template supplied by [Mr A]) specifies:

- $200 is for Board
- $65 for food
- $61 for therapy
- Anything additional to this is extra including travel, clothing GP fees and toll calls

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Thus in the contract with residents there is no allowance for programme costs and indeed this would be difficult to cost out given the emphasis on each individual choosing their own activities. This aspect of the management of the programme means that people do not know what actual costs will be incurred when entering this programme. In my opinion this breaches the NZCCA Code of Ethics 1.8.2 '… being informed in advance of important aspects of the counsellor–client relationship that might influence a client's decision to enter that relationship, such as financial arrangements concerning professional fees, record keeping, personal commitments and time constraints, and the limits of confidentiality'.

WINZ payments for residents are for various amounts most of which appear to be insufficient to cover the above assuming that residents do not have access to additional funds beyond these WINZ payments.

It is of concern that residents are regularly incurring debt with the service which they then 'work off'. This situation exacerbates the power differential in the relationship [Mr A] has with the residents and falls outside the generally accepted nature of a therapeutic relationship and would be considered a breach of NZCCA Code of Ethics 1.5:

> 'Counsellors recognise the power differential implicit within every counsellor–client relationship, and seek to minimise the potential negative impact of that differential.'

The engagement of residents as sub-contractors for services whereby they are invoicing [the facility] for work undertaken is a clear breach of Dapaanz Code of ethics which state:

> 'It is the responsibility of practitioners to avoid dual or multiple relationships and other conflicts of interest when appropriate and possible. When such situations cannot be avoided or are inappropriate to avoid, practitioners have a responsibility to declare that they have a conflict of interest, to seek advice, and to establish safeguards to ensure that the best interests of members of the public are protected.'

The accounts of [Mr B]:

In undertaking some gardening work for which he invoiced the Trust, [Mr B] did not seem to understand or agree clearly to the financial arrangements of the work undertaken. He did not understand the rationale for [the facility] charging his services out for more than he was being paid. A sub-contracting relationship was established anyway under instruction from [Mr A] and this work undertaken. As such this could be seen as a breach of the Dapaanz Code of Ethics which state that the practitioner will 'ensure that the difference between professional and personal involvement with individuals is explicitly understood and respected and that one's behaviour as a member of Dapaanz is as a professional'. Further, the Code of Ethics notes that the implications of this on practice is to 'refrain from abusing a position of trust to seek special benefits, financial or personal gain'. This is also evidenced with the inclusion of references from current residents of the service to support [Mr B's] response to the complaint.

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[Mr A] advised [Mr B] to form a company to process the finances associated with this work. Not only was this advice given (and an erroneous rationale provided for this advice) but the Trust paid for the formation of a company of which [Mr B] was the sole director resulting in [Mr B] becoming indebted to the Trust for the sum of over $300.

Professional Boundaries

It is of concern that [Mr A] believed it was within his scope of practice to give business advice to [Mr B] to form a company in order to process work undertaken while resident at [the facility]. While I do not have the full details of [Mr B's] background, nothing in his history noted [in the informational material] for [the facility] would suggest he has sufficient training or knowledge in this area to offer this level of advice. Even if he was fully qualified to offer this advice, to offer it without a clear agreement that [Mr B] was engaging him for this express purpose would constitute a breach of his existing relationship as a counsellor of [Mr B]. NZCCA Code of ethics 1.7 states 'Counsellors recognise the potential for multiple relationships to exist, in that "counsellor" and "client" may relate to each other in different roles in other environments. Counsellors seek to recognise when such circumstances exist and to establish clear boundaries for the conduct of differing roles.' The multiple roles that [Mr A] engaged [Mr B] (either real or perceived) include; counsellor–client, contractor–sub contractor, programme director (with financial control)–treatment resident, and [Mr A] refers to residents as 'family members'. In my opinion there is a conflict between establishing professional relationships as a counsellor/addiction treatment practitioner and developing more intimate, family-like relationships such as that described in this situation. The notion that 'genuine relationship building could be "mandated"' as described in [facility] material does not fit with any generally accepted treatment modality that I am aware of.

It would appear that many of the issues presented in this situation have occurred as a result of the lack of clear boundaries and professional roles on the part of [Mr A]. I would recommend this is a key issue to be clarified in supervision and in doing so may assist in clarifying the parameters of the service and what is being offered."

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