Clinical Psychologist, Ms A
Department of Corrections

A Report by the
Deputy Health and Disability Commissioner

(Case 19HDC01491)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report discusses the personal relationship that developed between a clinical psychologist and a man. The man received direct therapeutic contact from the psychologist whilst participating in a rehabilitation programme at a prison.

2. The report highlights the ethical duty of psychologists to maintain appropriate professional boundaries after therapeutic relationships have ended.

Findings

3. The Deputy Commissioner considered that the psychologist held an ethical duty to the man to maintain appropriate professional boundaries after their therapeutic relationship ended, irrespective of whether or not she continued to practise as a clinical psychologist at the time. The Deputy Commissioner regarded the man as still in a vulnerable situation, having recently left prison and continuing to receive ongoing rehabilitation to re-integrate back into the community. The Deputy Commissioner found that by entering into a relationship with the man, the psychologist breached Right 4(2) of the Code.

Recommendations

4. The Deputy Commissioner recommended that should the psychologist return to work as a clinical psychologist, the NZPB require her to undertake further training on ethical and boundary issues, and require her to be mentored regularly by a mentor selected by NZPB, and that the mentor should report to NZPB on whether the psychologist is respecting professional boundaries.

5. The Deputy Commissioner recommended that Corrections introduce specific guidance outlining individual staff members' responsibility regarding when and how to escalate issues of transference, and managers' obligations around how to handle transference issues; review all Psychology Supervision Agreements and/or related policies and procedures to ensure the inclusion of the responsibilities of the supervisor and supervisee when issues of romantic transference are raised, and a supervisor's responsibility to retain all supervision notes for ten years; and circulate a copy of the anonymised version of this report to all psychological services staff across Corrections' facilities, for continuing education.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from the New Zealand Psychologists Board (NZPB) about the services provided to Mr B by Ms A. The following issues were identified for investigation:

- *Whether Ms A provided Mr B with an appropriate standard of care from 2016 onwards, including whether she maintained professional boundaries.*
- *Whether the Department of Corrections provided an appropriate standard of care to Mr B from 2016 onwards.*

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

8. The parties directly involved in the investigation were:

Ms A	Clinical psychologist
Department of Corrections	Group provider

9. Further information was received from:

Mr B	Consumer
Dr C	Clinical psychologist/Manager of Psychological Services
Ms D	Clinical psychologist
Ms E	Programme facilitator
Probation officers	
Rehabilitation unit	
Senior psychology advisor, NZPB	

Information gathered during investigation

Introduction

10. This report discusses the personal relationship that developed between a clinical psychologist, Ms A, and a former client, Mr B.

Ms A

11. Ms A registered as a clinical psychologist in 2014. She had two intern placements in prisons, and had worked at the prison since 2016. During 2016, she started a full-time role as a psychologist based at the unit.

Mr B

12. Mr B was sentenced to life imprisonment. Mr B was released from prison in 2019, aged in his thirties.

Rehabilitation programme

13. The prison delivers a rehabilitation programme (the programme) in a residential prison unit for prisoners (participants) who have a high risk of violent re-offending. Department of Corrections (Corrections) describe the programme as "high intensity".

14. Therapy groups have ten participants and are approximately three hours long. The groups take place three to four times weekly and are co-facilitated by two members of therapy staff. Individual treatment sessions can be requested by participants. There is a high level of contact between participants and staff. At the completion of group treatment, participants undergo further assessment to consider their progress, and they may have follow-on treatment.

15. During the time Mr B was at the unit, Dr C, a clinical psychologist, was the manager of the prison's psychological services, and had primary responsibility for the services provided. Dr C's job description outlined her responsibility for leading, developing, and supervising a team of psychological services staff. Dr C was Ms A's manager and clinical supervisor at the unit. Ms D, a clinical psychologist, and Ms A provided the majority of therapy Mr B received.

Overview of Mr B's time at the unit

16. In February 2016, Mr B transferred to the unit. In August 2016, he began the core treatment component of the programme. In September and October 2016, Ms A conducted assessment interviews with Mr B. During these assessments he provided details about his childhood. He also explained that prior to his incarceration he had not had many relationships, and his longest romantic relationship had been four months long.

17. During Mr B's time at the unit, he received over 300 hours of direct therapeutic contact from Ms A and Ms D. Mr B's individual programme treatment plan outlined that he needed to address his depression and develop a prosocial identity. The notes provided by Corrections highlight that Ms A conducted 21 individual therapy sessions with Mr B. Mr B also attended 92 group sessions.

18. In June 2017, Mr B completed the core treatment component of the programme. Between June and November 2017, Mr B had follow-on treatment at the unit. Mr B remained at the unit after completion of the programme, and attended the graduates group on a weekly basis, and also attended the community groups. Corrections told HDC that at that point in time, case notes were not made about attendance in the graduates group.

Disclosure of feelings for Ms A

19. In July 2017, Mr B requested an individual therapy session with Ms A. Ms A's note of this therapy session outlined that Mr B was experiencing positive transference[1] towards her, which appeared to be of a romanticised nature. She noted that Mr B reported that he had been experiencing this for several months, and that recently he had been finding it difficult to manage his thoughts and feelings and had been attempting to cope by challenging his thoughts.

20. Ms A documented that she discussed with Mr B the reasons for developing positive transference, particularly with regards to clients sharing personal information with therapists and misinterpreting the connection they feel with the therapist as romantic feelings. Ms A recorded that she reiterated the professional nature of the therapeutic relationship, and that Mr B appeared clear on the boundaries. The notes document that Mr B became distressed and expressed embarrassment and regret about informing Ms A of his feelings. Mr B indicated that he would prefer to transfer to another unit, as he perceived that it would be easier for him. Ms A noted a discussion about the importance of completing the maintenance phase of the programme.

21. Dr C stated that in the context of clinical supervision, Ms A told her and some other members of the therapy team about Mr B's transference. As a result of this knowledge, they collaboratively developed a plan to ensure that Mr B was well supported and that he managed the boundaries of the therapeutic relationship well. Dr C said that Ms A reassured her that she remained comfortable providing Mr B with treatment and was confident that therapeutic boundaries remained intact. Ms A told HDC that professional boundaries were always maintained during the tenure of the working relationship.

22. Ms E, a programme facilitator, told HDC that at the time of the events, there was no established process for dealing with romantic transference in a team-based manner.

23. Corrections told HDC that romantic transference was dealt with by way of supervision (either individual supervision, co-facilitation supervision, or both). Corrections said that it was expected that the supervisee would raise matters, but how they raised an issue to the supervisor was the staff member's prerogative. Corrections told HDC that in 2017, if transference from a participant required discussion, the participant could discuss it within peer supervision (which was held in a team-based manner).

24. After the disclosure of transference, Mr B remained at the unit. Between July and October 2017, Ms A had 11 individual therapy sessions with Mr B. There are no further references to transference in Mr B's therapy notes.

Transfer to self-care unit

25. In February 2018, Mr B moved to a self-care unit to work on reintegration skills for release from prison. Ms A told HDC that she had very little therapeutic contact with Mr B in 2018,

[1] In psychoanalysis, this refers to a patient's transfer onto the analyst or therapist those feelings of attachment, love, idealisation, or other positive emotions that the patient originally experienced toward parents or other significant individuals during childhood.

but did provide therapy to Mr B whilst he was at the self-care unit. Corrections told HDC that it cannot verify the number of times Ms A visited Mr B in the self-care unit because Ms A did not document her visits.

26. Ms A told HDC that she tried to make a formal record of the contact she had with Mr B whilst he was in the self-care unit, but other staff at the unit told her that once an individual's treatment task had been closed, there was no way to load case notes into Corrections' case-note database.[2] Ms A said that during her time working at the unit, issues about recording case notes for meetings after a participant left the unit was a concern that she communicated to other staff.

27. In contrast, Corrections told HDC that in February 2018, psychologists could enter case notes into Corrections' case-note database once a treatment task had been closed. Corrections stated that the psychologist could either re-open the original treatment task[3] and enter notes under that task, or open a new treatment task and enter the notes there.

28. Ms A told HDC that she may have recorded the contact she had with Mr B on his Word document case notes in "the G: drive",[4] but she cannot recall with certainty. Corrections confirmed that no notes were made by Ms A in "the G: drive" whilst Mr B was in the self-care unit.

Ms A's resignation from Corrections and withdrawal from NZPB

29. In August 2018, Ms A submitted her resignation. Her last day of employment was in September 2018. Ms A told HDC that she resigned because she was no longer happy in her role as a psychologist.

30. In September 2018, Ms A voluntarily removed herself from the NZPB register. Ms A told HDC that she decided that for her own health and well-being, she needed a change in direction in her life, and therefore did not foresee an imminent return to psychology.

Mr B's release from prison and start of relationship

31. In April 2019, Mr B was released from prison and moved to a unit[5] for continuing rehabilitation.

32. Mr B told HDC that his relationship with Ms A started after he was released from prison, in a chance encounter with Ms A on an outing.

33. Ms A stated that she began communicating with Mr B in April 2019 (shortly after his release from prison) and entered into a personal relationship with him shortly after this. No information has been provided to HDC indicating that there was any continuing contact.

[2] Corrections case-note database is called "IOMS".
[3] In "Psych IOMS" (in this specific case, the treatment task would have been a group treatment task).
[4] A storage location on a computer system.
[5] A rehabilitation centre designed to help to re-integrate serious offenders back into the community, and to help prevent further criminal activity.

34. In approximately May or June 2019, Mr B disclosed to the rehabilitation unit staff that he was in a relationship with Ms A.

Action taken by Corrections after disclosure of relationship

35. In June 2019, Community Corrections emailed Dr C about the romantic relationship between Mr B and Ms A, and asked for advice.

36. Dr C told HDC that she sought advice, consultation, and supervision from her manager and from the Corrections' Principal Psychologist. Dr C said that it was decided that the issue would be escalated to her manager, and that Dr C should seek further advice from NZPB and, if appropriate, a complaint would be made to the NZPB. In July 2019, Dr C wrote to the NZPB.

37. Corrections told HDC that an investigation regarding the relationship between Ms A and Mr B was not undertaken because Ms A had left Corrections' employment, and it was aware that a complaint had been lodged with the NZPB.

Supervision

38. Ms E told HDC that she observed Ms A having casual contact with Mr B regularly. Ms E said that Ms A talked to Mr B for about 10 to 15 minutes after each community meeting. Ms E stated that between June 2016 and May 2017 (when Mr B worked in the prison's therapy office[6]), Ms A often talked with Mr B in an intense manner (in hushed voices). Ms E said that Ms A had ad hoc individual sessions with Mr B on a semi-regular basis, and Ms A told her that the sessions were related to Mr B having suicidal ideation.

39. Ms E told HDC that on several occasions she raised with Dr C the frequency of the unplanned contact between Ms A and Mr B, and Dr C agreed that she would follow this up.

40. Dr C told HDC that she raised with Ms A the concerns expressed by Ms E about the amount of time Ms A spent with Mr B, and Ms A's usual explanation was that she was concerned about Mr B's safety regarding potential risk of harm to himself or others.

41. However, Ms A told HDC that no one raised with her any concerns about her conduct towards Mr B.

42. Dr C told HDC that there are no written records of the discussions held in supervision with Ms A because her supervision notes were disposed of when she left her position at Corrections.

43. Ms A told HDC that there were no discussions or notes of Dr C having raised concerns about Ms A's increased time spent with Mr B because the discussions did not take place.

[6] The cleaning work was undertaken in an open-plan setting, and typically interactions with staff were brief conversations.

44. Corrections told HDC that Dr C did not provide the incoming Manager of Psychological Services with any supervision notes, but had a handover conversation to discuss each of the psychologists.

45. Corrections provided HDC with a copy of an agreement between Dr C and Ms A entitled "Psychological Service Post-registration (Level 3) Supervision Agreement" (the Agreement). The Agreement outlined: "[S]upervision case notes and evaluation records will be kept in [Ms A's] supervision file. The file will be held securely by [Dr C] for the term of the supervisory relationship."

46. Corrections' internal website stated: "If the supervisee leaves Ara Poutama Aotearoa, the [Manager of Psychological Services] keeps the supervision file."

47. NZPB advised HDC: "[A] supervisor should retain supervision notes, we recommend this is for ten years after the last contact. No, they would not generally provide them to the next supervisor."

Further information

Mr B

48. Mr B told HDC: "[T]his relationship is good for me. It has been a positive thing in my life and I cherish and love my family more than anything."

Ms A

49. Ms A told HDC that she does not believe that Mr B's decision-making ability was influenced by their prior work together. She said that neither she nor Mr B were mentally unwell or vulnerable at the time they decided to pursue a relationship, and neither party has been emotionally or psychologically harmed as a result. She said that she would never have made the decision to enter into a relationship with Mr B if she believed that it would be in any way harmful.

50. Ms A told HDC that she understands that it is rare for therapists and former clients to develop healthy, equal partnerships, but it is not impossible, and even the Code of Ethics[7] acknowledges that this could happen after an intermediate period of time. Ms A said that she and her partner truly believe this to be one of those exceptional cases. She stated that their family and friends can also attest to this, and it is evidenced by their ongoing stable and committed relationship.

51. Ms A told HDC: "I understand there will be individuals who simply do not wish to understand my choices."

NZPB

52. HDC sought information from NZPB. NZPB outlined to HDC that if the psychology relationship involves therapy, then another sort of relationship would never be condoned because of the nature of the transferences and power imbalance inherent in therapy, and that these transferences and power imbalances can develop very quickly and can persist for

[7] The Code of Ethics for Psychologists working in Aotearoa/New Zealand.

a long time after therapy has finished. NZPB further stated that romantic or sexual behaviours are considered boundary breaches, and are always harmful, even if sought by or seemingly agreed to by the client.

Responses to provisional opinion

Corrections

53. Corrections was given an opportunity to respond to the provisional opinion. It accepted all the recommendations in the provisional opinion. It told HDC that it accepts that these events have demonstrated that there is room to improve its record-keeping and documentation practices, and it continues to review and enhance its processes at the unit in this regard. Corrections further stated that it will update its internal website to state that supervision documentation needs to be retained for ten years by the Manager of Psychological Services.

Dr C

54. Dr C was given an opportunity to respond to the provisional opinion and had no comments to make.

Ms A

55. Ms A was given an opportunity to respond to the provisional opinion but did not provide a response.

Opinion: Ms A — breach

56. This report concerns the relationship between a Corrections clinical psychologist, Ms A, and her previous client, Mr B.

Duration of therapeutic relationship

57. From February 2016 to February 2018, Ms A provided high intensity and regular therapy to Mr B. At the unit, Mr B received 300 hours of therapy in which he disclosed highly personal information. This included 22 individual therapy sessions with Ms A and 92 group sessions. It is unclear how many of the 92 group sessions attended by Mr B included contribution by Ms A, as this information was not recorded.

58. In February 2018, Mr B transferred to a self-care unit, and Ms A told HDC that she provided therapy to him whilst he was at the self-care unit. There are no written records of therapy Ms A provided to Mr B in the self-care unit.

59. As there are no written records, I cannot establish the exact date on which the therapeutic relationship between Ms A and Mr B ended. In any case, Ms A's last day of work at Corrections was in September 2018, and she was providing psychological services to prisoners until this date. In September 2018, Ms A voluntarily removed herself from the NZPB register.

Relationship

60. In May or June 2019, Mr B disclosed to rehabilitation unit staff his relationship with Ms A. Ms A confirmed to HDC her relationship with Mr B, and said that she began communicating with him in April 2019 (shortly after his release from prison) and entered into a personal relationship with him shortly after this.

61. Principle 2.1.10 of the Code of Ethics for Psychologists working in Aotearoa/New Zealand states:

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

62. NZPB told HDC that if the psychology relationship involves therapy, then another sort of relationship would never be condoned because of the nature of the transferences and power imbalance inherent in therapy. NZPB further stated that romantic or sexual behaviours are considered boundary breaches, and are always harmful, even if sought by or seemingly agreed to by the client.

63. I agree with NZPB and consider that the power imbalance between a psychologist and a patient or a former patient cannot be dismissed easily, and that it is inappropriate for a psychologist or a former psychologist to form a relationship with a previous patient.

64. In assessing whether Ms A's relationship with Mr B was inappropriate and/or unethical, I have considered Ms A's submissions that:

- Neither she nor Mr B were mentally unwell or vulnerable at the time they decided to pursue a relationship;
- She does not believe that Mr B's decision-making ability was influenced by their prior work together; and
- Neither party has been harmed emotionally or psychologically as a result.

65. Without specific evidence from Mr B on the latter two points, I am unable to determine the impact of the relationship on his decision-making or emotional or psychological well-being. However, I reiterate PBNZ's view that there is an inherent power imbalance in therapy which persists beyond the termination of a therapeutic relationship, and that this can affect personal decision-making. In addition, I disagree with Ms A's assertion that Mr B was not vulnerable. Mr B was admitted to prison when he was in his late teens, and was released in his thirties, having spent the majority of his adult life in prison. Within the context of therapy, Mr B disclosed details about his childhood, and that his longest romantic relationship had lasted only four months.

66. I consider that it was inappropriate and unethical for Ms A to enter into a relationship with Mr B in 2019 given that previously she was his clinical psychologist between 2016 and 2018. The maintenance of professional boundaries is an integral part of the provision of health

services, and its importance in the provider–consumer relationship cannot be emphasised strongly enough. Trust is fundamental to this relationship, in ensuring that the consumer is assured that the provider is acting with the consumer's best interests in mind.

67. I consider that Ms A held an ethical duty to Mr B to maintain appropriate professional boundaries after their therapeutic relationship ended, and irrespective of whether or not she continued to practise as a clinical psychologist at the time. Mr B was still in a vulnerable situation having recently left prison, and was receiving ongoing rehabilitation to re-integrate back into the community. Accordingly, by entering into a relationship with Mr B, Ms A breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights.[8]

Documentation — adverse comment

68. As outlined above, Ms A told HDC that she provided therapy to Mr B when he was residing in the self-care unit. Ms A said that she attempted to record notes of these sessions but there was no way to do so in Corrections' database. Corrections disputes this, and told HDC that it has always been possible for psychologists to enter case notes into Corrections' case-note database once a treatment task has been closed. Ms A told HDC that the notes she made may have been saved on Corrections' "G-drive". However, Corrections told HDC that it checked the "G-drive" and it contained no notes made by Ms A whilst Mr B was in the self-care unit.

69. NZPB guidance on Keeping Records of Psychological Services (adopted in 2011 and revised in 2014 and 2017) notes that there are several purposes for record-keeping. Of relevance, record-keeping for each client, including the assessment notes and records of any intervention, aids appropriate ongoing intervention, and assists the client with documented evidence in the event of any legal process or subsequent complaint or competence concern.

70. It is a basic expectation that health practitioners document the care they provide to their patients, and it is the responsibility of each health professional to find a way to achieve this. I am critical that Ms A did not do this.

Opinion: Dr C — adverse comment

71. In her role of Manager of Psychological Services at the unit, Dr C was responsible for leading, developing, and supervising a team of psychological services staff. Dr C was Ms A's direct line manager and was involved in supervision sessions with Ms A.

72. There are conflicting statements about whether or not concerns about Mr B and Ms A were raised at supervision sessions between Ms A and Dr C. Dr C told HDC that she discussed with

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

Ms A the concerns that members of staff raised with her about the amount of time Ms A spent with Mr B. Ms A told HDC that Dr C did not raise these concerns with her.

73. Dr C discarded her supervision notes when she left Corrections. Corrections' internal website stated: "If the supervisee leaves Ara Poutama Aotearoa,[9] the [Manager of Psychological Services] keeps the supervision file."

74. NZPB advised HDC: "[A] supervisor should retain supervision notes, we recommend this is for ten years after the last contact … [T]hey would not generally provide them to the next supervisor."

75. I note that the NZPB Best Practice Guide — Guidelines on Supervision (revised in November 2018) states:

> "The supervisee and the supervisor should both retain notes arising from the supervision process. It is suggested that both supervisors and supervisees retain supervision records for a period of ten years, even if a practitioner leaves the employing organisation or practice setting in the meantime. This would enable the psychologist to meet his or her obligations under the Health (Retention of Health Information) Regulations 1996 that clinical record[s] are to be [retained] for ten years; to respond to any complaint or competence concern arising; and to maintain records for the Continuing Competence Programme."

76. Dr C did not retain the supervision notes and, because of this, there is no contemporaneous documentation of the supervision that took place. Hence I cannot verify Dr C's or Ms A's version of events and assess the adequacy of Dr C's supervision of Ms A. In any case, it is clear that Dr C should not have disposed of the supervision records, as this was contrary to the NZPB guidelines. I am critical that Dr C destroyed records that should have been kept for ten years, and I remind Dr C of the importance of good record-keeping.

Opinion: Corrections — other comment

77. The formation of a personal relationship between Mr B and Ms A provides Corrections an opportunity to reflect on how it could have provided greater support and guidance to its therapy staff on how to manage romantic positive transference during the course of therapy, as well as improve on systems/processes for documentation. I set out my comments on this matter below.

Guidance on managing romantic positive transference

78. In July 2017, Mr B told Ms A that he was experiencing positive transference (which appeared to be of a romanticised nature) towards her. Following this, Ms A's colleague, Ms E, reported

[9] Corrections.

increased contact between Ms A and Mr B. Dr C told HDC that this was addressed in supervision (although this is disputed by Ms A), but Dr C took no further action to escalate the issue.

79. Ms E reported that at the time of events there was no established process for dealing with romantic transference in a team-based manner. However, Corrections told HDC that at the time of events, romantic transference was dealt with by way of supervision (either individual supervision, co-facilitation supervision, or both), and that there has always been an expectation that matters would be raised by the supervisee. Corrections stated that the manner in which the issue was raised to a supervisor was the member of staff's prerogative.

80. Corrections' Code of Conduct (see Appendix B) states that employees must maintain appropriate professional boundaries and relationships with offenders, and avoid situations and behaviour that may be considered unethical or a conflict of interest. The Code of Conduct contains examples of conduct that falls below Corrections' expectations, such as having a personal sexual relationship with an offender, prisoner, or ex-offender or prisoner with whom the employee has had contact in the course of his or her duties.

81. Whilst noting the content of Corrections' Code of Conduct, I am thoughtful that there was no specific guidance that outlined individual staff members' responsibility regarding when and how to escalate issues of transference, and outlined managers' obligations around how to handle transference issues.

Record retention and documentation

82. As outlined above, there are differing recollections between Ms A and Dr C around the content of discussions at supervision sessions, and these matters cannot be verified because Dr C discarded her supervision notes upon her departure from Corrections. Furthermore, Ms A told HDC that she did not document the therapy she provided to Mr B whilst he was in the self-care unit.

83. I note that HDC's investigation into this matter has highlighted a number of areas in which record-keeping and documentation appear to have been deficient. I suggest that Corrections consider whether further enquiries should be made into the adequacy of documentation within the psychological services at the prison.

84. I also consider that it would be prudent for the supervision agreement and Corrections' internal website to set out the expectation that supervision documentation is to be retained by the Manager of Psychological Services for ten years, in line with NZPB's guidance.

Changes made since events

85. Corrections advised HDC that the unit therapy staff have made significant changes to their practice in that they now openly discuss transference/countertransference issues in their peer supervision sessions in order to receive feedback and support from their peers.

86. Corrections said that it recognises that the matter of professional boundaries is of great importance to its staff, the people they care for and manage, its stakeholders, and the wider reputation of psychological practice. Corrections identified useful training for staff and clinical supervisors, and circulated the following resources to all four regions:

a) Training entitled "When Good Practitioners Go Bad … Professional Boundaries for Health Practitioners (A brief overview)" by Dr Jane Freeman-Brown.

b) "Psychology Practice: The Maintenance of Professional Boundaries" — a literature review conducted by Ara Poutama Aotearoa in 2020.

c) A "Boundaries Handbook" — a reflective workbook for professionals.

Recommendations

87. I recommend that should Ms A return to work as a clinical psychologist, the NZPB require her to undertake further training on ethical and boundary issues, and require her to be mentored regularly by a mentor selected by NZPB. The mentor should report to NZPB on whether Ms A is respecting professional boundaries.

88. I recommend that Corrections:

a) Introduce specific guidance that outlines:

   i. individual staff members' responsibility regarding when and how to escalate issues of transference; and
   ii. managers' obligations around how to handle transference issues.

b) Review all Psychology Supervision Agreements and/or related policies and procedures to ensure the inclusion of:

   i. the responsibilities of the supervisor and supervisee when issues of romantic transference are raised; and
   ii. a supervisor's responsibility to retain all supervision notes for ten years.

c) Circulate a copy of the anonymised version of this report to all psychological services staff across Corrections' facilities, for continuing education, within three months of the date of the anonymised report being published on the HDC website.

89. Corrections is to provide evidence that the above has occurred, within three months of the date of this report.

Follow-up actions

90. A copy of this report with details identifying the parties removed, except the Department of Corrections, will be sent to the New Zealand Psychologists Board, the New Zealand Psychological Society, and the New Zealand College of Clinical Psychologists. The New Zealand Psychologists Board will be advised of Ms A's name.

91. A copy of this report with details identifying the parties removed, except the Department of Corrections, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Relevant standards

The Code of Ethics for Psychologists working in Aotearoa/New Zealand

Principle 2 Responsible caring

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

Comment: It is not appropriate to terminate a professional relationship in order to facilitate an intimate relationship.

Principle 3 Integrity in relationships

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

New Zealand Psychologists Board Best Practice Guide — Keeping Records of Psychological Services (adopted in November 2011)

Purpose of record keeping:

- To ensure there are records for each client including the assessment notes and records of any intervention to aid appropriate ongoing intervention, for the client's personal use, for any legal process, and to provide documented evidence in the event of any subsequent complaint or competence concern.
- As an aid to memory for the psychologist.
- To provide a record of contact for the client's use for insurance reimbursement and other health-related claims.
- To enable the transfer of care to another psychologist should that be desirable.
- To assist in the comparison of similar cases and assessing treatment approaches.
- To comply with relevant legislation.
- To support accounting processes and keeping statistical data.

New Zealand Psychologists Board Best Practice Guide — Guidelines on Unprofessional Behaviour in the Workplace and its Management (May 2010)

Competence or conduct concerns

Colleagues are encouraged to report any concerns about a psychologist's competence and conduct to the Board. If there is a serious concern, contact the Board's Registrar immediately. If a health practitioner is concerned that a psychologist may pose a risk of harm to the public by practising below the required standard of competence, the health practitioner may notify the Board's Registrar under section 34(1) of the HPCA Act.

New Zealand Psychologists Board Best Practice Guide — Guidelines on Supervision (Revised November 2018)

Record keeping

Records of supervision need to be kept which include:

- Copies of all supervision contracts and updates.
- The date and duration of each session.
- A supervision logbook which shows brief notes on the agenda, the main points discussed and agreed actions. The log book may be kept by either the supervisor or the supervisee, or in duplicate, as agreed between the parties.
- In particular, ethical or safety issues should be noted in the log book, including any risk assessments.

The supervisee and the supervisor should both retain notes arising from the supervision process. It is suggested that both supervisors and supervisees retain supervision records for a period of ten years, even if a practitioner leaves the employing organisation or practice setting in the meantime. This would enable the psychologist to meet his or her obligations under the Health (Retention of Health Information) Regulations 1996 that clinical record[s] are to be [retained] for ten years; to respond to any complaint or competence concern arising; and to maintain records for the Continuing Competence Programme.

The supervision agreement or contract and the attendance record may be a public document whereas the supervision records, which may contain client details or other sensitive material, should be kept confidential. It may be preferable to store supervision content directly relevant to a client on the client file.

Appendix B: Relevant policies

Corrections' Code of Conduct

Corrections' Code of Conduct applies to all Corrections' employees, including contractors, consultants, or volunteers.

The Code of Conduct states that in order to be accountable at Corrections, employees must be honest and truthful and do the right thing, even when no one is looking. Employees must maintain appropriate professional boundaries and relationships with offenders, and avoid situations and behaviour that may be considered unethical or a conflict of interest, or a conflict with the Code of Conduct.

The Code of Conduct contains examples of conduct that falls below Corrections' expectations, including inappropriate behaviour or relationships. Examples of inappropriate behaviour include having a financial, personal, or sexual relationship with an offender, prisoner, or ex offender or prisoner, with whom the employee has had contact in the course of his or her duties.

Employees are required to sign to acknowledge that they have received, read, and understood the Code of Conduct.