Counsellor, Mr B

A Report by the

Deputy Health and Disability Commissioner

(Case 08HDC17394)

Overview

In January 2008, Ms A began receiving counselling services from Mr B, a counsellor with a District Health Board's Community Alcohol and Drug Service. On the evening of 29 April 2008, Ms A and Mr B began a text conversation. Shortly afterwards, Mr B drove out to see Ms A at her partner's home, about 60kms away. Ms A's partner was working nights. Mr B arrived at about 10pm, and soon after he and Ms A went for a short drive. He and Ms A kissed and engaged in consensual sexual foreplay. Mr B took Ms A back to her partner's home. After Ms A had got out of the car, Mr B sent her a text asking for oral sex. She refused and Mr B left.

Parties involved

Ms A	Consumer/Complainant
Mr B	Provider/Counsellor
Dr C	Senior Psychiatric Registrar
Mr D	Service Manager Specialist Mental Health Services
Ms E	Human Resources Advisor
Mr F	CADS Acting Unit Manager
Mr G	CADS Unit Manager
Ms H	Group Manager Mental Health and Community Services

Complaint and investigation

On 20 October 2008, the Commissioner received a complaint from Ms A about the services provided by Mr B. The following issue was identified for investigation:

The appropriateness of the care provided to Ms A by Mr B, including his maintenance of professional boundaries.

An investigation was commenced on 28 October 2008. This report is the opinion of Rae Lamb, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

Information was obtained from Ms A, Mr B, the New Zealand Police Service, Telecom, Dr C, Ms A's friend's daughter, and a District Health Board (the DHB).

Information gathered during investigation

Mr B
Mr B began working as an Alcohol and Drug Counsellor with the DHB's Community Alcohol and Drug Service (CADS) in mid 2004. He had joined the Drug and Alcohol Practitioners' Association of Aotearoa New Zealand (DAPAANZ) two months earlier, and was registered as an 'Alcohol and Other Drug Practitioner' a few months later. Mr B did not renew his DAPAANZ membership for 2008 and this, with his registration of competence, formally expired on 31 December 2008.

Mr B's job description required that he have, or be working towards, current accreditation of competence with DAPAANZ. It also required that he adhere to the Code of Ethics for the DHB and any other relevant professional organisations.

Background
On 3 January 2008, Ms A referred herself to CADS, seeking assistance in relation to her alcohol use, and identifying associated grief and family issues. The referral was allocated to Mr B. Ms A had her first appointment with Mr B on 15 January at the CADS offices, and they continued to meet every week or fortnight throughout the following three and a half months. On 7 February, Mr B referred Ms A to CADS Senior Psychiatric Registrar Dr C, for a psychiatric assessment. Ms A continued to see Dr C throughout this period also.

At the end of February 2008, Dr C confirmed that Ms A had a chronic major depressive disorder and chronic post-traumatic stress disorder, in addition to her alcohol dependence. There had been episodes of violence, and physical and sexual abuse in Ms A's childhood. Several important people in her life had died suddenly and/or violently. There were difficulties in her relationships with her daughters, other family members, and her partner. Ms A had a history of restricted eating and impaired body image.

Counselling
Both Mr B and Ms A recall that they had about 10 to 12 appointments between January and April 2008. Mr B advised that his usual practice at each appointment was to arrange the next one, and record this in his diary. Clinical notes were usually made following each appointment, either electronically or by hand. There are clinical records for five of Mr B's meetings with Ms A (on 15 January, 24 January, 7 February, 13 February and 6 March 2008). The CADS electronic record shows additional face-to-face contacts on 12 March and 23 April, but there are no corresponding clinical notes.

Mr B sometimes communicated with Ms A by text between appointments, using his personal mobile phone. This was to confirm or reschedule an appointment, and sometimes just to "check in" and see how things were going. These text conversations were initiated by both Mr B and Ms A.

Mr B subsequently advised that although there were shared mobile phones for CADS staff, it was not always convenient to use these. The nature of the work and the needs of his clients were such that it was sometimes necessary to contact clients at

unscheduled times and out of office hours. Mr B stated that he was aware that he should not have used a personal mobile phone for this. Mr D, the DHB's Service Manager for Mental Health Services, advised that the use of personal mobile phones for work purposes was not condoned, but he was aware of other staff practising similarly.

Ms A stated that she initially considered Mr B to be a very good counsellor. She spoke with him about her alcohol use, and other areas of difficulty in her life at the time, including her relationship with her partner, contact with her daughters, and accommodation issues. At the beginning of March, Ms A was involved in a motor vehicle accident; she was not seriously injured but the legal implications of the accident were another area of concern for Ms A.

Following this accident, Ms A did not have access to her mobile phone. She gave Mr B the phone number of a friend's daughter, who was 17 years old. Mr B had met the friend's daughter only briefly. He sent text messages to her phone, at first to arrange appointments with Ms A, but then asking whether the friend's daughter would like to meet up for a drink or two. He then asked if she would like to go to his house for some fun. When she did not accept he stopped sending messages to her.

Ms A later explained that although she thought Mr B was a good counsellor, she was somewhat surprised by the information he shared with her on occasion about his personal circumstances. She stated that they communicated "like you would with your mates" and it did occur to her that this was "a wee bit weird". Ms A also stated that she had told her partner she thought her counsellor was physically attractive. She also told Mr B that she had told her partner this.

Mr B stated that he considered his relationship with Ms A was constructive, and that although she was dealing with a number of difficult personal issues in addition to her alcohol use, she was making progress. In his clinical note on 7 February 2008, Mr B noted as an outcome of their appointment that part of the plan was to "(c)ontinue building therapeutic relationship and trust". On 13 February 2008, he noted that they had discussed the positive changes Ms A was making and reviewed the strategies for her to continue to reach her goals. These included "improving self worth and self perception".

Both Ms A and Mr B recalled one occasion when Ms A had been upset and he put his arm around her shoulders. Ms A considered this was a genuine attempt to comfort her and she did not find it concerning or untoward.

29 April 2008

On 29 April 2008, Ms A was staying at her partner's home, in a rural area. Her partner was at work. Just before 8.30pm, Ms A received a text from Mr B. Ms A was upset about difficulties in relation to contact with her daughter, and they exchanged a few texts about this. Ms A stated that Mr B offered to visit her. She thought this was a little unusual, given the time of day and the distance from the city, but she agreed. A number of texts were then exchanged as Ms A gave Mr B directions to the address.

Ms A's phone records show she sent 21 texts to Mr B between 8.28 and 9.59pm.[1] Mr B's phone records show he sent 25 texts to Ms A between 8.26 and 9.59pm. Ms A made two phone calls to Mr B during this period. These were also to confirm the route.

Mr B arrived at about 10pm. Ms A invited Mr B into the house, but he declined and they sat outside for a few minutes. Mr B then suggested they go for a drive, and Ms A agreed. They drove a short distance (in Mr B's car) and parked. They kissed and there was consensual sexual foreplay. Ms A then asked Mr B to take her back to her partner's home, which he did. She got out of the car, and went inside. A few minutes later Ms A received a text from Mr B, who was still in the car outside the house, asking her for oral sex. She sent a text back saying no. Mr B responded to this with a text saying "see, you can say no", or words to that effect. There were six texts from Mr B to Ms A between 10.29 and 11.30pm, and five texts from Ms A to Mr B between 10.30 and 11.33pm.

Subsequent events

The following day there was further text and phone communication between Ms A and Mr B, in which Ms A confirmed she would not be attending any further counselling sessions with him. There was no further contact between them after 30 April 2008.

On 2 May, on the advice of a friend, Ms A reported the incident to the Police. Mr D was advised through a DHB consumer advisor that Ms A had made an allegation to the Police in relation to Mr B. Details of the allegation were initially unclear. The DHB decided not to initiate the employment investigation process at that point, as insufficient information was available and staff did not want to interfere in a potentially serious police inquiry. Contingency plans were put in place in the event that Ms A arrived at CADS or at the Emergency Psychiatry Service unexpectedly.

On 6 May, the DHB confirmed with the Police that there were no concerns with its staff speaking with Mr B. Mr D and CADS Acting Unit Manager Mr F met with Mr B and advised him that they were commencing an employment investigation. Mr B stated that he did not believe he had crossed any professional boundaries. He was advised to have no further contact with Ms A.

On 7 May, Ms A met with the Police again. They confirmed that the alleged incident was not a criminal offence and that if Ms A wanted to make a formal complaint with respect to Mr B's actions, she should contact his employer. Mr D contacted the Police, confirmed that they were not laying charges, and was given further details about the nature of the allegations.

On 9 May, Mr D wrote to Mr B, informing him of the specific allegations, confirming that the matter was under investigation, and requesting a meeting on 12 May.

Mr B met with Mr D and the DHB's Human Resources Advisor, Ms E, as arranged. At this meeting, Mr B confirmed that he had communicated by text with Ms A on

[1] The texts were deleted shortly after these events so the content was not available.

occasion to arrange appointments and to check how she was generally. He acknowledged that it had been unwise to use his personal mobile to contact Ms A, and said this was an oversight. However, Mr B denied the events of 29 April as reported by Ms A. More specifically, he denied that there had ever been any social or sexual content in his communication with Ms A, or that he had visited her at her partner's home.

The following day, Mr D wrote to Mr B to inform him that as they had not received a complaint from Ms A they had decided not to interview her at that stage, and that as they could not substantiate the allegation no disciplinary action would be taken at that time. Mr B was reminded of his professional responsibilities and advised that another counsellor would be allocated to work with Ms A.

On 16 May, Ms A spoke about the incident with Dr C. At this time, Ms A did not wish to make a formal complaint to the DHB. However, Dr C was concerned about the seriousness of the allegations, and wrote to Mr D to bring the matter to his attention formally, and to request investigation and action.

At her next appointment with Dr C on 19 June, Ms A agreed to make a formal complaint to the DHB. This was submitted in writing the same day. On 23 June, Mr D wrote to Mr B advising that a complaint had now been received from Ms A and that this would be investigated. Mr B was reminded to have no further contact with Ms A.

On 30 June, Ms A and her partner met with Mr D and CADS Unit Manager, Mr G. Ms A agreed to contact Telecom with a view to obtaining records of her calls and texts from 29 April. It was agreed that Ms A's future appointments with Dr C would be at a different location. Ms A subsequently stated that she found this meeting very distressing and that she felt as though she was not believed.

In July, Ms A began having counselling with another counsellor from CADS.

On 9 July Mr B submitted his resignation from the DHB. It would appear that this was acknowledged in writing by Mr G, although a copy of this letter was not provided. On 11 July, Mr D wrote to Mr B requesting a meeting the following week to discuss Ms A's complaint. On 16 July, Mr B advised that he was unable to work out the period of notice and attached a medical certificate confirming he was medically unfit to resume work at that time.

Mr B's resignation was formally accepted on 21 July, with a request that Mr B provide a written response to four questions in relation to Ms A's complaint. Mr B responded to the questions; he confirmed that he had had text correspondence with Ms A, denied that he had travelled to her partner's home, denied that Ms A had been in his car, and advised that Telecom were not able to obtain his phone records. He added an apology to Ms A and the DHB for his behaviour, stating that he had made a "devastating error in judgement".

Ms A forwarded her phone records to the DHB at the beginning of August.

On 11 August, Ms A received a letter from Ms H, Group Manager Mental Health and Community Services, advising that as a result of Mr B's resignation, the DHB was unable to complete its investigation of her complaint. Ms H explained that as Mr B had declined to meet, they had insufficient information to complete the investigation and determine an outcome. She stated that Mr B had denied that the incident had taken place. She stated that the file would be kept open in case any further information came to light, and thanked Ms A for providing them with her Telecom telephone record. The cost of obtaining the record was met by the DHB.

HDC received a complaint from Ms A on 20 October 2008.

Mr B's response to the complaint

As stated above, Mr B advised his employer during the course of the internal investigation that he did not meet with Ms A on 29 April 2008 as she had claimed. He similarly advised HDC in writing, and during a face-to-face interview, that the allegations were untrue. Mr B maintained this position from May 2008 until June 2009.

HDC obtained Mr B's telephone records for 29 April, and additional information about the cell-site locations for the two telephone calls between Ms A's phone and Mr B's phone that evening. The location of the cell-sites supported Ms A's account, suggesting that Mr B was travelling towards Ms A's partner's home at the time of these calls.

Mr B was asked to comment on this information. In a telephone interview seven months after the start of HDC's investigation, Mr B admitted that he had driven to see Ms A on 29 April, and that there had been sexual contact between them.

Mr B's account of events that night differed in some respects from Ms A's recollection. Mr B stated that it was Ms A's invitation rather than his suggestion that prompted his visit to her that evening. He stated that *she* had initiated the sexual contact, and that he reciprocated. He stated that *he* had acted to end the physical contact shortly afterwards, realising it was a mistake. He advised *he* suggested to Ms A that he should take her back to her partner's home, and that she had agreed, acknowledging she also felt a bit uncomfortable. Mr B stated that they had conversation "of a sexual nature", but he was not able to provide any further detail about this. He did not recall sending Ms A a text asking for oral sex, but agreed that he had sent her a text commenting on her having been able to say no.

Mr B advised that at the time of these events he was under a lot of pressure, and that he was dealing with his own health concerns and other stresses in his personal life. Mr B stated that he was aware his actions were not appropriate in view of his role and the "perceived power imbalance". He acknowledged his actions were not consistent with "the Code of Ethics and the Health and Disability Code". Mr B apologised to Ms A for having put her in this position, and to HDC for having wasted its time. He spoke about having sabotaged his career, and that these events had had huge implications financially, for his career, and for his family.

Mr B advised that he is no longer working as a counsellor or in the field of mental health, and he does not intend to engage in this area of work again. He has written to Ms A apologising for his actions.

Relevant standards

Although Mr B had not renewed his membership of DAPAANZ for 2008, neither did he cancel this, and it did not formally expire until 31 December 2008. The relevant professional standards are attached as **Appendix A**.

Opinion: Breach — Mr B

Ms A had the right to services that complied with professional and ethical standards.[2] Under Right 2 of the Code, she had the right to be free from discrimination, coercion, harassment, and sexual, financial, or other exploitation.[3]

Professional boundaries
It is simply not acceptable for health professionals to engage in sexual relationships with their clients. Although the physical intimacy occurred on only one occasion and did not go beyond sexual foreplay, there was nevertheless a clear failure on Mr B's part to maintain a professional relationship with Ms A.

Professional boundaries in counselling are fundamental to providing extremely vulnerable clients with a safe environment in which they are able to engage in a therapeutic process. As the Commissioner has previously commented in relation to a different, earlier, case:

> "The maintenance of professional boundaries is an integral part of counselling, a process that involves an intense therapeutic relationship where the client confides fears, feelings, emotional responses and vulnerabilities. The importance of maintaining professional boundaries in the counsellor/client relationship cannot be overemphasized. [Mr A], as a counsellor aware of the relevant ethical codes, could reasonably be expected to have recognised the need to maintain professional boundaries, and to be alert to situations where they were under threat and becoming blurred."[4]

[2] Code of Health and Disability Services Consumers' Rights (the Code), Right 4(2) — Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
[3] Right 2 — Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.
[4] See www.hdc.org.nz 03HDC06499 (11 February 2004).

Ms A acknowledged that she found Mr B physically attractive, and Mr B was aware of this. However, Ms A was the client; it was not her responsibility to know, establish or maintain appropriate professional boundaries. In yet another previous case involving a sexual relationship between a counsellor and his client, HDC's expert advisor, registered counsellor Anita Bocchino, stated:

> "A sexual relationship between counsellor and client is **never** the fault of the client. It is incumbent upon the counsellor to manage professional boundaries because such relationships are never appropriate or helpful in counselling and in fact, are usually deemed to be detrimental to the wellbeing of the client. The sexual relationship damages not only the client's trust in the counsellor but also their trust in other people, including other therapists."[5]

Ms A told Mr B that she had talked to her partner about him and the fact that she found him attractive. This should have signalled clearly to Mr B that at the very least, he needed to be alert to the possibility that Ms A may have feelings that would compromise his ability to provide safe, constructive support. As previous investigations have highlighted, counselling and psychotherapy are particularly intense therapeutic relationships.[6] It is not uncommon for these relationships to result in transference, whereby the client in some way idealises the therapist. Scrupulous attention to the maintenance of professional boundaries is therefore required.

Instead, Mr B chose to use this information as permission to pursue a course of action for his own gratification. Failing to adhere to professional boundaries in this way is a breach of trust that can result in physical and/or emotional harm. Ms A was at risk of both.

There is no evidence to indicate there was sexual contact between Mr B and Ms A other than on 29 April 2008. However, I am not convinced that it was a sudden, wholly unsignalled lapse in Mr B's judgement. It would appear that in early March 2008 he had stopped keeping clinical records for his appointments with Ms A. Ms A had noted Mr B's tendency to share personal information with her as being more like a friend than a counsellor. Mr B acknowledged that when he set out to visit Ms A that evening he knew it was not a good idea. It is likely that the journey took the best part of an hour — plenty of time, it would seem, to reflect and reconsider the wisdom and implications of such action.

Exploitation

The fact that the sexual contact between Mr B and Ms A was consensual is irrelevant in this context. There is a power imbalance inherent in any such therapeutic relationship. In the case mentioned earlier, Ms Bocchino also commented on the issue of power in the client–counsellor relationship. She stated:

> "Unequal interpersonal power in the client–counsellor relationship allows the potential to exploit a client. Power as it is used here relates to the ways and extent to which one person gains and maintains influence or ascendency over another.

[5] See www.hdc.org.nz 06HDC09325 (6 December 2006).
[6] See www.hdc.org.nz 01HDC09143 (3 October 2002) and 06HDC09325 (6 December 2006).

> Relationships in counselling are unequal from the outset as merely asking another to help confers power on the person asked. *Counsellors must be aware and alert to the inherent inequality in the relationship. This inequality is usually enlarged when there are ethnic, gender or other important differences between the counsellor and the client.*"[7]

In this case, the inequality of the relationship was accentuated by Ms A's emotional vulnerability. From all accounts, Ms A had faced more than her share of difficulties in life, including sexual and physical abuse. As has been noted in previous investigations, survivors of sexual abuse are particularly vulnerable to forming relationships and partnerships that are re-victimising.[8]

Ms A had recognised that her use of alcohol was unhelpful and she sought help from a suitable organisation. It was her right to expect that the service offered would be competent, and that it would comply with professional and ethical standards. It was her right to expect that those providing the service would, at the very least, do no harm.

Both Mr B and Dr C identified that Ms A had difficulties with self-esteem and low self-worth, low mood and anxiety. While there were indications that Ms A was making progress during these first few months in 2008, her personal situation and well-being remained fragile. She was having some success with her efforts to reduce her drinking, but her situation in this respect was by no means under control. She was involved in a car accident in early March. Her relationship with her partner remained fraught. It is clear from the clinical notes that Ms A spoke openly with Mr B about the difficulties she was facing, and her thoughts and feelings. He was very aware of her vulnerabilities.

Mr B responded to Ms A's refusal to perform oral sex with a comment to the effect that this had demonstrated her ability to say no. Mr B had visited Ms A on the pretence of offering her support at a time of distress, engaged in inappropriate physical intimacy, and then attempted to reassert his control by relating what had happened between them back to Ms A's personal characteristics. This was manipulative and a blatant misuse of the authority afforded by his professional role.

Honesty and credibility

The question of who suggested Mr B visit Ms A on the evening of 29 April, who initiated the sexual contact, and who acted to end it, is largely immaterial. My finding in this case would be no different if Ms A had invited Mr B to visit her that evening, if she had initiated the physical contact, and if he had acted to end this.

Having said that, I find Ms A's account in relation to these matters more believable. The reports Ms A provided to the Police, Dr C, the DHB and HDC have been consistent with the exception of a few minor details. Mr B has been unable to recall or unwilling to provide specific information on some matters.

[7] See www.hdc.org.nz 06HDC09325 (6 December 2006).
[8] See www.hdc.org.nz 06HDC09325 (6 December 2006) and 06HDC18422 (14 May 2008).

Ms A explained that Mr B had suggested he would go and see her on the evening of 29 April because she was upset about difficulties with access to her daughter. Mr B was certain that Ms A had invited him to visit her that evening, but could not recall what reason she gave for this.

Ms A said that Mr B had responded to her refusal to perform oral sex with a text about her ability to say no. Mr B said he did not recall asking for oral sex, but did remember sending the text about saying no. The text makes sense in the context of a specific request from Mr B. Mr B was able to say only that there had been conversation "of a sexual nature".

In addition, I find Mr B's overall credibility extremely questionable: he has clearly demonstrated his capacity for dishonesty. It is noted that it was only when the evidence made his position untenable, that Mr B admitted to visiting Ms A on 29 April and engaging in an inappropriate relationship. Prior to this he falsely denied that he had done so.

Co-operation with investigation
Mr B co-operated with this investigation in so far as he responded to written requests for information and agreed to be interviewed. Nevertheless, for several months he misled HDC by providing false information. His response to the DHB's enquiries was similarly dishonest.

The Commissioner has recently commented on investigations being compromised by health providers seeking to avoid responsibility for their actions through dishonest responses to legitimate queries.[9]

Moreover, Mr B's actions in this regard showed a continued lack of regard for Ms A's welfare. Investigation required that Ms A be interviewed, exposing her unnecessarily to further stress. She was well aware that Mr B had denied the events outlined in her complaint and that her credibility and integrity would therefore be questioned. It is clear from the clinical notes that what happened with Mr B, as well as his subsequent denial of these events, had an adverse effect on Ms A.

Mr B's personal problems cannot be accepted as an explanation for either his inappropriate behaviour with Ms A, or his failure to take responsibility for his actions at the outset.

Summary of findings
The sexual intimacy between Mr B and Ms A on 29 April 2008 was inappropriate and unacceptable in the context of Mr B's professional role and responsibilities. In addition, for several months Mr B falsely denied Ms A's allegations and attempted to mislead the DHB and HDC. His behaviour was contrary to his obligations under the DAPAANZ Code of Ethics[10] in relation to trust, honesty and integrity, and professional conduct. Accordingly, I find that Mr B breached Right 4(2) of the Code.

[9] www.hdc.org.nz 08HDC14245 (27 February 2009).

[10] See Appendix A.

The unequal interpersonal power in relationships between clients and counsellors allows the potential for exploitation. Mr B knew that Ms A's personal situation and well-being at this time were fragile. He was aware of events in her past that accentuated her vulnerability. Mr B chose to disregard these matters, and gave no apparent thought to the consequences of his actions for Ms A. His conduct was sexually exploitative and a breach of Right 2 of the Code.

Additional Comment — The District Health Board

I have some concerns about the way in which this complaint was handled by the DHB. I note in particular the decision not to interview Ms A as part of the initial investigation and the decision to take no further action because the DHB had concluded that the allegation could not be substantiated. I consider that the DHB failed to adequately support Ms A or recognise the distress caused by the implication that her version of events had not been believed.

Mr D spoke with the Police on 2 May 2008 and was advised as to the nature of the allegations. This was discussed with other management staff from CADS, Human Resources, and Allied Health. Within a few days, Mr D was given further details about the allegations and it was confirmed that this was not a criminal matter. However, the alleged conduct clearly qualified as "serious misconduct" under the DHB's Code of Conduct.[11] The letter from Mr D to Mr B on 9 May advised that the matter was under investigation.

Mr D wrote to Mr B on 13 May following their meeting the previous day, advising that as they had not received a complaint from Ms A they had decided not to interview her at this stage. They had considered Mr B's explanation and as they could not substantiate the allegation made against him they would not be taking disciplinary action at that time. Mr D noted his concern at the judgement shown by Mr B in using his personal mobile to contact Ms A, and for giving her a hug during a previous consultation. Mr B was reminded that there are standards of behaviour in relation to integrity and conduct, and that he was required to adhere to the protocols and standards of his profession.

I am unclear as to why a formal complaint from Ms A was needed to proceed with the investigation at this point. In response to my provisional opinion the DHB stated: "[the DHB was] undertaking an employment investigation to establish the relevant facts in order to make a decision that could potentially have a significant impact on [Mr B's] employment future." However the provision of health care services to Ms A was quite separate from any employment issues and it should have been dealt with accordingly. I appreciate that the progress of the investigation may still have been hampered by Mr B's denial of the allegations — as happened subsequently when Ms

[11] The DHB's Code of Conduct includes under serious misconduct: "Breach of professional protocols or standards whether established by [the DHB] or the relevant professional body."

A's complaint was received and the investigation was re-commenced. However, I am concerned if such matters cannot be followed up without the trigger of a formal client complaint. This is particularly important in areas such as substance misuse and mental health, where staff are working with highly vulnerable clients. The DHB stated that mental health employees are a vulnerable group, as many of their actions occur without witnesses. They said that it was important not to prejudge complaints but noted that many clients are mentally unwell when they complain. I accept that the DHB should follow a fair process. However, there should be no assumptions about the veracity of a complaint because it was made by a mental health consumer.

The DHB stated that information provided by Dr C on 12 May led the DHB to decide not to seek further information from Ms A. No record of that information has been provided to me. However, in a letter to Mr D on 16 May, Dr C noted that a serious allegation had been made and although no detail was provided, she indicated the need for this matter to be addressed. As she advised, her ability to work alongside Mr B had been compromised. Until the matter was satisfactorily resolved, it was clearly going to impact on CADS' service provision. The DHB felt that there was no immediate need to take further action to redress this matter because it had removed Mr B from Ms A's treatment team. The DHB decided not to commence a Patient Complaint Investigation because Dr C's letter of 16 May did not indicate that Ms A had given consent for an investigation to be undertaken. I consider that the DHB should have contacted Ms A and asked her for her views about an investigation. I do not consider this would have amounted to soliciting a complaint.

A complaint was received on 19 June 2008 and I consider that the DHB could have offered better support to Ms A beyond acknowledging that complaint on 19 June and meeting with her on 30 June. At that meeting she was told that, in light of Mr B's denial and the lack of "collaborating evidence", the investigation could not proceed. This is unsatisfactory. In most cases of sexual misconduct there will be no independent witnesses, and Ms A was left with the impression that she had not been believed.

Mr B's employment terminated on 21 July 2008 and the DHB has said it could not take matters further. However, I consider that the investigation into Ms A's complaint could have continued after this date even though Mr B had denied the allegations. Evidence from Ms A's telephone records had been requested which could substantiate her complaint. Even though it was no longer the employer, if the DHB found the complaint to be justified, it could have taken action such as initiating a complaint to HDC, or encouraging Ms A to do so.

Follow-up actions

- Mr B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- A copy of this report will be sent to the District Health Board.

- A copy of this report with details identifying the parties removed, except the name of Mr B, will be sent to the Drug and Alcohol Practitioners' Association of Aotearoa New Zealand and DHBNZ.

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

Addendum

The Director of Proceedings decided to take a claim to the Human Rights Review Tribunal. However, the matter was resolved between the parties through a process of restorative justice that included the counsellor paying compensation to the consumer and undertaking voluntary work in the community, prior to a Statement of Claim being filed.

Appendix A

The DAPAANZ Code of Ethics (2005):

Principle 3. Trust

"Trust is of paramount importance in any relationship between client, provider and community in any health related service for the public."

> "Members recognise that:
>
> There is an intense level of affective involvement inherent in a professional relationship."
>
> …
>
> "[Members should:] 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."
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> …
>
> "In practice, this implies that: Practitioners should avoid … any practices that may be seen as taking advantage of clients."
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> …
>
> "Practitioners must not engage in or encourage sexual intimacy with a client at any time during the professional relationship or for at least two years following its termination. The Code recognises, however, that the power relationship may not cease to influence personal decision making and the sexual relationships with former clients may never be appropriate or ethical."

Principle 6. Honesty and Integrity

"Integrity means that the practitioner's behaviour should be at all times sincere, honourable and reliable in their dealings with their clients."

Principle 9. Professional conduct

"Accepting responsibility for his/her own interventions."

> "Members recognise that: The practitioner accepts professional responsibility for one's own actions, decisions and the ensuing consequences."
>
> ..
>
> > "In practice, this implies that: The practitioner at all times maintains standards of personal conduct which reflect well on the profession and enhance public confidence."