Counsellor, Mr B

A Report by the
Deputy Health and Disability Commissioner

(Case 20HDC02346)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the failure of a counsellor to maintain professional boundaries with his client.

2. The counsellor was the primary therapist for a woman who lived in a residential mental health service between June 2017 and September 2018. The relationship developed into an intimate, physical relationship in early 2018, and continued after the woman's discharge from the facility.

Findings

3. The Deputy Commissioner found that by entering into an intimate and sexual relationship with the woman, concurrently with a professional relationship, the counsellor failed to comply with professional, ethical, and other relevant standards, and, accordingly, breached Right 4(2) of the Code. The Deputy Commissioner considered that the counsellor took advantage of the woman's vulnerability by pursuing a relationship while she was a client of the healthcare facility and he was her primary therapist. The Deputy Commissioner found the counsellor's conduct to be exploitative, and therefore in breach of Right 2 of the Code.

Recommendations

4. The Deputy Commissioner recommended that should the counsellor return to work as a therapist or counsellor, the New Zealand Association of Counsellors (NZAC) require him to undertake further training on ethical and boundary issues and to be mentored regularly, and that NZAC consider whether a review of his conduct is warranted.

Complaint and investigation

5. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided by a counsellor, Mr B. The following issue was identified for investigation:

- *Whether Mr B provided Ms A with an appropriate standard of care from 2017 to 2020 (inclusive).*

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

7. The parties directly involved in the investigation were:

Ms A	Consumer
Mr B	Provider/counsellor

8. Further information was received from the mental health service.

Information gathered during investigation

Background

9. Ms A has a history of post-traumatic stress disorder, obsessive compulsive disorder symptoms, eating disorder symptoms, and chronic self-harm behaviours.

10. Ms A was a resident at a mental health service (the Service)[1] between June 2017 and September 2018 for treatment.

11. This report discusses the development of a personal relationship between Ms A and her primary therapist, counsellor Mr B.

Ms A's referral and admission to the mental health service

12. Ms A was referred to the Service on 6 January 2017 by her treating clinical psychologist.

13. Ms A was offered placement in the programme.

14. Ms A arrived at the mental health service in 2017 (aged in her twenties) to begin residential treatment. She was allocated to counsellor Mr B[2] (aged in his forties), who was her primary therapist for the duration of her admission.

Role of primary therapist

15. The Service told HDC that the role of the therapist includes the formulation of treatment plans, the provision of twice-weekly individual therapy for two clients, completion of progress reports, liaison with referring clinicians, and collaboration with the treatment team to ensure that treatment is following the plan and adheres to the therapeutic model.

16. As Ms A's primary therapist, Mr B was responsible for counselling Ms A twice per week in 1:1 sessions, and facilitating group classes and outings in which Ms A participated.

17. Mr B said that he did not know much about Ms A's clinical and personal background when he first began providing services to her. However, Mr B also told HDC that he was aware from Ms A's clinical records of her history of self-harming, anxiety, and post-traumatic stress disorder.

Development of personal relationship

18. Mr B told HDC that his relationship with Ms A outside the therapeutic counsellor/patient context began on the evening of 20 February 2018 (approximately seven months after her admission). Mr B said that by this time they were very close professionally, and had disclosed to each other similar life experiences/trauma they had faced.

[1] Provides community-based mental health services, and treatment for clients in a residential setting which usually lasts between 12 and 18 months. The mental health service told HDC that generally clients are very complex. Treatment includes twice-weekly individual therapy sessions with clinicians, multiple skills classes, crisis coaching, skills practice groups, and 24/7 access to coaches.

[2] Mr B has a Bachelor of Applied Social Science (Counselling) and a Certificate in Social Work and Counselling.

19. Mr B said that he was attempting to calm Ms A, who was concerned about the possible need to relocate to a community centre. They were standing in the semi-dark in silence after starting an exercise to co-regulate their breathing, when they kissed. Mr B told HDC that his relationship with Ms A became intermittently sexual from that day onwards.

20. In her complaint to HDC, Ms A said that Mr B took her out of the residential facility at night, and brought her back at approximately 4.00am, an estimated 48 times.

21. Mr B agrees that he and Ms A saw each other outside of working hours while he was her counsellor.

22. Mr B said that he was in love with Ms A. He stated that at the time, he believed he and Ms A were healing each other, and they would have a life-long enduring love that was worth compromising his career for. Mr B said that he takes full responsibility and is regretful of his actions.

23. Mr B told HDC that he has experienced trauma in his life, and that he and Ms A supported each other to grieve and heal their traumatic experiences. He said that he was not well enough at the time to understand how damaging his behaviour was to Ms A, in the context of a therapeutic relationship.

24. Mr B said that he believes some staff may have suspected that they had moved beyond a professional relationship, but he did not disclose anything about the relationship with Ms A to his manager or any other staff at the service.

25. Mr B stated that he considered transferring Ms A's care to another therapist, and discussed the idea with her, but Ms A refused the possibility.

Events following discharge from the Service

26. Mr B said that on 8 July 2018, he and Ms A informed her parents that they were in a relationship. They then discussed an "exit strategy" that would allow a quiet exit and end to his career, while also "minimising the effect on the good work being done at [the Service]".

27. Ms A graduated from the Service on 30 September 2018, 15 months after her arrival, and moved home to live with her parents. She continued to receive care from the Service, via its home-based service.

28. Ms A told HDC that after she left, Mr B resigned from his position at the Service, withdrew from the New Zealand Association of Counsellors (NZAC), and moved in with Ms A and her family. Mr B said that he moved in at Ms A's request.

29. Mr B told HDC that he left the Service on the same day as Ms A. Information provided by the Service indicates that Mr B's role as therapist ceased on 27 September 2018, but he remained employed as a casual coach/support worker until his employment at the Service ended a few weeks later.

30. Mr B stated that he left the Service because he was in love with Ms A, felt strong feelings of acceptance, care, and emotional intimacy for her, and felt that he was unable to continue being a counsellor because of his actions. He also said that he was losing faith in the Clinical Manager at the Service, and the therapeutic model, and discovered that he was being paid less than his colleagues, and that these were also contributing factors.

31. Mr B said that between April 2019 and February 2020, he paid to live at Ms A's parents' house. He stated that in September 2019, Ms A and he agreed to try for a child. Ms A became pregnant.

32. On 10 February 2020, Ms A's parents asked Mr B to leave their house. Ms A told HDC that she ended her relationship with Mr B early in the pregnancy because Mr B was displaying "stalking" and "predatory" behaviour.

33. Mr B told HDC that it is not clear to him why the relationship ended, as the break-up was poorly communicated. He said that as they had a baby on the way, and he was under the impression that they were still trying to reconcile, he remained in contact with Ms A.

34. Mr B said that the conversations ended when Ms A served a temporary protection order alleging that Mr B's questions to try to resolve the relationship and support the birth amounted to harassment and grooming. He stated that following a "stopping violence" course, he now has a better understanding of what Ms A felt at this time.

35. Mr B is listed as "Father/Matua" on the baby's birth certificate.

Protection order

36. On 1 September 2020, the Family Court granted a without notice temporary protection order.

37. Mr B noted that he was not provided with an opportunity to respond to the allegations prior to the temporary protection order being granted. In his response to the provisional opinion, Mr B stated that he had been shocked to receive the temporary protection order, but had complied with the conditions of the order and attended (and engaged with) the required stopping violence course.

38. On 30 October 2020, an undertaking was signed by Mr B not to contact Ms A for any reason other than to arrange contact with their child, or to discuss guardianship matters, and to complete the requirements of a non-violence programme. In return for the undertaking, Ms A agreed to discontinue her application for a final protection order.

39. The temporary protection order was discharged on 17 November 2020.

Mr B's employment at the mental health service

Support and training provided to Mr B

40. Mr B commenced employment at the Service as a coach and support worker in April 2015. He commenced his role as a therapist at the Service in May 2016, following training.

41. Mr B said that upon his arrival at the Service, there was no Clinical Manager, and clinical staff were relieved when the Clinical Manager commenced employment at the Service.

42. Mr B stated that to his recollection, the orientation at the Service was "piecemeal". He said that following his training, he was "thrown in" and allocated his first client within weeks, and that at the time of his training, he was already "at the edge of his ability". He considers that nobody took an interest in his practice, and that supervision was not formally offered at the Service for at least six months following his training, and initially it was ad hoc or minimal.

43. Mr B said that during his employment at the Service, he mostly "learned from the book" and taught himself, because he was being exposed to the skills he was teaching to patients for the first time in his life.

44. The Service disagreed with Mr B's assertion that his induction was "piecemeal". It advised that the orientation process was reviewed and discussed with another employee who had been inducted at the same time as Mr B. The other employee considered that the process was adequate for understanding the role, and that they were well supported by more senior coaches who mentored them and demonstrated how best to perform the role and maintain boundaries.

45. The Service advised that as part of the normal induction process, Mr B signed the Service's Code of Ethics, and Organisational Rules (see Appendix A). Core value one of the Service's Code of Ethics explicitly states:

> "Trustees and Staff [will]:
>
> 1. Know the difference between personal and professional relationships.
> 2. Ensure that the vulnerabilities of others are not exploited for one's own interests.
> 3. Practice within one's own level of competence and seek out additional information or guidance when required.
>
> …
>
> 9. Conduct themselves in a manner that reflects honesty, integrity, reliability, impartiality, and diligence.
>
> …
>
> 13. Accept responsibility and accountability for one's own actions taking all necessary steps to prevent or minimise harm.
>
> …
>
> 14. Understand, promote, and uphold the ethical values of the mental health service."

46. The Service's Organisational Rules state: "Sexual relationships between staff members and clients are expressly forbidden."

47. The Service stated that it had paid for Mr B to attend training when he had shifted into a therapist role in May 2016. In response to Mr B's comments that the Centre did not have a permanent Clinical Manager when he started, the Service said that the lack of a permanent Clinical Manager in 2015 would not have resulted in a deficiency in oversight, or a misunderstanding of boundaries for any staff member. The Clinical Manager commenced employment in January 2016, and therefore there was a Clinical Manager during the time Mr B was a therapist.

48. The Service stated that furthermore, Mr B had received clinical training as a counsellor, which would have included the importance of professional boundaries. He was also under external supervision for counselling registration while employed at the Service.

49. The Service told HDC that it does not agree that Mr B had deficient supervision at any point during his employment, noting that for the six months prior to Mr B commencing individual therapy with Ms A, he had been receiving monthly external supervision (for counselling registration), two-weekly peer supervision/consultation meetings, and weekly to fortnightly internal supervision with the Clinical Manager. In the month after beginning therapy with Ms A, Mr B had also begun weekly supervision with a clinician to address the identified need to increase his adherence to the therapy model, and meet the therapist competency requirements.

50. Finally, the Service told HDC that Mr B had been observed to be acting outside of his scope of practice in terms of how he was managing Ms A's trauma. Mr B had reported in his notes and to the consultation team about Ms A's initial disclosure around her trauma, despite not being trained to conduct trauma therapy. The Service said that Mr B was provided with supervision on how to manage the disclosure and future conversations about the incident, and advised to direct his clients' trauma-related issues to the Clinical Manager. The Service advised that despite this, Mr B was observed to be continuing to elicit information about the trauma incident.

51. In response to the provisional opinion, Mr B stated that he vehemently denies that he purposely set out to elicit trauma-induced material from Ms A. However, he noted that this is in no way an attempt to minimise or justify his admitted failings. He said that he shared all the information that Ms A provided her consent to share with the Clinical Manager and the wider team throughout the period that the Clinical Manager was providing concurrent therapy to Ms A. Mr B also noted that the Clinical Manager did not prevent him from being Ms A's lead therapist.

52. Mr B stated that he accepts that he was working outside of his scope of practice when discussing Ms A's trauma with her, but that at the time he had only a partial understanding of the concept of what "scope of practice" meant.

53. The Service advised that processes have been updated as part of ongoing quality improvement of the orientation and training, and provided a copy of the revised induction process. In addition to more general orientation updates, there is now an orientation process for both coaches and clinicians for an element of the programme, which includes 2–

3 weeks of observation and completion of an orientation checklist focusing on skill development.

Mr B's performance

54. The Service told HDC that during Mr B's employment, concerns were raised about his performance and ability to fulfil his role as a therapist. These concerns related to his appointment being early in his career, the clients being of a high level of complexity, development gaps in his knowledge, and concerns about his setting of clear boundaries with clients. Consequently, 1:1 supervision with Mr B was put in place. He was asked to record therapy sessions, which were reviewed by the supervision team, and was given feedback.

55. The Service said that despite this, the supervision team remained concerned that Mr B was not adhering to guidelines, and that there were subtle signs that Mr B was continuing to provide treatment as a friend, rather than on a therapist/client basis.

56. The Service said that these signs included Mr B spending more time with Ms A than other clients, and being overly protective of her by underestimating her resilience or being overly complimentary. The Service said that it discovered that Ms A had obtained Mr B's personal cellphone number, and while Mr B explained that this was an error and he had inadvertently called Ms A from his personal cellphone, it raised further concerns about his ability to maintain a therapeutic distance.

57. The Service said that because of these issues, Mr B was asked whether he had developed a friendship with Ms A, which he denied. As a result of these issues remaining following 1:1 supervision, the Service commenced a formal performance management/ improvement programme in May/June 2018, which remained in place at the time of Mr B's resignation. The Service advised that professional boundaries were specifically discussed in in-house supervision, and there was a particular focus on boundaries in the performance improvement plan. Mr B told HDC that at the time, he felt the scrutiny was unjustified.

Knowledge of relationship

58. The Service said that it did not become aware of the personal relationship between Mr B and Ms A until January 2019. At that time, Ms A was in the Service's home-based services programme. The Service did not know that Mr B and Ms A had remained in contact, and it was not suggested if they had, that there was anything more than a friendship, although this in itself raised ethical concerns. The Clinical Manager and another lead therapist made contact with Mr B and discussed the ethics of this, and made enquiries with the NZAC.

59. The Service said that the Board became aware of a sexual relationship between Mr B and Ms A in December 2019, when Ms A told a team member about the relationship and that she was pregnant. The full extent of the relationship was disclosed by Ms A slowly over sessions between January and September 2020 with the support of her home therapist and the Service's team.

60. Mr B told HDC that he accepts that members of the Service's supervision team did their best to help him to improve his therapeutic practice, and that no other staff members were aware of his sexual relationship with Ms A.

61. In October 2020, the Service completed an internal investigation into its response to Mr B's actions. The report recommended additional training for all staff regarding the setting and maintenance of appropriate boundaries.

Further information

62. Mr B told HDC that he regrets the impact his behaviour has had on the Service and his colleagues, and that at the time, because of his own traumatic background, he was not able to detect the level of harm he caused Ms A.

63. Mr B said that he takes responsibility for his inappropriate actions, and he apologises to Ms A. Currently he is not working in a therapy or counselling role.

Responses to provisional opinion

Ms A

64. Ms A was provided with an opportunity to respond to the "information gathered" section of the provisional opinion. She had no further comments to make.

Mr B

65. Mr B was given the opportunity to respond to the provisional opinion, and his comments have been incorporated into the report where relevant. In his response, Mr B advised that he accepts full responsibility for his behaviour, and is remorseful for the harm he caused Ms A.

66. Mr B noted that it remains clear that his opinion regarding the adequacy of his induction process differs from that of the Service, and he acknowledges the changes made to the Service's induction programme since his employment. Mr B stated that while he maintains that the Service's induction was piecemeal, he acknowledges his responsibility for his actions, and he is disappointed in himself for letting down his colleagues and the organisation.

Opinion: Mr B — breach

Introduction

67. Mr B provided services to Ms A between June 2017 and September 2018, while employed as a therapist. During this time, Mr B and Ms A engaged in an inappropriate intimate relationship. Mr B continued this relationship with Ms A after his employment with the Service ended, until Ms A ended the relationship in early 2020.

68. Under Right 2 of the Code of Health and Disability Services Consumers' Rights (the Code), Ms A had the right to be free from discrimination, coercion, harassment, and sexual,

financial, or other exploitation. Under Right 4(2) of the Code, Ms A had the right to have services provided to her that complied with professional, ethical, and other relevant standards.

69. At the time of events, Mr B was required to comply with the Code, and the expectations of his employer, as outlined in the Service's Code of Ethics and Organisational Rules.

70. While at present the counselling profession in New Zealand is not regulated under the Health Practitioners Competence Assurance Act 2003, and there is no requirement for counsellors to register with any association for counsellors, Mr B was registered with the New Zealand Association of Counsellors (NZAC) throughout the time he provided services to Ms A. This means that he was also required to comply with the Code of Ethics of the NZAC.

Scope of practice

71. Mr B was subject to a formal performance management programme at the time of his resignation in August 2018, because of concerns about his ability to maintain a therapeutic distance with Ms A and adhere to guidelines. I note the Service's comments that Mr B had reported in his notes and to the consultation team about Ms A's initial disclosure about her trauma, despite not being trained to conduct trauma therapy, and that measures were put in place to support Mr B in his management of the disclosure and any future conversations about the incident. Despite this, Mr B continued to act outside his scope of practice by eliciting further information about the trauma incident.

72. I am critical that Mr B continued to act outside his scope of practice despite being made aware that he was doing so. I note that Mr B has since accepted that he was acting outside his scope of practice. As a trained counsellor, Mr B should have recognised when he was providing advice or counselling outside his training, and should have sought appropriate support.

Relationship with Ms A

73. Mr B has admitted to engaging in a sexual relationship with Ms A while he was employed as a therapist at the Service, and while providing her with counselling services. As such, there is no dispute that Mr B and Ms A engaged in a relationship of a personal nature while Mr B was Ms A's primary therapist.

74. As Ms A's therapist, Mr B was aware of her history of trauma and mental illness, and of her vulnerability. Any relationship between a counsellor and a client involves a power imbalance in favour of the counsellor, a degree of vulnerability on the part of the client, and trust that this vulnerability will not be abused. In this instance, there was also a significant age difference of 25 years. It was Mr B's responsibility to maintain appropriate professional boundaries in the counsellor–client relationship, and he failed to do so, instead choosing to take advantage of Ms A's vulnerability.

75. Despite Mr B's own submitted vulnerabilities, he had a responsibility to manage his own personal circumstances as well as to maintain professional boundaries with Ms A. Once Mr B realised that his relationship with Ms A had crossed a professional boundary, he had many

opportunities to disclose the issue and seek collegial support and advice from his supervisors at the Service. However, he did not do so. Mr B should have been aware that his behaviour and actions were inappropriate and in contravention of the standard expected.

76. It is my view that Mr B should have been aware of the standards he was required to meet when providing counselling services.

77. In addition to being subject to the Service's Code of Ethics, Mr B was subject to the NZAC Code of Ethics, a set of professional standards which, as set out in Appendix A, provide that counsellors must not engage in sexual or romantic activity with their clients, and must not exploit the potential for intimacy made possible in the counselling relationship, even after the counselling has ended.

78. I am therefore satisfied that Mr B contravened professional and ethical standards by having a personal, intimate relationship with Ms A while employed as a therapist at the Service, and by continuing this relationship subsequent to his employment ending.

Conclusion

79. The intimate relationship initiated by Mr B while engaged as Ms A's primary therapist was inappropriate and unacceptable in light of his professional role and responsibilities. Mr B's behaviour was contrary to his obligations under both the NZAC and the Service's Code of Ethics, in relation to trust, honesty, and maintaining professional boundaries. When a healthcare provider engages in a sexual or intimate relationship with a client, fundamental ethical standards are breached.

80. The maintenance of professional boundaries is an integral part of health services, and by entering into an intimate and sexual relationship with Ms A, concurrently with a professional relationship, Mr B breached professional boundaries and ethical standards, and, in turn, breached Right 4(2) of the Code.

81. In addition, it is my view that Mr B took advantage of Ms A's vulnerability by pursuing a relationship while she was a client of the Service and he was her primary therapist. I consider his conduct to have been exploitative. Therefore, I consider that Mr B also breached Right 2 of the Code.

Recommendations

82. I recommend that:

a) Should Mr B return to work as a therapist or counsellor, NZAC require him to undertake further training on ethical and boundary issues, and that he be mentored by a mentor selected by NZAC, for a period NZAC deems appropriate. The mentor should report to NZAC on whether Mr B is maintaining professional boundaries.

b) Should Mr B seek to return to work as a counsellor in any capacity, NZAC consider whether a review of Mr B's conduct is warranted, and report back to HDC on the outcome of its consideration.

Follow-up actions

83. A copy of this report will be sent to the mental health service.

84. A copy of this report with details identifying the parties removed will be sent to the New Zealand Association of Counsellors, and it will be advised of Mr B's name.

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

86. Due to the nature and seriousness of Mr B's breaches of the Code, a referral to the Director of Proceedings was considered. However, noting that Mr B has accepted full responsibility for his actions, and has left the profession and indicated that he does not intend to return to work as a counsellor, on balance, I am satisfied that in this particular case, a referral is not required.

Appendix A: Relevant standards

Standards and guidelines

New Zealand Association of Counsellors

The Code of Ethics of the New Zealand Association of Counsellors (NZAC) 2016, to which Mr B was registered at the time of these events, provides:

> "**5.11 Multiple relationships**
>
> a. Counsellors assume full responsibility for setting and monitoring the boundaries between a counselling relationship with a client and any other kind of relationship with that client and for making such boundaries as clear as possible to the client
>
> b. Counsellors should consult with their supervisor(s) when dual or multiple relationships arise.
>
> …
>
> **5.13 Sexual and Other Inappropriate relationships With Clients**
>
> a. Counsellors shall not engage in sexual or romantic activity with their clients.
>
> b. Counsellors shall not exploit the potential for intimacy when made possible in the counselling relationship, even after the counselling has ended.
>
> …
>
> d. Counsellors shall not provide counselling to persons with whom they have had a sexual or romantic relationship.
>
> **7.3 Responsibility to the Profession**
>
> a. Counsellors shall uphold and foster the values, integrity and ethics of the profession.
>
> …"

Mental health service

The Service's Code of Ethics, signed by Mr B on 4 May 2015, provides:

> "Where there is ethical doubt or conflict, employees should work with management, or Trustees with Board colleagues, to identify the best course of action. Decisions and the rationale behind them should be documented. Refer to the following for detailed guidance:
>
> - Statutes
> - Licensing Board regulations
> - Case Law
> - Code of Ethics and Guidelines of professional associations

- Consensus of professionals
- Consensus of the community
- [Mental health service] Policies and Protocols.

…

Core value 1

Safe, competent, and ethical practice to ensure the protection of clients, colleagues and the public.

Trustees and Staff:

…

4. Know the difference between personal and professional relationships and assumes responsibility for those relationships.
5. Commit to building relationships and behave in a manner that protects the integrity of those relationships.
6. Ensure that the vulnerabilities of others are not exploited for one's own interests.
7. Practice within one's own level of competence and seeks out additional information or guidance when required.
8. Strive to maintain a level of personal health, mental health, and well-being in order to provide competent, safe, and ethical care.

…

10. Conduct themselves in a manner that reflects honesty, integrity, reliability, impartiality, and diligence.

…

11. Recognise one's own limitations and use professional judgement when accepting responsibilities.

…

15. Accept responsibility and accountability for one's own actions taking all necessary steps to prevent or minimise harm.
16. Conduct themselves in a manner that promotes a positive image of the mental health service.
17. Understand, promote, and uphold the ethical values of the mental health service."

The Service's Organisational Rules, also signed by Mr B on 4 May 2015, provides:

"1 INTRODUCTION

…

viii. Employees are expected to conform to standards that are commensurate with the qualifications or professional membership held by them. For example, a qualified nurse should be fully aware of, and perform to, the accepted ethical and practical standards of the nursing profession and a qualified social worker should perform to a standard common to the qualifications held. The experience of an employee may also be a factor in the expectation of performance.

…

4 SERIOUS MISCONDUCT

i. Without limiting the definition, serious misconduct may include:

…

xv. Sexual relationships between staff members and clients are expressly forbidden.

…"