Principles Underlying a Model Policy on Relationships Between Staff and Service Recipients in a Mental Health System

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Objective: **The authors participated in a work group to produce a model policy addressing the boundaries of relationships between staff and recipients of service in a public mental health system that provides and regulates services in a variety of treatment settings.** ***Methods:*** **The chief medical officer of the New York State Office of Mental Health assembled a work group of administrators, clinicians, state officials, and a representative of service recipients. The group reviewed the professional literature and existing ethics guidelines and policies addressing relationships between staff members and service recipients and made recommendations for a new policy.** ***Results and conclusions:*** **The work group formulated five guiding principles: prevention of the exploitation of recipients of services by staff; the right of recipients to be treated as competent autonomous human beings; recognition that certain developmental stages, treatment settings, and pre-existing relationships increase a service recipient's vulnerability to exploitation and call for more stringent regulation of staff actions; acceptance of a spectrum of permissible relationships for staff and recipients outside of the relationship dictated by the staff member's job description; and recognition of the difference between a relationship focused on treatment or service provision and other professional relationships between providers and current or former recipients. The principles were used to develop a model policy on relationships between staff and recipients that addresses both the organizational complexity and the recipient-centered rehabilitation model of a large state-operated mental health system. (*Psychiatric Services* 50:1447–1452, 1999)**

The provision of mental health services is an organizationally complex undertaking involving myriad relationships between persons who receive services and persons who work for service providers or for other agencies that are regulated by those providers. As psychiatry continues to move away from psychoanalytic neutrality and custodial care into a broader range of service paradigms, many of which emphasize the empowerment of service recipients, the outlines of these relationships become increasingly blurred. Organizations, individual providers, and service recipients are often left in confusion, as the following vignettes illustrate.

A recipient of services is employed part time as a peer counselor at the clinic at which she receives services. The clinic holds a monthly staff dinner. Should she be invited?

A therapy aide at a rural psychiatric hospital moonlights as one of the few fishing guides in the area. A recently discharged patient wishes to hire him for a fishing trip. Should he refuse?

A psychiatric case manager has the job of coordinating concrete services, such as entitlements, housing, and medical care, for his clients. He and one of his clients find that they share common interests and a common outlook on life. In fact, both would rather just be friends and have someone else coordinate the client's concrete services. How should they proceed?

Clarifying the boundaries of such relationships is an especially challenging task for public mental health authorities, which encompass a complex array of services. Many public mental health authorities operate or regulate hospitals that provide acute, intermediate, and long-term care and also operate or regulate a variety of outpatient programs, including those offering comprehensive psychiatric emergency services, partial hospitalization, continuing day treatment, intensive psychiatric rehabilitation, intensive and supportive case management, clinical services, assertive community treatment, peer advocacy, and psychosocial clubs. In addition, public mental health authorities usually provide or regulate a range of housing al-

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ternatives for service recipients, including family or foster care, supervised and supportive community residences, and crisis residences.

Within this array of services, the types of relationships range from those involved in staff members' provision of involuntary treatment to service recipients in an emergency room to those involved in service recipients' participation in psychosocial, advocacy, and housing programs that are operated by other service recipients. Across this variety of relationships, state mental health authorities retain the obligation to ensure that service recipients are not exploited by staff. This obligation cannot be fulfilled without impinging on the rights of service recipients to make autonomous choices unless public mental health authorities have a clear understanding of the parameters of staff-recipient relationships that are applicable in any service setting.

This paper describes the efforts of a work group convened by the New York State Office of Mental Health to clarify appropriate relationships between staff members and service recipients. It discusses the principles identified by the work group that were incorporated into a proposed model policy addressing staff-recipient relationships.

Methods

To clarify the conceptualization of staff-recipient relationships, in 1994 the chief medical officer of the New York State Office of Mental Health appointed a work group to explore this issue and develop a model policy for staff's interaction with service recipients that would incorporate its findings. The work group met during 1994 and 1995 and submitted its final recommendations to the chief medical officer in 1996. The work group consisted of two psychiatric administrators, a psychiatric nurse, a psychiatrist, a therapy aide, a social work administrator, a recipient of services representing the Office of Mental Health's bureau of recipient affairs, and representatives of the Office of Mental Health's legal, investigative, operations, and quality assurance divisions.

The work group reviewed the literature about relationships between staff and service recipients, professional guidelines in this area, and existing policies on staff-recipient relations in effect in facilities operated by the Office of Mental Health. As a result of these activities and extensive discussions among work group members, the work group formulated basic guiding principles that were incorporated into a model policy.

The existing policies of state-operated psychiatric centers in New York outlined a range of levels of restrictiveness—from prohibitions on all personal or social relationships between current or former service recipients and staff to explicit prohibitions on a limited set of activities between staff and current recipients such as sexual activity, accepting gifts, or staff members' inviting recipients into their homes. This lack of uniformity was one of the issues the work group was convened to address. To create a framework for a uniform model policy, the work group elucidated basic principles that would be operationalized in the policy. Elucidating the basic principles was particularly important because of the potential for some principles to conflict with others. Failure to explicitly recognize the potential conflicts would result in a lack of clarity in any policy that would be developed.

Clarifying the boundaries of relationships between staff and service recipients is an especially challenging task for public mental health authorities, which encompass a complex array of services.

Results

Literature review

The literature on relationships between providers and recipients of mental health services is quite narrowly focused on the boundaries of the psychotherapist-patient relationship and focuses particularly on sexual relationships between therapists and patients. Even many of the general discussions of patient-therapist boundaries are framed around a "slippery-slope" hypothesis that categorizes all boundary violations as potential steps on the road to a sexual relationship between the therapist and the patient (1–3).

Some authors have discussed specific aspects of sexual relationships between therapists and patients—for example, relationships after termination of therapy (4,5)—and others have discussed the incidence of sexual contact in various settings such as residency training (6), inpatient units (7), or general psychiatric practice (8,9). Epstein and associates (10) used a self-assessment questionnaire—the Exploitation Index—as a survey instrument and educational tool to examine actual and potential boundary violations in the psychotherapeutic relationship.

Several authors have broadened the conceptualization of the relationship beyond that of therapist and patient. The concept of the "dual relationship"—the existence of any additional relationship between the patient and therapist—has been applied chiefly to psychotherapy and has been generally seen as harmful (11,12). An example of a dual relationship is a therapist's employing a patient to paint his or her house. The work group used the concept of dual relationships as a basis for delineating a wider universe of provider-recipient relationships beyond the therapist-patient relationship. In this wider universe, dual relationships may not be as harmful as they are usually characterized.

Review of professional guidelines

Several mental health professions have addressed dual relationships.

The focus of the guidelines varies from quite narrow to somewhat broader. Both the American Medical Association and the American Psychiatric Association define sexual activity with current patients as unethical. In its guidelines the American Psychiatric Association goes further, defining sexual activity with former patients as "almost always" unethical (13,14).

The American Psychological Association begins its guidelines with the premise that psychologists should avoid potentially harmful dual relationships but recognizes that such relationships are not always avoidable (15). For example, in small communities, a psychologist may have difficulty avoiding social contact with clients. The association's guidelines direct psychologists to remain alert to the potential of such relationships for reducing their effectiveness or harming the other party and to refrain from engaging in relationships that do so. Again sexual intimacy is singled out as harmful to the patient. In addition, the guidelines recommend a two-year posttherapy ban on sexual activity with former patients, after which the psychologist must bear the burden of proof in demonstrating that such a relationship would not be exploitive (15).

The National Association of Social Workers instructs social workers to refrain from potentially exploitive or harmful dual relationships and explicitly prohibits sexual activities with clients (16). The American Nursing Association refers to respect for the dignity, worth, and self-determination of clients (17).

Legal issues

Case law on the exploitation of recipients of services, like the mental health literature in this area, largely centers on sexual relationships. The mental health practitioner who indulges in sex with recipients of service can become embroiled in civil, ethical, professional, and even criminal disciplinary proceedings. The consequences of sex between practitioner and recipient are usually devastating for both parties. Practitioners stand to lose their reputation, professional license, and source of income following civil and criminal litigation. Professional organizations may undertake proceedings pursuant to ethical violations leading to expulsion and publication of a notice of the sexual misconduct.

Recipients of mental health services who have been sexually exploited by their therapists are exposed to a profound violation of trust. They have often experienced progressive boundary violations preceding the sexual act, and the act itself often produces a significant degree of psychological harm. Their treatment is interrupted, they are likely to regress in their psychiatric condition, and they may flee all mental health treatments. They may be unable to summon the trust necessary to develop a therapeutic alliance with another practitioner in the future.

Sexual exploitation may also result in a civil lawsuit against the employer of the provider. The courts have invoked the legal doctrine of "respondent superior" in holding hospitals or government institutions vicariously liable for the actions of individual providers as long as that person acted within the scope of his or her employment. Hospitals may argue that a therapist who sexually exploits a recipient did not do so within the scope of employment and that the hospital should not be held vicariously liable. Courts may in fact rule that as a matter of law, the sexual misconduct of an employee falls outside the scope of employment.

However, the law has been known to take a broad view of the meaning of scope of employment. In a recent case the court held that "the fact that an employee is not engaged in the ultimate object of his employment at the time of his wrongful act does not preclude attribution of liability to an employer" (18). In some cases employers have been held vicariously liable for the sexual misconduct of their employees. In a 1990 case, a trial court upheld the doctrine of respondent superior, holding a pastoral counseling center liable for the actions of one of its counselors who sexually abused the petitioner (19). The court found that although the therapist "was not authorized to become sexually involved with his clients, that contact occurred in conjunction with his legitimate counseling activities."

A search of the case law yielded no cases involving the exploitation of a service recipient by nonprofessional staff. However, under the doctrine of respondent superior, a hospital could well be held vicariously liable for the behavior of nonprofessional members if that behavior fell within the scope of their employment.

Guiding principles

The work group identified five principles that provided the framework for a model policy addressing relationships between staff of mental health agencies and recipients of services. The principles are listed below, and the model policy is shown in the box on the next page. (The model policy is a product of the staff-recipient relations work group and is not a policy of the New York State Office of Mental Health.)

- An agency is responsible for preventing the exploitation of recipients of its services by its staff.
- Recipients of services have the right to be treated as competent autonomous human beings in all their relationships with staff.
- Certain developmental stages, treatment settings, and pre-existing relationships increase a person's vulnerability to exploitation and call for more stringent regulation of staff actions.
- There is a spectrum of permissible relationships for staff and recipients that fall outside of those defined by the staff member's job description.
- There is a spectrum of vulnerability within the gamut of professional relationships between staff and recipients of services, with current treatment relationships at the most vulnerable end of that spectrum.

Discussion

The first principle identified by the work group was that agencies are responsible for preventing staff members from exploiting recipients. The work group's review of policies on staff-recipient relationships suggested that this principle is a traditional basis for such policies and that it is often the only underlying principle.

Model policy addressing relationships between staff members and recipients of mental health services in a state-operated mental health system[1]

Definitions used in the policy statement

- Close personal relationship: Spending substantial amounts of time together outside of the provision of services that constitute a recipient's treatment plan but excluding sexual contact
- Commercial advantage: The purchase or provision of goods or services at other than fair market value
- Commercial relationship: The purchase or provision of goods or services (other than mental health services) at fair market value.
- Domestic partnership: A relationship that resembles marriage in all respects except that of legal sanction.
- Exploitation: The use by an employee of a recipient's person or property or of the treatment or service provision relationship in a manner that results in or is intended to result in personal profit or gain (beyond the employee's authorized compensation) or personal advantage for the employee
- Sexual contact: Any touching of the sexual or other intimate parts of a person for the purpose of gratifying the desire of either party. Any verbal or written statements intended to promote or produce such physical contact
- Treatment or service provision relationship: The provision of mental health services or residential counseling or supervision services or participation in the specific planning of such services for an individual recipient. This relationship involves but is not necessarily limited to members of the recipient's treatment team.

Policy statement

Any relationship that involves the exploitation of a service recipient by an employee is explicitly prohibited.

Exploitation includes but is not limited to:

- Any sexual contact between any employee and any recipient of services who is under the age of 18
- Any sexual contact between any employee and any individual receiving inpatient services with the exception of employees and recipients who have a pre-existing spousal or domestic partner relationship. In this case the facility's policy on consensual sexual contact should apply
- Any sexual contact between an employee in a treatment or service provision relationship (inpatient, outpatient, or residential) and the recipient of those services
- Any close personal relationship between any employee and any recipient of inpatient services with the exception of pre-existing spousal, domestic partner, or close personal relationships
- Any close personal relationship between an employee in a treatment or service provision relationship (inpatient, outpatient, or residential) and the recipient of those services
- The establishment of a treatment or service provision relationship (inpatient, outpatient, or residential) in the context of a pre-existing sexual contact
- The solicitation or acceptance by any employee of any commercial advantage from a recipient of services including the solicitation of any gifts or acceptance of gifts of more than token value
- Any commercial relationship between any employee and any recipient of inpatient services with the exception of a pre-existing commercial relationship

In cases of the initiation of sexual contact between an employee and an individual with whom the employee had previously been in a service provision relationship, the burden of proof always resides with the employee to demonstrate that such sexual contact is not exploitive

For employees in a noninpatient treatment or service provision relationship with a recipient of services 18 years or older, should the potential for a nonexploitive close personal relationship arise, the employee and the recipient of services should mutually determine which of the two relationships shall be continued. If the treatment or service provision relationship is to be terminated, the burden of proof remains with the employee to demonstrate that the termination is done in a manner that does not injure the recipient or compromise his or her access to services, that the choice was made in a noncoercive and nonexploitive manner, and that the employee maintains the recipient's rights of confidentiality

This policy applies equally to volunteers

This policy applies equally to employees or volunteers who are also recipients of services

Employees in any treatment or service provision setting with recipients under the age of 18 years are explicitly prohibited from having any sexual contact or close personal relationship with any such recipient. This prohibition applies both to the time services are provided and to any future involvement between the employee and such former recipient of service

[1] This model policy is a product of the staff-recipient relations work group and is not a policy of the New York State Office of Mental Health.

The work group operationalized exploitation as "the use by an employee of the Office of Mental Health of a recipient's person or property or of the treatment or service provision relationship in a manner that results in or is intended to result in personal profit or gain (beyond the employee's authorized compensation) or personal advantage for the employee." This definition provided a broad foundation from which specific prohibitions could be elucidated. The work group struggled with the murkiness of the concept of "intent" but decided that it would be unfair to exonerate an employee simply because an attempt at exploitation had not succeeded.

The second and equally important principle was the right of recipients of services to be treated as competent autonomous human beings in both their treatment and their nontreatment relationships with staff. The work group felt that the traditional prohibitions on staff from having any relationship beyond that of treatment provider with current and former recipients of services served to perpetuate the view of recipients as infantile, totally vulnerable, and incompetent to make sound decisions about who they socialize with, do business with, or even fall in love with. The work group also believed that this view was perpetuated by extending traditional prohibitions to clerical and maintenance staff, staff members at other service sites operated by the same facility, and other staff members who were not directly involved in the treatment relationship.

The work group also decided that the relationships of service recipients who work as agency staff would be governed by the same policy that applies to the relationships of other staff members. The group noted that if service recipients are to have autonomy, they must also be responsible for their actions. To ask recipients who function as staff members to adhere to a different policy would undermine and infantilize them in their role as staff members.

The third principle was based on the idea that a spectrum of vulnerability to exploitation exists among service recipients. Recipients at certain developmental stages, recipients who receive services in certain treatment settings, or recipients who have certain pre-existing relationships may have increased vulnerability to exploitation and must be protected by more stringent regulation of staff actions. This principle led to a policy of absolute prohibition of staff members' having sexual contact or a close personal relationship with recipients who are under age 18 or former recipients who were under age 18 while receiving services. In addition, sexual contact between staff and recipients who are receiving inpatient services was prohibited. Further, staff members were prohibited from establishing treatment relationships with recipients with whom they had prior sexual contact.

The recognition of the power differential inherent in the inpatient treatment setting led to further prohibitions on staff members' establishing commercial or close personal relationships with recipients of inpatient services. The prohibition on close personal and commercial relationships between staff and inpatients was not extended to cases in which these relationships predated the inpatient services, as long as the staff member and recipient were not in a relationship involving treatment or provision of mental health services. A similar exception to the prohibition on sexual relationships was established in the case of a pre-existing marriage or domestic partnership.

Recognition of the power differential in inpatient treatment led to further prohibitions on staff members' establishing commercial or close personal relationships with recipients of inpatient services.

The difference between the policies on commercial relationships, close personal relationships, and sexual relationships implies the fourth underlying principle—that a spectrum of permissible relationships exists for staff and recipients outside of the relationship dictated by the staff member's job description. The work group concluded that the potential for abuse or harm varies with the type of relationship and so therefore must the stringency of the prohibitions or safeguards connected with each type. The work group defined a commercial relationship as "the purchase or provision of goods or services (other than mental health services) at fair market value." Commercial advantage was defined as a commercial relationship in which the principle of fair market value was not observed.

A close personal relationship was defined as "spending substantial amounts of time together outside of the provision of the services that constitute a recipient's treatment plan but excluding sexual contact." Sexual contact was defined as "any touching of the sexual or other intimate parts of a person for the purpose of gratifying the desire of either party" as well as "any verbal or written statement intended to promote or produce such physical contact."

The fifth principle recognized the existence of a spectrum of professional relationships between staff and recipients, with an associated spectrum of potential for harm. The elucidation of this principle involved differentiation between relationships focused on treatment or service provision and other forms of professional relationships between providers and current or former recipients. From the point of view of both psychodynamic theory and common sense, the potential for a sexual relationship between a recipient and staff member to be coercive and destructive varies depending on the nature of the professional relationship. It would be more harmful if the staff member is the recipient's therapist or an aide counseling the recipient on activities of daily living than if the staff member is a therapist in a different program or a clerical worker in the facility's business office.

The model policy prohibits sexual relationships and close personal relationships between staff members who are providing services or treatment and the recipients of those services. The work group included the concept of service provision with treatment to encompass the wide range of therapeutic, direct care, and support relationships in which both transferential and practical power imbalances in-

crease the potential for harm. The work group defined a treatment or service provision relationship as "the provision of mental health services or residential counseling or supervision services or participation in the specific planning of such services for an individual recipient. The group noted that the service provision relationship "involves but is not necessarily limited to members of the recipient's treatment team."

The issue of sexual contact between staff and recipients with whom they have had a prior treatment or service provision relationship has been the subject of considerable controversy in the psychiatric literature (4,5). Cogent arguments can be made for lifetime prohibitions, time-limited prohibitions, or case-by-case analysis. Ultimately, the work group chose the last option with the additional caveat that the burden of proof rests with the employee to demonstrate to program administration that the sexual contact does not exploit the previous relationship. This approach was felt to be most consistent with placing value on both autonomy and protection.

Another related issue with which the work group grappled was how to proceed if the potential for a nonexploitive close personal relationship arose in the context of an existing outpatient treatment relationship. Here again the work group took its guidance from the principles of preventing exploitation while maximizing recipient autonomy. The first principle dictated that the two relationships could not coexist, the second that the decision about which relationship would be pursued must be made mutually by the staff member and service recipient.

In such situations, the staff member would bear the burden of proof to show that the relationship did not compromise the recipient's future access to services, that the recipient's choice to enter the relationship was not coerced, and that the recipient's confidentiality was maintained. Although the idea of burden of proof is difficult to operationalize, including the term in a policy statement at least conveys the message that the choice to enter a close personal relationship should not be made lightly.

Conclusions

By identifying a set of underlying principles that apply to relationships between staff and recipients of services, the work group was able to draft a model policy that addresses both the organizational complexity and recipient-centered rehabilitation model of a large and diverse state-operated mental health system. ♦

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