ARIZONA STATE BOARD OF NURSING GUIDELINES FOR SEXUAL MISCONDUCT AND BOUNDARY VIOLATION CASES

ARS 41-1091 (B)
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TERMS AND CONCEPTS USED IN POSITION PAPER

1. **Actions which constitute sexual misconduct**-
   - Any direct, intentional genital stimulation or sexual gratification via oral, manual, genital instrumental or other means.
   - Any manipulation or penetration of any bodily orifice by any means that is not medically indicated.
   - Any exposure, touch, or manipulation of the breasts, nipples, genital area, buttocks, or anus that is not medically indicated, is not reasonably part of routine care of the patent, or is engaged in for purpose of sexual gratification.
   - Any medically indicated procedure or aspect of routine care involving the sexual or private parts of that body that is sexualized, prolonged, or altered in order to provide sexual gratification.
   - Any sexualized comments or gestures, any verbalizations intended to invite or suggest sexual contact or romantic relationship.
   - Kissing, fondling, dating, or flirting with patients.
   - Behavior that involves involvement with a client whether inside or outside of the professional setting which may reasonably be interpreted as romantic, or intended for sexual arousal/gratification, or be reasonably interpreted by the patient as being sexual in its intention.
   - Encouraging the patient to masturbate or masturbation by the practitioner while the patient is present.
   - Offering to provide practice related services such as drugs in exchange for sexual favors.
2. **Arousal** To be stimulated for action or to physiologic readiness.
3. **Boundaries** The limits of the professional relationship that allow for a safe therapeutic connection between the HCP and the client.
4. **Boundary Crossing** Brief excursions from an established boundary for a therapeutic purpose, e. g., appointment changes, disclosure of bits of personal information, small gifts. The crossing is brief with return to the established limits of the professional relationship. Crossings are made based on what is best for the needs of the client.
5. **Boundary Violation** A deviation from the established boundary in the HCP-client relationship where the HCP's and the client's needs are confused. Boundary violations are characterized by role reversal, secrecy, and sometimes the creation of a –dual relationship with the client.

6. **Client** Any individual receiving nursing services from a HCP.

7. **Cognitive Distortion** The process of twisting one's actions into a different meaning.

8. **Exhibitionism** To expose or show one's genitals in an indecent manner.

9. **Frottage** A form of sexual misbehavior, secretly rubbing one's genitals against another without permission.

10. **Health Care Provider (HCP)** Anyone of the following: Certified Nursing Assistant, Licensed Practical Nurse, Registered Nurse, Certified Nurse Practitioner

11. **Mistaken Beliefs** Collection of thoughts about yourself, others, and the world that are believed to be true, but are based on wrong judgment or erroneous conviction.

12. **Offense Cycle/Cycle of Abuse** Systematic approach to life that promotes isolation and justifies misbehavior.

13. **Paraphilia** A Deviation (sexual) to which a person is attracted.(As per DSM-IV) Over a period of six months recurrent and intense sexually arousing fantasy, sexual urges or behaviors involving sexual activity which is deviant. The fantasies, sexual urges or behaviors cause clinically significant distress or impairment in social, occupational or other important areas of function. (per Dr. Steven Gray) The sexual behavior in question is either illegal, societal immoral or a violation of various cultural or business practices. Some examples of paraphilias are: voyeurism, rape, obscene phone call or mail, pedophilia, pornography, professional sexual misconduct, frottage, prostitution, incest, sexual harassment.

14. **Paraphiliac** An individual who is attracted to a deviant sexual activity.

15. **Post-Termination Relationships** A relationship between an HCP and a client that exists after the client is no longer receiving treatment from the HCP

16. **Sexual Impropriety** Anything that may compromise behavior such as gestures or expressions that are seductive, sexually suggestive or sexually demeaning to a patient including but not limited to:

- Disrobing or draping practices that reflect a lack of respect for the patient's privacy, deliberately watching a patient dress or undress.
- Examining or toughing genitals without the use of gloves.
- Inappropriate comments about or to the patient including but not limited to making sexualized or sexual demeaning comments to a patient, criticizing the patient's sexual orientation, making comments about potential sexual performance during an examination or consultation, requesting details of sexual history or sexual likes or dislikes when not clinically indicated for the type of consultation.
- Using the practitioner/patient relationship to solicit a date.
- Initiation by the practitioner of conversation regarding the sexual problems, preferences or fantasies of the practitioner.

17. **Sexual Misbehavior** The use of sexual behavior to experience attention, power, revenge, or resignation.

18. **Voyeurism** Seeking sexual gratification from looking at the sex organs of others and /or watching

POSITION STATEMENT ON BOUNDARY VIOLATIONS AND SEXUAL MISCONDUCT

Introduction

The Arizona State Board of Nursing, in keeping with its role to protect the public health safety and welfare, believes it is important to delineate and provide education about boundary violation behavior that could lead to problems in Healthcare Provider (HCP)-client relationships, up to and including, sexual misconduct. The Board also believes it is imperative to take a strong position regarding licensure and or certification of individuals who engage in sexual misconduct towards clients in the workplace, individuals who have been convicted of sexual misconduct or individuals whose sexual misconduct outside the workplace may affect the ability to safely care for clients.

The Board adopts the following assumptions as the basis of its position.

1. Clients under the care of a HCP are vulnerable by virtue of illness or injury and the dependent nature of the HCP-client relationship. Clients who are especially vulnerable include the elderly, children, the mentally ill, sedated and anesthetized clients, those whose mental or cognitive ability is compromised and clients who are disabled or immobilized. In addition, HCPs by the virtue of their role, have access to information about clients, and HCPs see clients in situations that clients would normally only share with individuals involved in the most intimate of relationships with the client.

2. In all HCP-client relationships there is an imbalance of power with the HCP having more power than the client. It is therefore **always** the HCP's responsibility to understand what the difference is between a personal versus a professional relationship. It is **always** the HCP's responsibility to delineate and maintain appropriate boundaries in HCP-client relationship.

3. Boundaries are established in all relationships, but in HCP-client relationships boundaries are the limits of the professional relationship that allow for a safe therapeutic connection between the HCP and the client. Boundaries provide a mechanism for a HCP to control the power differential that exists in the HCP-client relationship and to maintain a safe connection with the client that is based on what is best for the client's needs. When boundary limits are altered, especially when altered multiple times, the purpose for the relationship can become ambiguous resulting in harm to the client and possibly the HCP.

4. Specific delineations of boundary parameters for all types of HCP-client relationships cannot be made without considering many factors. Variables such as the type of care setting, community culture, client needs, the nature of therapy received and nursing services provided, age of client and degree and length of involvement affect the appropriate delineation of boundaries.

5. Boundary crossings by a HCP are brief deviations from the established boundaries with a rapid return to the established boundaries. The crossing may be inadvertent, thoughtless or even a deliberate decision to deviate based on a belief by the HCP that the crossing will achieve a positive therapeutic outcome for the client.

6. Boundary violations occur when there is a deviation from delineated boundaries and the motivation for the deviation may stem from a desire to meet the HCP's needs and not the client's. In boundary violations there may be a reversal of roles between the HCP and the client (the client is "taking care" of the HCP), secrecy, or the formation of a dual role with the client (friend and client). In contrast to boundary crossings, boundary violations may also be progressive, with one violation leading to another, characterized by increasing levels of inappropriate behavior and potential harm to the client.

7. The same action (i.e. personal disclosure, giving or receiving gifts from a client) could be classified as a boundary crossing or a boundary violation in different situations. The main difference between boundary crossings versus boundary violations is that violations are not based on the client's needs, rather the violations are based on the HCP's needs. Violations can also occur when naïve or uninformed HCPs yield to the temptation of a predatory client or due to a HCP's own personal vulnerability, HCPs yield to the temptation to use the client relationship to meet the HCP's needs.

8. Sexual misconduct often begins with boundary violations, but not all boundary violations lead to such serious conduct. Once boundary violations have occurred there is a greater possibility of sexual misconduct occurring, i.e., "slippery slope" situations.

9. Sexual misconduct is an extreme boundary violation that involves the use of power, influence and or knowledge inherent in one's profession to obtain sexual gratification, romantic partners, and or sexually deviant outlets. Any behavior by a HCP that is seductive, sexually demeaning, or reasonably interpreted by a client as sexual is a violation of the HCP's caretaking responsibility to the client. Sexual misconduct includes any and all sexual and romantic behaviors, physical and verbal, with the clients the HCP is intended to serve.

10. A client's consent to, initiation of, or participation in sexual behavior or involvement with a HCP does not change the nature of the conduct because the HCP has full responsibility to maintain proper boundaries.

11. Once a HCP-client relationship has been established, the HCP has the burden of proof in showing that the relationship no longer exists. The mere passage of time is not solely determinant of the issue. Because of the varying types of HCP-client relationships, variety of settings, differing practice types and inequity in power in HCP-client relationships, individual analysis of each situation is essential.

12. Sexual contact between a HCP and former client after termination of the HCP-client relationship may still constitute unprofessional conduct if the sexual contact is a result of exploitation of trust, knowledge influence or emotions derived from the professional relationship.

13. Sexual misconduct towards clients or others in the workplace raises serious questions regarding the individual's ability to provide safe, competent care to vulnerable clients

14. Sexual misconduct which occurs outside the workplace may raise questions as to whether that same misconduct will be repeated with clients, and therefore may impact the ability of the HCP to safely provide client care.

15. Protection of the public is the Board's primary goal in cases of sexual misconduct by HCPs. Revocation may be the most effective means to this end in some cases. In others, the Board may restrict and monitor the practice of a HCP who is actively engaged in a treatment program. Such rehabilitation of the HCP is a secondary goal which will be pursued only if the Board can be assured that the public is not at risk for recurrence of the misconduct.

To augment a HCP's ability to delineate and maintain appropriate boundary behavior with clients the Board strongly recommends the following actions by HCPs: (taken from the Washington State Board of Registered Nursing's Sexual Misconduct Statement)

1. HCPs should be aware of any feelings of sexual attraction to a client, and should discuss such feelings with a supervisor or trusted colleague. Under no circumstances should a HCP act on these feelings or reveal/discuss them with a client.

2. HCPs should transfer the care of a client to whom the HCP feels a sexual attraction towards. Recognizing that such feelings in themselves are neither wrong nor abnormal, HCPs should seek help in understanding and resolving them.

3. HCPs must be alert to signs that a client may be interested in or encouraging a sexual relationship. All steps must be taken to ensure that the boundaries of the professional relationship are maintained. This could include transferring the care of the client to another HCP.

4. HCPs must respect the dignity and privacy of clients at all times. HCP's should be particularly aware that examinations and treatments involving the sexual or private parts of the body can be upsetting to the client, and HCPs must prevent or minimize any such trauma.

5. HCPs should provide a professional explanation of the need for each of the various components of examinations, procedures, tests, and aspects of care to be given. This can minimize any misperceptions a client might have regarding the HCP's intentions and the care being given.

6. HCPs communications with clients should be clear, appropriate and professional.

7. HCPs should never engage in communication with clients that could be interpreted as flirtatious, or which employ sexual innuendo, off-color jokes, or offensive language.

8. HCPs should not discuss their personal problems, or any aspects of their intimate lives with clients.

The Cycle of Abuse

Sexual misconduct should be thought of in terms of a cycle of abuse with distinctive separate steps. Each step has specific cognitive distortions which involve the HCP offender utilizing normalizing, minimizing, projection of blame and denial to justify their actions. The denial seen in the cycle can manifest in different forms: "I didn't do it", "I did it, but the victim came on to me, and/or the victim wanted it", "I did it, but I wasn't turned on to it or aroused to it", "It was an accident," and "It was due to situation factors i.e. being drunk, mixed up, stressed out".

The Cycle of Abuse can also be coupled with a number of other diagnosis, most notable character disorders. Most common are: schizoid personality disorder, anti-social personality disorder, borderline personality disorder, narcissistic personality disorder, and obsessive/compulsive disorder. Offenders may also commonly suffer from mood disorders and/or substance abuse.

The steps of the cycle are:

CYCLE	DEFINITION
Victim Posture	The HCP/offender sees themselves as a victim both in life in generral and in specific situations. Cognitive distortions utilized in this step include ideas that others are out to use or abuse you, and/or an idea that other's abuse justifies your own abuse.
Anticipation of rejection and abusive compensatory behavior	In this step of the cycle the HCP/offender avoids intimacy through various compensatory behaviors such as: isolating, Bragging/storytelling, being an aggressor, becoming a moralist or a pleaser.
Thinking errors	"I fear being rejected, so I reject others first "It's better to be rejected for my compensatory style than the real me." "If they know who I really am, other's won't like me"
Emotional and Social Isolation	The HCP/Offender avoids genuine intimacy and begins to affiliate with others who have a similar thinking style and mistaken beliefs.. This is done to avoid rejection.
Cognitive Distortions	The HCP/offender believes no one has feelings quite like theirs. There is no one with whom they can talk openly about their feelings problems.
Need Fulfilling (Maybe sexually abusive fantasy)	The abuser manages their emotional distress like boredom, anxiety, fears through an active fantasy life which eventually becomes sexual.
Acting Out • Victim selection	HCP/offender analyzes potential victims considering a victim's age, physical size, disparity, emotional experience, financial resources, intellectual,, socio-economic

• Engagement Boundary crossing/Boundary violation	status, employment, presence of substance abuse. The HCP/offender begins by breaking down the emotional boundaries of the victim, and the victim is usually not aware it is happening. The actions of HCP/offender create a situation where the victim feels 'special'. These actions can include: • Health care provider may spend a disproportionate amount of time with a patient, • Health Care Provider is with a patient off duty • A Client feels the health Care Provider is the only one who understands him/her • Health Care Provider keeps secret(s) with the patient • Health care provide gives Client gifts
Grooming Boundary violations	This stage has the same intent as the engagement stage, but the actions are now physical. Health Care Provider and Client engage in: • Kissing • Inappropriate hugging • Inappropriate touching, hand on thigh, knee, waist etc. • Any touching that appears normative, but when sexualized is inappropriate
Sexual Contact	The Healthcare Provider engages in intercourse, oral/genital contact. Oral/anal contact, or oral contact groping of breasts or genitals masturbation, exposure, voyeurism or frottage.
Transitory guilt and shame	The Health Care Provider will experience and may express what appears to be remorse and transitory guilt.
Reconstitution	The Health Care Provider engages in hyper-normal activities designed to disguise acting out and to manage transitory guilt of being the super-employee, super nurse. The image is created so others won't believe this person could have done these things

A major difficulty with identifying, assessing and treating sexual misconduct is that many of the components of the Cycle of Abuse are covert. The intent may be known only to the HCP/Offender; and, at times, the HCP/Offender's delusion thinking will preclude even them from having a clear understanding of their own intent.

INVESTIGATION TECHNIQUES IN CASES INVOLVING BOUNDARY VIOLATIONS AND OR SEXUAL MISCONDUCT

All complaints of sexual misconduct will be considered as serious, and will receive priority for timeliness of investigation and will be investigated with meticulous thoroughness.

Complaints will be received by the Board and assigned to a Board investigator.

The complainant and HCP will be notified by mail of the pending investigation and the identity of the investigator.

The investigator will interview the complainant, alleged victim and any witnesses suggested by the complainant or alleged victim as soon as possible. The interview should occur as rapidly as possible to assure alleged victim and witnesses can relate as many details as possible. The investigator should obtain as much information about the scene and circumstances surrounding the incidents, and any information that the alleged victim can relate which would specifically identify the perpetrator (distinctive physical markings, clothing etc.).

Interviews with all witnesses should be conducted separately to avoid collaborative details being shared by witnesses. If the victim needs a support person to be with them during the interview, the investigator should attempt to find an individual who will not be needed as a potential witness at a Board hearing proceeding.

The investigator will subpoena any and all necessary medical records, police reports, and court records. The HCP's personnel file for present and past employers for at least 5 years will also be subpoenaed.

The HCP is informed of the investigative process, outcomes from any Board investigation, right to a hearing. The HCP is interviewed to obtain their information about alleged incidents. The HCP is also asked for any documents or witness they feel the Board investigator should interview or review as part of the investigation.

In each case the investigator must analyze:

- Credibility of witnesses
- Consistency of details reported by different witnesses, or by the same witness if the witness has been interviewed more than one time.
- History of any other incidents with the HCP where it appeared boundary violations and or sexual misconduct may have occurred.
- History of a pattern of other complaints of such a nature by the complainant against the HCP or other Health Care Providers.
- Initiation of the boundary violation and or sexual misconduct behavior by the HCP or failure of the HCP to maintain appropriate boundaries when faced with romantic or sexual verbiage or actions from a client.
- Existence and appropriateness of a post termination relationship with a client. The investigator will need to consider:
    - Were there formal termination procedures?
    - Did the HCP transfer the client's care to another care giver?

- Was the therapy with the client terminated for the purpose of entering a sexual or romantic relationship with the HCP?
- How much time has passed since the HCP-client relationship ended?
- How long was the HCP-client relationship?
- To what extent has the client confided personal or private information to the HCP?
- What was the nature of the client's health problem?
- What was the degree of emotional dependence or vulnerability of the client?
- Did the behavior that occurred in the post-termination HCP-client relationship occur as a result of exploitation of the client's emotions, trust or was there an abuse of power by the HCP in the relationship?

The Board investigator should be aware of ten characteristics that can be associated with HCP/Client Sexual misconduct;

- Ambivalence—The victim may in a similar manner as a woman who has been in an abusive relationship: the victim may long to escape the exploitative practitioner yet fear separation form the practitioner.
- Feelings of guilt—Even though it is totally unfounded, many victims feel as if they are some way to blame for their sexual abuse. (These feelings may be partly engendered by the HCP/offender)
- Feelings of emptiness and isolation—Like victims of rape or battering, sexual misconduct victims may often feel emotionally hollow and alone.
- Sexual confusion—Due to being sexually traumatized, many victims develop a profound confusion about their sexuality and it can affect their sense of identity.
- Impaired ability to trust—Having opened themselves up and allowed themselves to be vulnerable with a resultant betrayal, many victims may develop a lifelong mistrust of professionals and others in general.
- Identity boundary and role confusion—When a HCP becomes involved with a client it is analogous to incest where roles and boundaries become blurred. This process may have an impact on the victim's ability to form appropriate boundaries with others and maintain a sense of identity and proper roles in their lives.
- Emotional lability—Often the experience of being sexualized by an HCP can be emotionally overwhelming to the client.
- Suppressed rage—Victims can feel an understandable rage toward the exploitative practitioner, yet this is often blocked by feelings of guilt and ambivalence.
- Increased suicidal risk—The rage victims feel may turn to self-destructiveness. Feelings of guilt or hopelessness may reach such high levels that suicide may seem the only way out.
- Cognitive dysfunction—The trauma caused by inappropriate sexual involvement with an HCP is often so great that cognitive abilities particularly attention and concentration may be impaired.

If it appears from the investigation that boundary violations and/or sexual misconduct are substantiated, the investigator should review the investigative materials and consider the following factors:

- Seriousness of the act
- Intent to harm
- Dishonesty or depravity on the part of the HCP
- One time act versus multiple occurrences of acts by the HCP

- Recognition and acceptance of responsibility by the HCP for the inappropriateness of the action
- Recognition by the HCP of the harm or potential for harm to the Client
- Expressions of genuine remorse by the HCP
- Expressions by the HCP of what they have learned or could do differently in a similar situation if it occurred again.

In each case the investigator must review the content of the investigation and determine on a case-by-case basis if an evaluation of the HCP would aid in determining whether the offense occurred, whether treatment is necessary or helpful for the HCP, and whether the HCP is safe to practice. If it is felt an evaluation would be appropriate, the investigator will refer the HCP to a professional with specific expertise in sexual misconduct for the evaluation. Once the HCP has confirmed the scheduling of an appointment, the investigator will send a letter to the evaluator identifying the presenting problem, concerns of the Board, questions the evaluator should address including identification of a sexual misconduct problem, opinion as to predatory nature of the HCP, need for and possibility of improvement of misconduct behavior with treatment, success rate for alleviation of problem with treatment, and safety to practice with suggestions for work restrictions and monitoring reports to the Board.

There may be some cases where the HCP's behavior is of such a serious nature (rape, sexual assault), that the Board's main objective is to remove the HCP from practice as rapidly as possible to prevent further client harm. In such cases, because of public safety concerns, the evaluation might not provide information that would alter the Board's decision, and requiring the HCP to submit to an evaluation under such circumstances would create an unnecessary expense for the HCP.

If, after the investigator reviews the material obtained in the investigation, the investigator determines the conduct presents an imminent risk of harm to the public (rape, sexual assault), the investigator would meet with the Executive Director and Assistant Attorney General to discuss possible summary suspension. If a Summary Suspension is not felt to be appropriate, the Executive Director with the advice of the Assistant Attorney General may agree to offer a consent for Revocation. (see Disciplinary Guidelines concerning sexual misconduct convictions, and sexual misconduct with clients and in the workplace, and sexual misconduct with clients not currently receiving care from HCPs)

If the HCP's behavior according to Board guidelines would suggest a disciplinary action less than revocation (see Disciplinary Guidelines) the investigator should determine whether an evaluation by a professional with expertise in sexual misconduct is appropriate and make the necessary referral. Results from that referral, and the investigative report will be reviewed by the Board for consideration of proper action.

FACTORS FOR BOARD CONSIDERATION

The Board should consider the following factors when they are trying to evaluate the safety of allowing a person to continue practicing who has committed a Boundary Violation or Professional Sexual Misconduct:

- The alleged offender's reliability as a self-reporter. This can be determined through the polygraph examination, and by analyzing validity scores on pencil/paper tests

such as the MMPI. In order to do an accurate assessment or conduct quality treatment and supervision, the alleged offender needs to eventually become a reliable reporter.

- The alleged offender's continuum of sexual interest must be delineated. This can be done by an evaluation which asks the offender to self report in combination with other measures of sexual interest such as penile tumescence or completion of testing such as the Abel 2.31. This type of testing is done to determine if the alleged offender has a paraphiliac interest that involves sexual arousal, and the degree to which he/she has that arousal as compared to appropriate interests.

- An evaluation needs to be done to understand the number and degree of cognitive distortions and mistaken beliefs that support the alleged offenders possible or alleged misbehavior.

- A delineation needs to be made as to the social issues that may impact on the alleged offender's behavior and potential for rehabilitation. These may include early childhood experiences and typical historical issues such as drug abuse, relationship with parents, siblings, co-workers and partners.

- An evaluation needs to consider cognitive distortions which are sexual in nature, arousal patterns, sexual development history, gender orientation issues, additional paraphilias, sexual dysfunction body image, and social sexual inadequacies.

- A determination needs to made as to the alleged offender's attitude toward the allegations, whether or not they admit the substantiated actions, if there is denial, their attitude toward treatment and assessment. This will help determine the alleged offender's amenability for treatment and prognosis for intervention and under what settings.

- Actuarial factors that may improve or deter from the prognosis
    - Any documented additional paraphilias, particularly "high risk" paraphilias including rape or exposure
    - Prior history by alleged offender of acting out
    - Early onset of acting out
    - Previous experience with treatment
    - Presence of serious personality disorders
    - Occurrence of any previous incarceration
    - History of serious mental disorder, substance abuse

DISCIPLINARY GUIDELINES

Upon finding that a HCP has committed unprofessional conduct by engaging in boundary violations and or sexual misconduct, the Board shall impose such discipline as the Board feels is necessary to protect the public. The following are recommendations for appropriate levels of discipline for HCP boundary violation and sexual misconduct behavior:

I. COURT CONVICTIONS RELATED TO SEXUAL MISCONDUCT

Denial or Revocation

Court convictions concerning sexual misconduct, which are classified as a felony or a misdemeanor involving moral turpitude, are grounds for denial of an initial application for licensure or certification and grounds for revocation of a license or certificate. Convictions where the offense was committed against a child or other vulnerable person, or where the health care professional used threats or coercion are convictions appropriate for denial or revocation. The length of time between the conviction and the application for licensure or certification may not lessen the concern about the offense due to the following: many victims fail to report offenses, the high rate of recidivism for some categories of sex offenders, and a lack of empirical evidence regarding the success of treatment for many type of offenders. Behaviors where the Board would consider denial of licensure of certification or revocation of licensure or certification include the following:

- Rape
- Sexual Abuse
- Convictions involving sexual misconduct with children
- Repeated convictions for sexual offenses such as voyeurism, even after therapeutic treatment.
- Attempted rape, or attempted acts of sexual abuse.

Possible Sanctions less than Revocation

Other sexual misconduct convictions should be considered on a case-by-case basis. If the behavior which caused the conviction represents any exploitation of a vulnerable person, a disciplinary sanction less than revocation may not be appropriate. Other factors the Board should consider include whether the conviction is recent or long ago with evidence of change in lifestyle. Behaviors that could fall into this category could include:

- Public indecency
- Prostitution
- Promoting or compelling prostitution
- Furnishing or distributing obscene material

Non-Disciplinary Sanctions

Single convictions for sexual misconduct that include conduct with other consenting adults may be appropriate for a letter of concern or may be appropriate for dismissal if the facts in the case support the description of the conviction and there is no plea bargaining from a higher more serious charge to arrive at the conviction. Crimes in this category might include:

- Publicly display of nudity or sex.

II. SEXUAL MISCONDUCT TOWARD CLIENTS

Sexual misconduct towards clients is never acceptable. In considering disciplinary action for cases involving sexual misconduct with a client the Board must evaluate the following factors:

- Seriousness of the act
- Intent to harm
- Dishonesty or depravity on the part of the HCP
- One time acts versus multiple occurrences of acts by the HCP
- Recognition and acceptance of responsibility by the HCP for the inappropriateness of the action

- Recognition by the HCP of the harm done to the client
- Expressions of genuine remorse by the HCP.

In general there may be a poorer prognosis for an HCP's rehabilitation if there is evidence of:
- Repeated incidents of sexual misconduct by the HCP
- Lack of responsibility for the action/inactions of the HCP
- Lack of recognition by the HCP as to the harm that has been done to clients.
- Lack of evidence of remorse by the HCP.
- HCP does not see need for treatment or assessment or HCP is resistant to seeking treatment or assessment.

Denial or Revocation

Revocation or denial of initial licensure or certification may be appropriate for the offenses described below. Summary Suspension may also be appropriate in cases presenting sufficient concern of imminent client harm. The primary concern is to remove the individual from contact with clients. Behavior within this category includes:

- Attempted rape or rape of a client or corpse of a client
- Sexual assault by force
- Confirmed incidents of inappropriate touch of genitalia or intimate body parts when there is no nursing care reason for such touch.
- Use of drugs to decrease resistance by a client
- Repetitive instances of behavior such as voyeurism
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Suspension, Probation

The offenses identified below are serious and may require revocation or denial, but in some cases Suspension may be appropriate until treatment is completed, or the HCP may be placed on probation. Since there has not been a conviction, an evaluation by a qualified health care professional prior to determining the appropriate sanction may assist in determining the validity of allegations, whether behavior was intentional and whether the behavior is likely to be repeated with other clients.

- Unnecessary touching
- Voyeurism, exposure, frottage
- Improper or prolonged examination techniques during breast or pelvic exams.
- Unnecessary exposure of client's body
- Repetitive instances of sexualized comments or gestures or any verbalizations intended to invite or suggest sexual contact or a romantic relationship.
- Inquires by HCP about the client's sexual fantasies, or discussion by the HCP of their own personal sexual fantasies with clients.

Probation, Decree of Censure, Letter of Concern

Lesser disciplinary sanctions such a probation, censure or letter of concern may be appropriate for the following types of behaviors which may illustrate poor boundary identification, and could be resolved by treatment focused on boundary and mental health issues rather than sexual offense issues:

- Incidents of verbalization with clients involving overt sexual innuendo, sexual comments or jokes with clients
- Unwanted touch (non genital areas)

- Unnecessary calls or contacts with a client after discharge
- Failure of HCP to maintain appropriate boundaries when the client displays verbal or physical actions denoting a romantic or sexual attraction to the HCP.

The Board should evaluate discipline in cases of this nature and evaluate the appropriateness of more severe discipline if incidents occur repetitively or in combination with other sexual misconduct behaviors.

III. SEXUAL MISCONDUCT WITH CLIENTS NOT CURENTLY RECEIVING CARE FROM THE HCP (POST-TERMINATION RELATIONSHIPS)

General Considerations

Some questions the Board must consider in determining whether the HCP-client relationship had actually terminated include the following:

- Were there formal termination procedures
- Did the HCP transfer the client's care to another care giver?
- Was the therapy with the HCP terminated for the purpose of entering a sexual or romantic relationship with the HCP.
- How much time has passes since the HCP client relationship ended?
- How long did the professional HCP client relationship extend for?
- To what extent has the client confided personal or private information to the HCP.
- What was the nature of the client's health problem?
- What was the degree of emotional dependence or vulnerability of the client

The Board should also consider that any sexual behavior or involvement with a client not currently receiving care from the HCP may be classified as sexual misconduct if the following factors exist :

- The behavior occurs as a result of knowledge derived by the HCP from within the context of a professional relationship.
- The behavior results from the exploitation of a client's emotions, trust or influence in a previous HCP-client relationship.
- The behavior reasonably appears to constitute an abuse of power on the part of the HCP.

Denial or Revocation

Sexual behavior between a HCP whose relationship with the client is that of a mental health treatment professional is serious and not acceptable to the Board. The nature of the mental health HCP-client relationship places the client in a vulnerable position. This conduct is grounds for denial or revocation of licensure.

IV. SEXUAL MISCONDUCT IN THE WORKPLACE INVOLVING OTHERS (NON-CLIENTS)

No action by Board-Employer-Employee Matter

Single incidents of sexual misconduct between a HCP and others in the workplace are the responsibility of the employer to investigate and administer appropriate remedies. Behaviors of this nature could include:

- Sexual comments, jokes or a general sexual content to conversations
- Pressuring for dates
- Unwanted touch

Investigation by Board with Possible Sanctions

Investigation by the Board with possible evaluation by a specialist and possible disciplinary sanctions should occur if the following behaviors are present:

- Repetitive incidents of sexual misconduct with multiple victims or repetitive incidents at different employment sites.
- Repetitive incidents of sexual misconduct by a HCP in spite of documented counseling from an employer.
- Sexual misconduct behaviors committed by a HCP with a co-worker in view or hearing of clients.
- Sexual misconduct with coworkers with concurrent reports practice errors or concurrent chemical dependency behaviors.

PETITION FOR RECONSIDERATION OR REINSTATEMENT OF LICENSE OR CERTIFICATE

Pursuant to R4-19-405 an HCP whose license to practice nursing has been denied or revoked may make application to the Board after a period of five years for issuance or reissuance of a license. The Rule further states that the applicant must provide substantial evidence that the basis for denial or revocation has been removed and that the issuance of license will no longer constitute a threat to the public health or safety. The Board may require physical, psychological or psychiatric evaluation, reports, and affidavits. These conditions shall be met before an application for issuance or reissuance is considered

Board staff should consider the following information during the investigation regarding an application for reinstatement or initial issuance:

- Credentials/expertise of any treatment facilities and professionals that have provided services for the HCP. The staff should ask what methods of treatment have been used including the use of polygraph testing.
- Has the individual experienced any relapses of behavior since treatment. If so what steps were taken to prevent further relapse.
- Description of changes in the HCP's life
- Program of recovery, steps necessary to prevent relapse in sexual misconduct behavior.
- Demonstration of victim awareness and empathy by the HCP
- Acknowledgment of sexual disorder and need to practice steps for continued recovery.
- Willingness to be monitored and/or to have practice restricted.

Board staff will interview the HCP, preferably in person, for the purpose of:

- Gathering information about the person's history since the last contact with the Board.
- Establishing whether the individual has had treatment and qualifications of the treatment facility and or provider.
- Arranging for releases of information to obtain records of treatment from any and all treatment facilities or providers.
- Arranging for the current treatment facility or provider to send a summary to the Board to address the individual's diagnosed area of sexual misconduct including predatory or non-predatory status, treatment completed, estimated success of treatment, status of individual's sexual misconduct behavior , recommendations for ongoing treatment, opinion as to the ability of individual to practice in a health care setting safely, recommendations for employment restrictions and the need for monitoring reports to Board. The investigator should also obtain a release so the past and present treatment records may be released to the evaluator who will be conduct the current independent evaluation.
- Providing the names of professionals with expertise in sexual misconduct who could perform an independent current evaluation. The current evaluation should address the initial diagnosis or problem, categorization as to predatory or non-predatory, success of treatment completed to that point, current status of individual's sexual misconduct behavior, prognosis, recommendations for ongoing treatment, an estimation as to the individual's safety to practice with recommendations as to appropriate work restrictions and monitoring reports to the Board.

Once the individual has confirmed an appointment with an appropriate professional to conduct the current evaluation, the investigator will send to the evaluator the revocation consent or order, or the order of denial. The investigator will also send copies of any materials submitted with the application for reinstatement or licensure, and copies of records from all treatment facilities and providers to the evaluator.

Once the evaluation is completed, the investigator will prepare an investigative report summarizing information received during the course of the investigation. The individual will be scheduled to appear before the Board at its next regularly scheduled meeting.

The following are questions that the Board may consider asking the individual during the appearance at the Board meeting:

- Ask the HCP to explain their the sex offense behavior-- assess how willing the HCP is to discuss the subject the individual is.
- Ask the individual what methods were used to access potential victims--assess the level of detail/disclosure
- How pervasive was the problem?--.limited to work, outside of work or both.
- How frequently was the behavior exhibited-- look for patterns
- Were other factors involved--drug or alcohol abuse, stress, family issues etc.
- How does the person "catch" himself/herself now to prevent relapse, and does the HCP have a defined relapse plan.
- What is the person's current support system, who is aware of the person's history?
- Does the person have an agreement with or external monitoring with anyone?

Experts suggest it may be useful to invite members of the HCP's support system or significant other to talk to the Board to confirm the information given by the HCP and/ or to engage their assistance in monitoring the HCP.

Approved by Board September 1997