AzBBHE ADVERSE ACTION TRACKING FORM
2014

PROFESSIONAL	FINDINGS	RESOLUTION
Kelly O'horo **LPC-14378** **2013-0079**	See 2013 Adverse Action Report	**Board Action 1/10/14**: The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 11/08/13.
Jennifer J. Bjerke **LPC-13051** **2011-0135**	See 2012 Adverse Action Report	**Board Action 1/10/14**: The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 11/01/12.
Stephanie B Sundseth **LPC-13327** **2014-0020**	On 10/29/13, Board received two complaints alleging that Licensee engaged in a sexual relationship with a male client ("Client"). When questioned, Licensee admitted to having sexual intercourse with Client.	**Board Review 1/09/14; Board Action 1/10/14 Executed Consent Agreement and Order:** Licensee's LPC license shall be surrendered. The surrender shall be considered a revocation of her license.
Pamela J Swanson **LPC-2152** **2011-0148**	An adult male client ("Client") was ordered by the Lake Havasu City Municipal Court ("Court") to complete domestic violence counseling. From 03/16/11 to 06/23/11, Licensee provided 8 counseling sessions to Client. Licensee provided behavioral health services via Skype for 6 of her 8 sessions with Client. On 04/21/11, Licensee submitted a letter to Court that indicating that Licensee met with Client to evaluate domestic violence issues. The evaluation was based on clinical observations, questioning, and Client's background information. Licensee told court that Client is "an excellent parent with no domestic violence or anger management issues whatsoever." Licensee has no formal education or professional experience in the assessment of evaluating parenting issues, never observed Client interact with his child, and did not document any information in Client's clinical record that supports her representation to the Court that Client had "excellent" parenting skills. She also did not document that she informed the Court that most of Client's sessions were conducted via Skype. Licensee's conduct was inappropriate where Licensee evaluated Client to determine if he needed domestic violence counseling services even though the Court had already ordered Client to complete such services. Licensee's records are insufficient to support her representations that Client was "an excellent parent with no domestic violence or anger management issues whatsoever." Licensee acknowledges that she did not have the necessary experience to adequately provide court ordered and/or domestic violence counseling services. Licensee did not maintain any documentation indicating that she informed Client of the limitations and risks associated with providing treatment via electronic media, as required. Client's consent for treatment form does not contain the following required elements: purpose of treatment, general procedures to be used in treatment including benefits, limitations, and potential risks, methods for a client to obtain information about the client's records, the client's right to participate in treatment decisions and in the development and periodic review and revision of the client's treatment plan, information regarding the limitations and risks associated with providing treatment via electronic media, or the date of Licensee's signature. The Licensee's billing records do	**Board Review 1/09/14; Board Action 1/10/14 Executed Consent Agreement and Order**: Licensee's LPC license expired by rule on 2/28/13. Licensee agrees not to renew her license or submit any type of application for licensure for 5 years.

Deborah L Schuler **LCSW-10288** **2013-0075**	In 03/10, Licensee began providing services to Client at Licensee's private practice. Licensee provided services to Client at both an Agency and at Licensee's private practice from 03/10 to 10/10. When Licensee's supervisors uncovered that she was treating Client through her private practice and the Agency, they advised her that this was a code of conduct violation and a conflict of interest. From 03/11 to 01/12, Licensee continued to see Client in her private practice and was involved in Client's treatment at another Agency. Despite the fact that Client presented on 03/10/10 with suicide ideation and multiple documented suicide risk factors, Licensee did not document that she completed any type of formal risk assessment of Client. Despite the fact that Client presented on 04/26/10 with suicide ideation and multiple documented suicide risk factors, Licensee again did not document that she completed any type of formal risk assessment of Client. Despite the fact that Client presented on 05/04/10 with multiple documented suicide risk factors, including self-injurious behavior, Licensee again did not document that she completed any type of formal risk assessment of Client. Given Client's repeated presentation with suicide ideation and/or multiple risk factors, Licensee's failure to complete formal risk assessments as needed to properly evaluate Client's suicide risk was inappropriate. Licensee's failure to obtain Client's signature on a treatment plan during almost 2 years of treatment was inappropriate. Client's treatment in Licensee's private practice ended in 01/12. Following Client's discharge from Licensee's private practice, Licensee engaged in a number of non-professional, personal contacts/activities with Client including: allowing Client to move in with her, attending couple's counseling with Client, paying for an attorney for Client when she had legal troubles, and going camping together. Two separate counselors provided treatment notes on the couple's counseling Licensee and Client attended together. Both noted they were "partners", had been together for six months, and one recorded that they had held hands through the sessions. Given Licensee's extensive professional relationship with Client, Licensee's decision to begin an extensive personal relationship with Client approximately	**Board Review 1/09/14; Board Action 1/15/14 Executed Consent Agreement and Order**: Licensee's LCSW license expired by rule on 11/30/13. Licensee agrees not to renew her license or submit any type of application for licensure for 5 years.
Howard R Rockett **LCSW-11050** **2011-0116**	In 02/10, the Court ordered the parents ("Parents") of an 8-year old boy ("Son") who were involved in a high-conflict custody/visitation dispute to participate in family counseling. At the time Licensee agreed to provide services in Parents' case, Licensee had no significant past work experience, specialized training, or continuing education related to providing therapy or other therapeutic services in high-conflict cases involving custody/visitation issues. As Licensee indicated during the Board's complaint investigation, this case was Licensee's first experience in private practice. Licensee was informed of the high-conflict nature of the case before he agreed to provide services. During Licensee's work on this case, he encountered a number of circumstances common to high-conflict custody/visitation matters including working with Parents who had a long history of conflict with each other regarding Son, had greatly opposing opinions regarding how much visitation time Son should have with Father, would benefit if Licensee provided an opinion to the Court that was consistent with their own preferences regarding visitation, and who would be at increased risk of suspecting that Licensee was siding with the opposite parent in the event that Licensee expressed views contrary to their own views. Despite Licensee's lack of training and experience as a court-involved therapist in high-conflict custody/visitation issues, Licensee did not seek consultation or supervision regarding a number of high-risk scenarios he encountered such as: consent, confidentiality, release of information, billing issues, decisions regarding what information/recommendations Licensee could/should provide to the Court, or whether it was appropriate for Licensee to continue providing services to some family members after discontinuing the provision of the Court-ordered services for Parents. Despite Licensee's lack of training and experience as a court-involved therapist in high-conflict custody/visitation issues, Licensee's failure to seek consultation, supervision, and/or legal advice regarding ethical issues where he had limited, if any, experience or training was	**Board Review 1/09/14; Board Action 1/10/14 Executed Consent Agreement and Order**: Licensee's LCSW license expired by rule on 11/30/13. Licensee agrees not to renew his license.

Howard R Rockett **LCSW-11050** **2011-0116**	Guardian clearly indicated that Licensee was to provide "counseling" to Son and Parents. As the counselor in this matter, it was Licensee's responsibility to: clarify his role and the nature of services to be provided, clarify with all participants which individuals he considered to be his clients and which individuals were participating as collaterals, clarify the nature of his professional obligations toward clients and collaterals, anticipate potential conflicts of interest or situations where he might have to perform in potentially conflicting roles and take appropriate action to minimize such conflicts. Licensee had no initial consent to treatment or other intake paperwork that provided any of the information/clarification identified above to Mother or Father. Licensee did not provide any documentation indicating that he verbally reviewed any such information with Mother prior to providing treatment. As a result of Licensee's documentation deficiencies, there is no evidence that Licensee clarified the nature of the services to be provided, clarified the nature of his role, clarified the nature of the roles of participants, or proactively addressed potential conflict of interest and confidentiality concerns. Licensee indicated the following with regard to the information he received prior to providing services in this matter: Guardian advised Licensee his role was counseling for [Son] and parents and to, "Help parents act like adults". Despite his limited role in this matter and the importance of remaining neutral when working with both parents in high-conflict cases, Licensee indicated that he also understood that one of his responsibilities "was to provide recommendations to [Guardian] regarding [Father's] visitation schedule." Licensee's expansion of duties in this matter to include visitation recommendations was inappropriate where none of the documents or information provided to Licensee before he began providing services in this matter indicated that he was expected or required to provide visitation recommendations. There is no evidence that Mother or Father were aware of or approved of Licensee's decision to expand his role to include visitation recommendations. According to treatment notes, Licensee met with the following: 10 sessions with Son and/or Mother and Son together, 1 session with Father and Son together, 1 session with Mother and Father together, 1 session with Father, Mother's husband ("Stepfather"), and Son together, 2 sessions with Stepfather and Son together. Licensee's billing records indicate that there were 4 additional sessions not documented in Licensee's progress notes as follows: 1 session with Stepfather and Son together, 1 session with Son and Mother together, and 2 sessions with Mother. Altogether, it appears that, over a 6 1/2 month period, Licensee facilitated a total of 21 sessions with various combinations of therapy participants including Son, Mother, Stepfather, and Father. Licensee did not document that he obtained written informed consent for any of the participants, or that he provided any information to any of the participants clarifying the nature of the services to be provided or the roles of the various participants. Licensee's failure to clarify the roles of the participants is particularly problematic given that nearly 25% of his sessions included Stepfather. Although Mother approved of Stepfather's presence in the sessions, Licensee did not obtain a signed release of information authorizing Stepfather's participation in sessions with Son. Such written authorization was particularly important because the Court order mandating Son and Parents' participation in family counseling did not identify Stepfather as a required participant. Licensee's failure to obtain written informed consent for treatment from any of the participants with whom he met for a number of months was inappropriate. Licensee failed to develop a treatment plan at any time during the 21 sessions over 6 ½ months he conducted in this matter. Licensee's progress notes consisted of 5 typed pages. Each typed page documented a number of phone calls and/or sessions and included one space, at the bottom of each page, designated for Licensee's signature. The progress notes that Licensee delivered to the Board in 11/11 were signed by Licensee in the designated spot	**Board Action: See Above.**
Howard R Rockett **LCSW-11050** **2011-0116**	at the bottom of each of the 5 pages. Given that the progress notes Licensee delivered to Father in 04/11 did not include Licensee's signature, it appears the progress notes Licensee provided to the Board were not signed contemporaneously with Licensee's creation of the notes.	**Board Action: See Above.**
Jeffrey B Taylor **LMSW-10568** **2011-0075**	See 2011 Adverse Action report	**Board Action 3/11/14**: The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 7/05/11.

Kent W Baker **LPC-10419** **2014-0005**	From 08/17/11 – 08/06/13, Licensee met with a client ("Client") for 51 sessions. Licensee did not maintain any type of treatment planning documentation for Client during the 2 years he treated her. One of Client's minor sons ("Son") participated in session with Licensee on three occasions. Licensee did not maintain any type of treatment planning for Son. While Licensee billed Son's sessions as "family therapy," there is nothing in Licensee's records to support the representation that Licensee was seeing Client and Son for any type of family therapy. Licensee did not maintain any written information that would allow a subsequent treatment provider to understand the nature and purpose of Son's treatment. Licensee indicated that he is aware that the Board has minimum documentation standards. Licensee does not maintain treatment planning documentation in his private practice. Licensee acknowledges that his progress notes generally do not contain sufficient information to properly capture the nature and content of his therapy sessions, or the following required elements: duration of time spent providing the behavioral health service, an indication of whether the counseling session was individual, family, or group, or the signature and date signed by Licensee. Licensee acknowledges that his billing records reflect that he provided services to Client on several dates that he failed to maintain progress notes, as required. Licensee maintained 3 types of progress notes for Client, hand-written notes, typed computer notes, and supplemental clinical notes. Licensee alternated between maintaining hand-written notes and typed notes. In 02/12, Licensee's internal and external hard drives crashed and he lost selected information from Client's clinical record. In 03/12, Licensee reproduced from memory the progress notes lost from Client's record by creating the supplemental clinical notes. As a licensed behavioral health professional, Licensee's conduct was inappropriate as it was his responsibility to ensure that his client records were protected at all times from loss, damage, or alteration, and that he had a secure back-up system in place to allow him to re-create records lost due to a computer malfunction. In order to address this loss, Licensee indicated that he re-created progress notes based solely on his memory of sessions that occurred up to 5 months prior. Licensee's re-creation of progress notes was inappropriate where: Licensee did not include any information on the supplemental clinical notes to reflect when he created them or that he created them from memory long after the sessions occurred. As a result, it is impossible from looking at Client's record to determine which notes were created after the fact based solely on Licensee's memory of sessions that occurred months before the notes were re-created. It is highly unlikely that Licensee was able to accurately recall the contents of sessions that occurred months earlier. Licensee's notes reflect that, on 07/02/13, Licensee provided Client with a list of crisis resources due to her husband's ("Husband") threatening behaviors. Licensee acknowledges that he did not maintain any record of the crisis resources he identified for Client. Licensee's notes reflect that, on 07/22/13, Licensee created a safety plan for Client, but did not maintain any written record of the contents of plan. Licensee's failure to maintain a written record of the crisis resources provided to and safety plan was inappropriate. Licensee treated Client from 08/11 – 08/13, and is required to maintain separate billing records that correspond with the client record. Despite this requirement, he failed to maintain billing records for Client from 08/11 – 03/12. In regard to maintaining billing records, Licensee indicated, "I do not keep all of them." He shreds them because he does not "want or need them." Licensee's	**Board Review 11/07/13; Board Action 02/04/14 Executed Consent Agreement and Order:** probation for 12 months; within 12 months, complete 3 semester credit ethics course and 3 semester credit course in intake, assessment, and treatment planning; 12 months of clinical supervision; shall not provide clinical supervision while subject to this Consent Agreement; $1,000 civil penalty stayed pending compliance with the terms of this Consent Agreement and Order.

Jeffrey C Friedman **LISAC-10376** **2014-0007**	Licensee acknowledged in writing that he received his Agency's ("Agency") Employee Code of Ethics, which indicated staff may not fraternize with any patient seeking treatment, presently in treatment, or a former patient for at least 1 year after a patient's discharge. Licensee had interactions with a client ("Client 1") while she was in treatment at Agency from 7/17/12-08/20/12 that were not documented because he was not an assigned member of her treatment team. Agency's Clinical Director reported that Licensee was required to document any type of service he provided to an Agency client. Following her discharge from Agency, Client 1 became a client in Agency's UK aftercare program, ("UK Program"), which is affiliated with Agency. While Client 1 was in the UK Program, Licensee exchanged 32 emails with her from 08/22/12 – 08/03/13 using his Agency computer. A review of those emails reflected there was no therapeutic basis for these communications, and Licensee used language that was overtly sexual/romantic. Licensee kept Client 1 informed with regard to his planned European vacation and sent regular updates providing Client 1 with the name and phone number of his London hotel, and invited her to dinner upon his arrival. Licensee also visited Norway on his vacation and Client 1 stayed at the same friend's ("Friend") house as Licensee. Following her discharge from Agency on 04/05/13, another Agency client ("Client 2") received treatment at the UK Program. Licensee was never an assigned member of Client 2's treatment team. Information obtained from Licensee's work computer reflects that, from 04/15/13 – 08/03/13, Licensee and Client 2 exchanged 18 emails. A review of those emails reflects that there was no therapeutic basis for these communications. Licensee used language that was flirtatious and invited Client 2 to engage in personal activities with Licensee. Licensee also visited Client 2 at her psychiatric treatment facility. When confronted with copies of his email communications with Client 2, Licensee indicated that it was difficult to defend his actions. Licensee's failure to maintain appropriate professional boundaries with Client 2 appears particularly problematic where Client 2's clinical records reflect that she was particularly vulnerable given the number of serious behavioral health problems she was experiencing. During investigation, Licensee originally maintained that he did not provide Client 1 with his itinerary for his trip, but emails recovered from his computer showed that he had. His misrepresentations during the investigation appeared to be deliberate.	**Board Review 2/06/14; Board Action 2/10/14 Executed Consent Agreement and Order:** Licensee's LISAC license shall be surrendered. The surrender shall be considered a revocation of his license.
Da'Mond Gadson **LAC-13467** **2012-0150**	See 2013 Adverse Action Report	**Board Action 4/08/14**: The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 02/19/13.
Heather (Addington) Schamis **LPC-12954** **2012-0028**	See 2012 Adverse Action Report	**Board Action 4/08/14**: The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 01/11/12.
Andrea March **LMSW-12753** **2012-0084**	See 2013 Adverse Action Report	**Board Action 4/08/14**: The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 04/22/13.
Robert Lovett **LAC-14148** **2013-0031**	See 2013 Adverse Action Report	**Board Action 4/08/14**: The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 03/12/13.

Stephanie B Sundseth LPC-13327 (revoked) 2014-0020	On 01/09/2014, the Board accepted Licensee's signed Consent Agreement for the surrender of her LPC license. On further review of Licensee's website, the Board identified concerns that it did not clearly put readers on notice that her license had been revoked. The Board advised her of those concerns and provided her with the opportunity to address them. While Ms. Sundseth did address some concerns on her website, her practice was still identified as "Gilbert Family Counseling". The Board also received an email from a patient alleging that Ms. Sundseth was sending unsolicited invitations to join her professional counseling practice to former clients. The email included names of other former clients which violated client confidentiality. The services Ms. Sundseth is providing in her private practice appear to constitute unauthorized practice of behavioral health as defined at A.R.S. § 32-3286(A). The Board ordered Ms. Sundseth to immediately Cease and Desist from providing behavioral health services as defined in A.R.S. § 32-3251 et seq.	**Board Action 04/17/14 Cease and Desist Order:** On 04/03/14, the Board reviewed this matter and recommended issuing a Cease and Desist Order to Ms. Sundseth, an unlicensed person, to cease and desist her unlawful practice of behavioral health services.