

AzBBHE ADVERSE ACTION TRACKING FORM  
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PROFESSIONAL	FINDINGS	RESOLUTION
<p><b>Rita M. Butler</b> <b>LPC-10528</b> <b>2013-0010</b></p>	<p>Agency 1 was responsible for providing services to a 6 year old child ("Child"). In 04/08, Licensee opened a private practice and treated Child from 10/08 through 10/10. Licensee acknowledged that she did not have any training or experience in diagnosing or treating DID and that she did not consult with anyone with training or experience in diagnosing or treating DID in children until 09/09. On 12/17/08, a PNP diagnosed Child with Anxiety Disorder, NOS; R/O Mood Disorder, NOS. On 12/23/08, Licensee began documenting that Child displayed dissociative symptomology. In 02/09, Licensee again documented that Child's behaviors and symptoms supported a possible DID diagnosis even though she had not yet consulted with a specialist in this area. In 06/09, Licensee documented that since her diagnosis of DID, Child has been less volatile at home and school and has been progressing in treatment. On 06/23/09, Psychiatrist completed a psychiatric evaluation of Child and diagnosed Child with PTSD; R/O RAD. Psychiatrist rejected DID as a possible diagnosis, adamantly advised Licensee not to address Child's dissociated parts, but rather focus on Child's feelings in the present, and warned that to do otherwise would run the risk of creating further iatrogenic splits in Child's psyche. In 09/09, Licensee began speaking with a Consultant on DID. Consultant was out-of-state and never treated Child. Consultant agreed with Licensee's diagnosis of DID for Child. Licensee continued to treat Child's DID diagnosis until 10/10. Even though she continued to treat Child, Licensee documented Child's deterioration in treatment. During treatment of Child, Licensee used Gestalt Dream Analysis with Child; allowed Child to swim in Licensee's family's pool, including having a "play date" with Licensee's granddaughter; invited Child's family to swim in her family's pool; and transported Child to and from therapy without appropriate written authorization. These incidents occurred without informing the CFT and without including any therapeutic value in a treatment plan. In 09/09, even after Consultant advised Licensee to set firmer boundaries with Child and Child's family and to reduce the frequency of her sessions, Licensee continued her over-involvement with Child and Child's guardians. Licensee failed to report possible abuse of Child to CPS. Licensee's consent for treatment form was inadequate. Licensee failed to develop any treatment planning documentation. Licensee failed to complete an investigative interview with Board staff. Licensee failed to have written authorization to speak with Child's teacher. In 07/11, Child began treatment with Therapist. Therapist had experience in treating trauma in children. At no time did</p>	<p><b>Board Review 01/03/13; Board Action 01/04/13 Executed Consent Agreement and Order:</b> Licensee's LPC license shall be surrendered. The surrender shall be considered a revocation of her license.</p>
<p><b>Marie Hanna</b> <b>LSAT-12019</b> <b>2011-0130</b></p>	<p>See 2011 Adverse Action Report.</p>	<p><b>Board Action 01/03/13:</b> The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 11/03/11.</p>
<p><b>Karen Mavrikos</b> <b>LAC-13597</b> <b>2010-0118</b></p>	<p>See 2010 Adverse Action Report.</p>	<p><b>Board Action 01/03/13:</b> The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 10/07/10.</p>
<p><b>Jon G. Longoria</b> <b>LSAT-12057</b> <b>2013-0054</b></p>	<p>Licensee's license was issued by the Board on 10/01/12. On 11/20/12, Licensee self-reported a 11/15/12 arrest for DUI. Licensee was involved in a single vehicle accident where several small bottles of alcohol were observed in his vehicle. Licensee reported that he had also taken prescription medications, including benzodiazepines and narcotic pain medication. Licensee was unable to complete the field sobriety tests due to his level of intoxication. On 12/10/12, Licensee self-reported a 12/06/12 arrest for DUI.</p>	<p><b>Board Review 01/03/13; Board Action 01/04/13 Executed Interim Consent Agreement and Order:</b> Licensee shall not practice and his LSAT license shall be suspended.</p>

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<p><b>Carl R. Schwartz</b> <b>LPC-0355</b> <b>2012-0118</b> <b>2013-0024</b></p>	<p>In 08/77, Licensee began working at Agency 1. In 03/92, Licensee was placed on disciplinary probation for violating Agency 1's Standards of Conduct when disregarding specific instructions to cease providing shelter for clients or former clients in his home. He was to refrain from outside contact with clients following termination of treatment, provide treatment to clients only at Agency 1's facilities, refrain from any overt display of affections with clients, and all communications with a former client will cease. Licensee indicated that a former client's allegation of sexual activity was not true. Licensee had rented space to this former 18 or 19 year old client. In 05/01, Licensee was reprimanded for taking 2 clients off residence for therapeutic work without checking whether these clients received their meds, resulting in a missed medication incident. On his 02/04 CPC renewal application, Licensee answered "no" to the background question about ever receiving any disciplinary action. On his 02/06 LPC renewal application, Licensee again answered "no" to the background question about ever receiving any disciplinary action. In 11/07, Licensee received a reprimand for failing to provide proper client supervision while client was on a home pass to Licensee's residence when he was prohibited from taking clients off campus without another staff member present. On his 02/10 and 02/12 LPC renewal applications, Licensee did not disclose the 03/92, 05/01, and 11/07 disciplinary actions taken against him by Agency 1. In 11/11, Licensee became Agency 2's clinical director. In 01/12, Agency 2 converted an existing residential home to house and treat male juveniles with sexual offending behaviors. Licensee provided biofeedback and/or neurofeedback services to a number of Agency 2's clients without obtaining appropriate written informed consent that would have provided specific information about biofeedback/neurofeedback services, the intended outcome, nature, and procedures, and any risks and side effects of these services. Licensee was observed by a co-worker having 2 of Agency 2's clients in his car. On 03/05/12, Licensee informed the owner that he was resigning from Agency 2, effective immediately, and then visited the sex offender home to say goodbye to clients. An 11 year old client asked to speak with Licensee and reported that a 15 year old client had molested him the night before</p>	<p><b>Board Review 01/03/13; Board Action 01/04/13 Executed Consent Agreement and Order:</b> Licensee's LPC license shall be surrendered. The surrender shall be considered a revocation of his license.</p>
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<p><b>Chelsie G. Reed</b> <b>LPC-12936</b> <b>2011-0025</b></p>	<p>In 05/10, Therapist referred Client to Licensee to address Client's sexual issues. Client continued with Therapist to address his ongoing anxiety issues. From 05/10 to 07/10, Client attended weekly therapy sessions with Licensee to address relationship and sexual issues. In 06/10, Licensee referred Client to Massage Therapist. On 08/21/10, Therapist called Licensee to discuss Client's concerns regarding Massage Therapist's conduct and Licensee's referring Client to a website and phone number for a sex surrogate. Following this conversation, Therapist filed a Board complaint against Licensee. Licensee saw Client on 07/27/10 and failed to document Client's report that Massage Therapist touched his genital area to facilitate reaching orgasm. Licensee later indicated that the session included discussion that a "hands on energy professional" is for "energy work and massage, not to have sex with or to fulfill a personal relationship". This information was not documented in Client's 07/27/10 session note. Licensee did not document any information of Client's report of Massage Therapist's inappropriate conduct until after Therapist contacted her. Immediately following the 08/21/10 conversation with Therapist, Licensee noted her concerns regarding Massage Therapist's conduct and amended her 07/27/10 progress note. On 08/22/10, Licensee added another addendum to her 07/27/10 progress note about referring Client to "a sex coach and also a sex surrogate-but that sex surrogate is not legal in AZ and thus" Licensee is concerned that Client needs to have good boundaries. Licensee had inconsistencies in her progress notes, her response to the complaint, and the investigative interview. Licensee did not develop a written treatment plan for Client's review and acceptance. Although the intake document included treatment planning language, Client did not sign this document. Licensee asserted that she referred Client to PCP on "multiple" occasions for "multiple issues" regarding physical functioning issues. Licensee failed to document any of these referrals in Client's record. Licensee asserted that she referred Client to Massage Therapist during their 06/29/10 session. Licensee did not document her referral to Massage Therapist in her 06/29/10 progress note.</p>	<p><b>Board Review 01/03/13; Board Action 01/15/13 Executed Consent Agreement and Order:</b> probation; within 12 months, complete 6 clock hours of continuing education addressing clinical documentation standards and behavioral health ethics; 12 months of clinical supervision; shall not provide clinical supervision while subject to this consent agreement; \$1,000 civil penalty stayed pending compliance with this consent agreement and order.</p>
<p><b>Carmen J. Howard</b> <b>LAC-11693</b> <b>2012-0124</b></p>	<p>On 09/19/11, Licensee began working at Agency 1. On 10/01/11, Licensee resigned without notice. While Licensee did not yet have a client case load, her abrupt resignation demonstrates clinical irresponsibility. On 11/01/11, Licensee began working at Agency 2. In 01/12, Licensee resigned giving two weeks notice of her last day of work. Appropriate transition of her clients was appropriately completed. On or about her last day at Agency 2, Licensee was allowed to rescind her resignation and continue employment. In 03/12, Licensee submitted her second resignation to Agency 2 without giving any notice. Licensee provided no opportunity for an appropriate transition of care for her clients. As a result, Agency 2 was unable to schedule CFT meetings to address the change of therapists with the minor clients, their families, or the treatment team. As a licensed counselor, Licensee is required to provide for an appropriate transition of care for clients before leaving a position. Agency 2 considered Licensee's immediate resignation to be client abandonment and determined that</p>	<p><b>Board Review 12/06/12; Board Action 01/04/13 Executed Consent Agreement and Order of Censure.</b></p>

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<p><b>Tara J. Nolan</b> <b>LCSW-10372</b> <b>2010-0132</b> <b>2011-0020</b></p>	<p>In 01/03, Licensee went to her 1st ex-husband's home to discuss a family issue and hit him on the back of the head. In 02/03, Licensee was charged with domestic violence related assault. This criminal case was pending when on 09/12/03 Licensee submitted a certification renewal application to the Board and failed to disclose her pending criminal charge, as required. On 09/22/03, Licensee accepted a plea agreement whereby Licensee agreed to participate in a diversion program. Licensee submitted licensure renewal applications in 01/06, 12/07, 11/09, and 12/11. Licensee failed to disclose her criminal charge on any of these renewal applications, as required regardless of participation in a diversion program. In 08/10, Licensee was charged with misdemeanor assault related to an incident involving Licensee's 2nd ex-husband's girlfriend. Licensee failed to report this criminal charge to the Board within 10 working days, as required. Court records reflect that Licensee completed a court ordered Domestic Non-Violence Program screening in 10/03 and the actual program in 06/04. In response to a 01/12 Board inquiry, Licensee submitted a written response indicating that she never had charges filed against her prior to Girlfriend's accusation, she has never been ordered by any court to seek treatment for anything, and has never been ordered to attend any counseling. In 05/10, Licensee authored a letter at the request of Client regarding her state of mind at the time of a marital property issue. Licensee wrote a letter that included a number of negative and potentially biased comments regarding Client's husband when the information appeared to have been based solely on information Client provided. Upon receiving a complaint regarding this matter, Licensee immediately shared the complaint with Client. When Client presented for treatment, Client has some significant behavioral health issues. Licensee failed to conduct any type of a formal assessment or formal suicide risk assessment even though Client presented with a number of suicide risk factors. During Client's second session, Client stated that she wished "she could die". Licensee failed to assess Client's suicide risk or develop a safety plan. Despite Client's continuing reports of acute dysfunction, Licensee continued to fail to document any efforts made to assess Client's suicide risk or develop a safety plan.</p>	<p><b>Board Review 11/01/12; Board Action 01/02/13 Executed Consent Agreement and Order:</b> 24 months stayed suspension; practice restriction, including terminating a private practice and practicing behavioral health working only in a supervised work setting in an agency licensed as an outpatient clinic by the Department of Health Services/Office of Behavioral Health Licensing; within 12 months, complete 6 clock hours of continuing education of the NASW Staying Out of Trouble course or an equivalent course addressing current behavioral health documentation standards in Arizona; within 12 months, take and pass a 3 semester credit hour graduate level behavioral health ethics course; 24 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.</p>
<p><b>Jan Owens</b> <b>LISAC-1288</b> <b>2011-0107</b></p>	<p>See 2011 Adverse Action Report</p>	<p><b>Board Action 01/07/13:</b> The stayed revocation was lifted and Licensee's license was revoked.</p>
<p><b>Janet M. Carpentier</b> <b>LISAC-10475</b> <b>2012-0032</b></p>	<p>On 03/16/11, Licensee caused a 5 car injury collision and was arrested and charged with DUI and other traffic citations. On 04/05/11, Licensee notified the Board of these charges. A preliminary review of Licensee's pharmacy records revealed multiple prescriptions for pain medications filled at multiple pharmacies. Licensee's BAC was 0.047%. Licensee's 03/16/11 drug analysis included multiple benzodiazepines in her system at the time of her arrest. Board Action 09/01/11 Interim Consent Agreement and Order: The professional shall not practice and the professional's license shall be suspended.</p>	<p><b>Board Review 12/06/12; Board Action 01/18/13 Executed Interim Consent Agreement and Order:</b> Licensee shall not practice and her LISAC license shall be considered an interim suspension of her license.</p>
<p><b>Tara Allen</b> <b>LPC-13154</b> <b>2011-0069</b></p>	<p>See 2011 Adverse Action Report</p>	<p><b>Board Action 02/07/13:</b> The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 08/01/11</p>
<p><b>Paul Cartone</b> <b>LPC-10042</b> <b>2009-0101</b> <b>2009-0134</b></p>	<p>See 2010 Adverse Action Report.</p>	<p><b>Board Action 02/07/13:</b> The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 11/05/10.</p>
<p><b>Amy Duemler</b> <b>LMSW-10596</b> <b>2011-0033</b></p>	<p>See 2012 Adverse Action Report.</p>	<p><b>Board Action 02/07/13:</b> The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 07/12/12</p>

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<p><b>Kathleen Exelby</b> LPC-0513 2009-0112</p>	<p>See 2010 Adverse Action Report.</p>	<p><b>Board Action 02/07/13:</b> The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 11/05/10.</p>
<p><b>Ronald Gransie</b> LPC-0730 2011-0140</p>	<p>See 2012 Adverse Action Report.</p>	<p><b>Board Action 02/07/13:</b> The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 05/22/12.</p>
<p><b>Mamta Gupta</b> LPC-1623 2010-0115</p>	<p>See 2012 Adverse Action Report.</p>	<p><b>Board Action 02/07/13:</b> The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 04/04/12.</p>
<p><b>Deborah Lane</b> LPC-10368 2011-0048</p>	<p>See 2012 Adverse Action Report.</p>	<p><b>Board Action 02/07/13:</b> The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 11/01/12.</p>
<p><b>Da'Mond Gadson</b> LAC-13467 2012-0150</p>	<p>On 01/29/10, Licensee attended a credentialing committee where there was an extensive discussion regarding the multiple misrepresentations Licensee made on his LAC application and on various employment applications. During this timeframe, Licensee was employed at Agency 9. The credentialing committee opened a complaint and recommended that the Board issue his license and accept a Consent Agreement for an Order of Censure. On 02/25/10, Licensee submitted an employment application to Agency 10. In 04/10, Licensee began working at Agency 10 while his LAC application was still pending. On 05/07/10, the Board approved a Consent Agreement issuing Licensee's LAC subject to an Order of Censure ("2010 CA"). Licensee did not advise the Board of his employment at Agency 10 until 06/07/10. Licensee failed to disclose his employment at Agencies 1, 2, 3, 4 and 8, as required on Agency 10's employment application. He failed to disclose his involuntary terminations from Agencies 2, 3 and 4, as required. He misrepresented dates of employment at Agencies 5 and 7. After Licensee advised Agency 10 of the 2010 CA, Agency 10 investigated and learned that Licensee also misrepresented his employment history on the employment application and on his resume he submitted to Agency 10. On 07/15/10, Agency 10 terminated Licensee's employment. On 09/15/10, Licensee submitted an application for employment at Agency 12. Despite the instruction to provide 10 years of employment history, Licensee only submitted 4 years of employment history and omitted his employment history at Agencies 1, 2, 3, 4, 5, and 6. Licensee omitted disclosing his involuntary terminations from Agencies 2, 3, and 4. The resume he submitted with his applications omitted information regarding Agencies 1, 2, 3, 4 and 5. Licensee also holds a real estate license in Arizona. The Department of Real Estate rules require that its licensees provide written notice within 10 days of adverse action by other boards. As a result of Licensee's failure to comply with the rules that apply to his real estate license, on 07/20/11, Licensee entered into a Settlement Agreement with the Department of Real Estate wherein he acknowledged that he had failed to disclose the 2010 CA within the required time period.</p>	<p><b>On 02/07/13, the Board held a Formal Hearing regarding this matter and executed the following Order on 02/19/13:</b> 6-month stayed suspension; probation; within 12 months, complete 6 continuing education hours addressing current behavioral health documentation standards and take and pass a three semester credit hour graduate level behavioral health ethics course; 24 months of clinical supervision.</p>
<p><b>Christina Allen</b> LISAC-11447 2012-0055</p>	<p>On 10/11/11, the Board opened a complaint against Licensee ("2012 Complaint"). During the investigation of the 2012 Complaint, additional information was received: a) Licensee and a friend would go to night clubs to drink and get high; b) Licensee consumes drugs and that clients reported having smoked marijuana with Licensee; c) In 10/11, agency decided to drug test all staff without notice; d) Licensee refused to provide a urine sample for testing; e) Licensee was terminated for failing to take a random drug test, which was treated as though she had a positive drug test. On 01/17/13, the Substance Abuse Credentialing Committee ordered Licensee to submit the results of a hair follicle drug test to the Board within 14 days. At the time this matter was heard by the Board on 02/07/13, Licensee had not submitted any results from a hair follicle drug test to the Board, as required.</p>	<p><b>Board Review 02/07/13 Preliminary Findings of Fact, Conclusions of Law and Order of Summary Suspension; Executed 02/19/13:</b> The Board found that the public health, welfare and safety required emergency action and summarily suspended Licensee's license. <b>Board Action 02/20/13:</b> Licensee's LISAC was reinstated based on a negative hair follicle test.</p>

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<p><b>Shawna Bowen</b> <b>LISAC-10656</b> <b>2010-0068</b></p>	<p>In 2009, Licensee was in private practice when a juvenile county probation department ("Probation") authorized Licensee to provide individual and/or family substance abuse treatment to a minor client ("Client"). On 07/29/09, Client's father ("Father") signed informed consent for treatment documents authorizing Licensee to treat Client and a written authorization for release of information permitting Licensee and Probation to exchange information regarding Client. The written authorization to exchange information did not identify a date or circumstance when the authorization expired. The consent for treatment documents did not include some of the required elements and included an inaccurate statement: "There are no risks in participating in this treatment." A 08/04/09 evaluation by a psychologist noted Client's use of marijuana, alcohol, inhalants, and over the counter cold medicine. Licensee's treatment of Client should be based on a thorough assessment of Client's substance abuse history. The 1 page substance abuse assessment contained limited information about Client's past and current use of marijuana, alcohol, and use of Oxycontin. There was no other reported uses of other substances. Licensee indicated that she continued assessing Client during subsequent sessions. Licensee's progress notes do not reflect that Licensee continued her substance abuse assessment over subsequent sessions. Licensee had Father sign the treatment plan prior to discussing the treatment plan with Father and Client. One of the goals for Client was not within Licensee's scope of practice, as it did not relate to substance abuse issues. There was no evidence that Licensee made appropriate referrals to Client and Father to an appropriate professional/agency to address Client's conduct issues and/or Father and Client's relationship issues. During more than one session, Client disclosed that Father "beats him", hits/chokes him, uses drugs, and keeps drugs in the house. Client indicated that some of these issues have been addressed by CPS. Licensee never verified whether CPS had been informed and never contacted CPS herself. Licensee provided her own phone number to Client as a contact if he became afraid or was in danger without developing an appropriate crisis plan, without being</p>	<p><b>Board Review 02/07/13; Board Action 02/08/13 Executed Consent Agreement and Order:</b> 24 months supervised work experience working only in a supervised work setting in an agency licensed as an outpatient clinic by the Department of Health Services/Office of Behavioral Health Licensing; if engaging in the practice of behavioral health, she shall do so only while working at an OBHL licensed agency; within 12 months, complete 6 clock hours of continuing education of the NASW Staying Out of Trouble course or an equivalent course addressing current behavioral health documentation standards in Arizona; within 12 months, take and pass a 3 semester credit hour graduate level behavioral health ethics course; 24 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.</p>
<p><b>Stephanie Hight</b> <b>LPC-10323</b> <b>2013-0053</b></p>	<p>From 09/04 to 05/10, Licensee worked as the Social Services Manager at an agency ("Agency 1"). Agency is an inpatient civil commitment treatment facility for sexual offenders. In 04/05, Licensee was suspended for 24 hours without pay for accessing sexually explicit content on her Agency computer. A client ("Client") received services at Agency from 08/08 to 12/08. Client reported: a) In 11/08, Client and Licensee developed a relationship while Client was residing at Agency. b) In 12/08, Client was released from Agency, and his relationship with Licensee developed into an intimate relationship. c) Client's intimate relationship with Licensee lasted approximately 6 months. Client provided photographs of Client kissing Licensee. During a 01/18/13 investigative interview, Licensee denied that she engaged in an intimate relationship with Client. It is impossible to reconcile Licensee's denial that she engaged in an inappropriate relationship with Client when observing the photographs. Licensee worked at another agency ("Agency 2") from 04/11 to 08/12. In 08/12, Licensee's employment with Agency 2 was terminated after Agency 2 discovered that Licensee engaged in an intimate relationship with a member of</p>	<p><b>Board Review 02/07/13 Preliminary Findings of Fact, Conclusions of Law and Order of Summary Suspension, Executed 02/19/13:</b> The Board found that the public health, welfare and safety required emergency action and summarily suspended Licensee's license.</p>
<p><b>Susan Kullman</b> <b>LCSW-2411</b> <b>2013-0038</b></p>	<p>Licensee documented 119 therapy sessions with an elderly client ("Client") from 01/06 through 10/10. Licensee acknowledged entering into a personal, social dual relationship with Client while providing psychotherapy to Client. In 04/07, when Client was diagnosed with late stage lung cancer, the dual relationship began, as Licensee indicated that she went to Client's home to give her "emotional and moral support". Licensee acknowledged that the dual relationship was a "serious error in professional judgment" and understood from the beginning that she should not have befriended Client. Licensee failed to obtain written informed consent for treatment; failed to develop any treatment planning documentation; failed to date her signature on her progress notes; failed to create individual progress notes documenting the behavioral health services provided to Client during therapy sessions, as required. The large majority of progress notes were monthly summaries where Licensee developed one progress note with multiple dates and recorded identical information for 4 to 5 therapy sessions.</p>	<p><b>Board Review 02/07/13; Board Action 02/08/13 Executed Consent Agreement and Order:</b> Licensee's LCSW license shall be surrendered. The surrender shall be considered a revocation of her license.</p>

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<p><b>Mitzi Mackenzie</b> <b>LMSW-12181</b> <b>2010-0041</b></p>	<p>In 07/09, Licensee began treating a young adult ("Client"). Client's mother ("Mother") and father ("Father") were representatives for purposes of Client's billing and payments. Licensee failed to establish specific financial arrangements for the payment of Client's therapy, including Licensee's use of collection agencies or legal measures for nonpayment of fees. On several occasions, Licensee overcharged for services she provided Client. Licensee had negotiated a reduced fee with Mother and Licensee adjusted the billing to reflect the agreed upon rate. Mother and Licensee communicated via email about Mother's difficulty in paying and other billing issues. Licensee inadvertently sent email responses to Client's email address instead of Mother's email address. Mother notified Licensee of this problem. Despite Mother's alert, Licensee continued to send emails regarding billing/payment issues to Client's email. After Client learned of Licensee's emails to Mother, Client advised Licensee that she was discontinuing therapy due to her discomfort over the financial issues and because she was extremely disappointed with Licensee's conduct. Client had been identified as a high suicide risk and had reported suicidal ideation as recently as 2 days prior to terminating therapy. Client's psychiatrist identified Client as high risk for suicide. Psychiatrist initiated a safety plan for Client. Instead of encouraging Client to attend a final therapy session, Licensee sent Client an email requesting her to immediately sign paperwork indicating that she was terminating therapy against medical advice ("AMA"). This led to a series of emails about Licensee's legality in having a client sign AMA paperwork. Mother emailed Licensee requesting that Licensee send billing to Father. Licensee responded to Mother about turning the account over to collections, which was inappropriate where Licensee failed to properly inform Client and Mother of her collection policies and procedures. As an LMSW, Licensee was required to work under direct supervision. Licensee had an agreement for clinical supervision for hours needed for independent licensure, the agreement did not indicate that the clinical supervisor had immediate responsibility and oversight over Licensee's practice. Licensee continued to practice after 04/08 without formal clinical supervision. Licensee failed to have a signed consent for treatment form for Client and there is a dispute about who wrote Client's initials on this form. Licensee failed to have Client sign/date a treatment plan and Licensee failed to sign/date the treatment plan. Licensee indicated that the treatment plan was discussed with Client. A release of information authorization only had Client's printed initials, and, again, there was dispute about who wrote the initials on this form. There were other record deficiencies,</p>	<p><b>Board Review 02/07/13; Board Action 02/08/13 Executed</b> <b>Consent Agreement and Order:</b> 12 months supervised work experience working only in a supervised work setting in an agency licensed as an outpatient clinic by the Department of Health Services/Office of Behavioral Health Licensing; if engaging in the practice of behavioral health, she shall do so only while working at an OBHL licensed agency; within 12 months, complete 6 clock hours of continuing education of the NASW Staying Out of Trouble course or an equivalent course addressing current behavioral health documentation standards in Arizona; within 12 months, take and pass a 3 semester credit hour graduate level behavioral health ethics course; 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.</p>
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<p><b>Bruce Somers</b> <b>MFT-Applicant</b> <b>RLMFT-</b> <b>15041(Revoked)</b> <b>2013-0016</b></p>	<p>In 1976, Licensee became licensed to practice marriage and family therapy in California. In 2004, Licensee began living in Arizona at least part time. From approximately 2006 to 2009, Licensee maintained a private practice in Arizona. In 2008, Licensee worked a few months at Agency 1. In 01/08, Licensee submitted a LMFT application in Arizona. Under penalty of perjury, Licensee indicated that all of the information provided by Licensee was true and correct. On that application, Licensee disclosed various work history in California. He failed to disclose his employment in Arizona, as required, which included his private practice in Arizona and his employment at Agency 1. In 01/09, Licensee requested that his LMFT application be considered as a reciprocal LMFT application. In 04/09, Licensee began working at Agency 2. A colleague submitted written verification in support of his R-LMFT indicating that Licensee completed 6000 hours of work experience while in private practice in California from 2003 to 2008. In 04/10, his R-LMFT application was approved. In 02/12, Licensee submitted a LMFT application to the Board. On that application, he again certified that the information was true and correct. Licensee again failed to disclose his private practice in Arizona and his employment at Agency 1 in 2008. During the processing of this application, the Board received a copy of a letter written by a former client, who indicated that he had known Licensee for over 3 years and that through his therapy sessions with Licensee over the past three plus years, had learned to like himself... When asked about this letter, Licensee acknowledged his own private practice in Arizona. Licensee engaged in the illegal practice of psychotherapy in Arizona from approximately 2006 to 2009. Licensee acknowledged his intentional misrepresentations on his Arizona applications for licensure. During the review of his LMFT application, the Board requested 5 client records for review. Licensee submitted redacted records. The Board requested un-redacted records. Licensee indicated that he inadvertently redacted original records and requested clients to sign records for a second time and to backdate their signatures. Asking clients to backdate their signatures in order to assist him in obtaining a license was inappropriate, as it is his responsibility to ensure that the client record is protected from alteration.</p>	<p><b>Board Review 01/03/13; Board Action 01/04/13 Executed</b> <b>Consent Agreement and Order:</b> Licensee's RLMFT license shall be surrendered. The surrender shall be considered a revocation of his license. <b>Board Action 02/07/13:</b> LMFT application was denied for unprofessional conduct.</p>
<p><b>Susan K. Warren</b> <b>LPC-1182</b> <b>2010-0083</b></p>	<p>See 2011 Adverse Action Report.</p>	<p><b>Board Action 03/11/13:</b> The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 11/03/11.</p>
<p><b>Jacquelyn Dearth</b> <b>LPC-11773</b> <b>LISAC-10730</b> <b>2012-0062</b></p>	<p>See 2012 Adverse Action Report.</p>	<p><b>Board Action 03/11/13:</b> The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 04/04/12.</p>
<p><b>Marla A. Riney</b> <b>LMSW-12786</b> <b>2011-0078</b></p>	<p>In 01/10, Licensee provided individual and group therapy to a 17-year-old client ("Client"). On 01/30/10, Licensee completed an assessment of Client. In her written response to the Board and during an investigative interview, Licensee indicated that Client's mother ("Mother") was present. Given the likelihood that a 17-year-old would be significantly less candid in responding to questions about sensitive issues, Licensee's decision to allow Mother to be present during Client's assessment without a documented need for Mother's participation was inappropriate. Licensee later indicated that Mother only participated in part of the assessment. Licensee's documentation does not reflect that Mother was allowed to participate only at the end of the assessment. The 01/30/10 assessment indicated that Client had a number of risk factors, including previous psychiatric diagnoses and treatments; current signs and symptoms of psychiatric disorders and substance abuse disorders; family history of mental illness and substance abuse; acute psychosocial crises and chronic psychosocial stressors, including actual or perceived interpersonal losses, family discord, and past or current sexual or physical abuse or neglect; explosive violence; anger when provoked; and previous thoughts of suicide. Licensee rated Client as a "medium risk". Licensee failed to identify whether she believed Client presented a medium risk of danger to himself or others or both and failed to elicit any information as to whether Client had access to weapons. Licensee did not create any type of appropriate crisis or safety plan for Client. Licensee saw Client for at least 3 additional sessions and failed to reassess Client. Client revealed that his older sister had sexually abused him years before. Licensee did</p>	<p><b>Board Review 03/07/13; Board Action 03/11/13 Executed</b> <b>Consent Agreement and Order of Censure.</b></p>

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<p><b>Robert F. Lovett</b> <b>LAC-14148</b> <b>2013-0031</b></p>	<p>In 01/12, Licensee submitted his LAC application and acknowledged a long history of polysubstance abuse and a criminal history related to his substance abuse. Licensee acknowledged participation in outpatient substance abuse treatment in 2002, 2006 and 2008. Licensee indicated that he currently drinks in social situations and does not currently participate in any relapse prevention program.</p>	<p><b>Board Review 02/07/13; Board Action 03/12/13 Executed</b> <b>Consent Agreement and Order:</b> Stayed revocation; 12 months probation; shall attend a recovery program in person at a minimum of 2 times per week; enroll in an approved program and participate in random biological fluid testing; shall abstain from polysubstances and alcohol; 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.</p>
<p><b>Harry A. Ivy</b> <b>LASAC-13307</b> <b>2013-0062</b></p>	<p>Since 2001, Licensee has been employed at 8 different behavioral health agencies. From 2005 through 2011, Licensee was involuntarily terminated for cause from Agencies 1, 2, 3, and 4. On his 05/12 LASAC application to the Board, Licensee failed to disclose his employment and termination from Agency 3, as required. When Licensee applied for licensure, he was employed at Agency 5. Following his resignation at Agency 5 and employment at Agency 6, Licensee failed to update the Board of his new place of employment address and contact number, as required.</p>	<p><b>Board Review 02/07/13; Board Action 03/12/13 Executed</b> <b>Consent Agreement and Order:</b> 24 months probation; within 12 months, complete 6 clock hours of the NASW Staying Out of Trouble continuing education course or an equivalent preapproved course; within 12 months, shall take and pass a three semester credit hour graduate level behavioral health ethics course; 24 months 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</p>
<p><b>Cheryl S. Bolte</b> <b>LISAC-10915</b> <b>2013-0057</b></p>	<p>On 11/06/12, Licensee contacted a therapist ("Therapist") for assistance regarding her drinking problem. On 12/31/12 Licensee entered into an inpatient treatment facility and was discharged on 01/29/13. The treatment center's discharge summary stated that Licensee accepted the treatment team's primary after-care recommendations for individual and group therapy and recovery monitoring. Since her discharge, Licensee has initiated the following after-care activities: monitoring through the Sober-Link monitoring system; breath samples four times a day, seven days a week, with the results reported to a counselor; attends AA meetings daily and has a sponsor, focused on 12 Step issues; attends individual counseling once a week and group counseling weekly;</p>	<p><b>Board Review 05/02/13; Board Action 05/02/13 Executed</b> <b>Interim Consent Agreement and Order:</b> Within 12 months, complete a 3 semester credit hour graduate level course in addictions; clinical supervision; monitoring; therapy; shall not provide clinical supervision while subject to this Consent Agreement.</p>

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<p><b>Francis L. Conrad</b> <b>LCSW-11315</b> <b>2013-0033</b></p>	<p>Licensee provided treatment to a child ("Son 1") from 09/10 to 07/12. Licensee's records contain a number of entries indicating that he was advised on several occasions regarding inappropriate sexual conduct by Son 1, including Mother's 11/23/10 reported concerns regarding Son 1's sexual behaviors, which had not been addressed since Son 1 had been kept apart from his younger sibling ("son 2") for one year. Licensee documented Father's partner ("Step-Mother") had concerns that Son 1 could be cruel and sexually inappropriate and had history of extreme violence towards Son 2 and a younger sibling ("Son 3"). Licensee acknowledged he received information during a family session with Mother, Father and Son 1 on that Son 2 (age 5) told Step-Mother that Son 1 (age 13) asked Son 2 to touch him inappropriately. Son 1 acknowledged this was true and immediately realized it was inappropriate and that Son 2 did not touch him. Father did not talk to Son 2 about this incident and did not know if touching occurred. Regarding his failure as a mandated reporter to immediately report this information, Licensee indicated that Father did not have any information other than what Son 1 reported and if touching did not occur, it would not be a reportable incident; and because Son 1 was not returning to Father's home, the incident did not need to be resolved during that session. Licensee's conduct was inappropriate where, as a mandated reporter, Licensee had a responsibility to immediately report any allegation of sexual abuse of a child to proper authorities. Prior to receiving the report, Licensee had received a number of reports indicating that Son 1 had previously engaged in inappropriate sexual conduct. At a minimum, this should have presented Son 1 as a possible risk of inappropriate sexual conduct. Licensee acknowledged that a child sexually acting out with a younger sibling is a serious issue. Given the age differential between the two boys, Son 1's admission and the allegations of prior sexual misconduct by Son 1, this conduct did warrant a mandated abuse report, as noted in the Maricopa County Protocol for Investigating Child Abuse. Under these circumstances, Licensee's failure to report the alleged sexual abuse of a 5 year old child by a 13 year old boy was inappropriate. Instead of immediately reporting the possible abuse of a child, as required, Licensee scheduled a family therapy session to discuss the incident. Licensee's decision to schedule a session with Sons 1 and 2 to conduct an investigation regarding the sexual abuse allegations was inappropriate. According to Maricopa County Protocol, once an initial disclosure has been made, further questioning or interviewing of the child should be done only by the investigating professionals as further questioning may interfere the forensic interview and/or create additional</p>	<p><b>Board Review 04/04/13; Board Action 04/22/13 Executed</b> <b>Consent Agreement and Order:</b> probation; within 12 months, complete 6 clock hours of continuing education of the NASW Staying Out of Trouble course or an equivalent course addressing current behavioral health documentation standards in Arizona; Within 12 months, complete a three semester credit hour graduate level course addressing childhood sexual abuse and its impact on comorbidity from an accredited college or university; Clinical supervision for 12 months; 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.</p>
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<p><b>Mary M. Hennessey-Peirce</b> <b>LCSW-10373</b> <b>LISAC-0579</b> <b>2011-0102</b></p>	<p>In 10/07, Licensee began providing therapy services to a 10-year old child ("Son"). Licensee sent a letter to the Court in 08/10 noting that son had witnessed domestic violence between his parents ("Mother" and "Father") and verbalized anxiety over seeing Father and included her opinion that the Order of Protection that Mother had against Father should not be quashed. Licensee indicated she included this recommendation because she had a strong relationship with the little boy and wanted to advocate on his behalf. After reading articles about the difference between forensic practice and individual practice, Licensee realized that she should not have sent her letter to the Court. The recommendation in the Licensee's letter to the Court was inappropriate as it was inconsistent with Licensee's role as Son's therapist; she did not complete the types of evaluative activities normally completed by professionals providing recommendations to the Court; and the information pertaining to Father was presented as fact rather than as information provided to her by Mother. In 02/11, Son expressed thoughts of self-harm. A Progress Note documented that Son reported having some feelings of self-harm and Mother reported Son made similar statements at school. Licensee talked with Son and Mother after Son identified thoughts of harming himself and continually assessed Son, but did not document any specific information regarding the thoughts, such as the duration and nature. Licensee did not conduct any type of documented risk assessment for Son or modify treatment plan to address these issues, and took no action to determine if further evaluation by another behavioral health professional was needed. On 02/03/11, Mother emailed Licensee and indicated that Son came home from a visit with Father with cuts on his face that Son said accidental and occurred while wrestling with Father but mentioned he was scared after Father got angry. Licensee gave Mother the name of a psychologist ("Psychologist") who does forensic work and advised Mother to document the incident and call CPS to make a formal report. Licensee did not make a CPS call with regard to the information Mother provided. Licensee advised Mother to call CPS because Son initially told Mother about the incident. Licensee indicated she reviewed the mandated law from the perspective that any adult who is aware of an incident needs to report, including parents and she trusted Mother to file the report and that report was "probably enough." Licensee should have contacted CPS herself. Consent for treatment forms were missing required elements: methods for a client to obtain records, client's right to participate in treatment decisions and development and periodic review/revision of treatment plan, client's right to refuse treatment or withdraw informed consent and be advised of the consequences of refusal or withdrawal, and client's right to be informed of all fees and refund and collection policies and procedures. Licensee's 10/07 treatment plan for Son did not include the date when the treatment plan shall be reviewed and signature and date signed by client's legal representative. Licensee did not complete any updated treatment plans for Son, as required, until 05/15/11, after</p>	<p><b>Board Review 04/04/13; Board Action 05/10/13 Executed Consent Agreement and Order:</b> Probation for 12 months; within 12 months, complete 6 clock hours of continuing education of the NASW Staying Out of Trouble course or an equivalent course addressing current behavioral health documentation standards in Arizona; Clinical supervision for 12 months; 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.</p>
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<p><b>Marci L. Kyle</b> <b>LMSW-Applicant</b> <b>2013-0070</b></p>	<p>By signing the certifying statement on her 09/11 LMSW application, Applicant attested under penalty of perjury that all information she provided in the application was true and correct to the best of her knowledge. The application background questions require the following Applicants to disclose the reason for leaving each identified place of employment. Applicants must specifically disclose any prior terminations or resignations in lieu of terminations from any behavioral health related position. On her LMSW application, Applicant represented that she "voluntarily" resigned from an agency ("Agency 1") in 2010. Applicant did not identify any prior terminations. Applicant's personnel record at Agency 1 indicated Applicant engaged in the following inappropriate conduct: On 07/26/10, Applicant bought food for a client ("Client") and went to Client's house in the evening to drop off the food. Applicant did not consult with her supervisor before purchasing food for Client. After reviewing this information, Agency 1 determined that Applicant's conduct violated Agency 1's policies. As an employee of Agency 1, Applicant was responsible for understanding and abiding by policies and procedures regarding client care and should have contacted Supervisor for advice if she had questions about a specific protocol. Applicant acknowledged that she should have talked to her supervisor before purchasing and delivering food to Client. Applicant signed a 08/04/12 corrective action form indicating that she was involuntarily terminated from Agency 1 and is not eligible for rehire. Applicant acknowledges that she engaged in the conduct identified in her personnel record and that she agreed with Agency 1's determination that her conduct was inappropriate. Applicant's failure to disclose her involuntary termination for cause from Agency 1 in response to an unambiguous background question on her LMSW application was inappropriate. Applicant also failed to disclose 3 behavioral health</p>	<p><b>Board Review 04/04/13; Board Action 04/22/13 Executed Consent Agreement and Order of Censure.</b></p>
<p><b>Alexadra E. Yassi</b> <b>LAMFT-Applicant</b> <b>2013-0037</b></p>	<p>On Applicant's 02/12 LAMFT application, Applicant disclosed a 12/30/09 DUI arrest. Applicant admitted to driving after having "2 shots" of alcohol and had a BAC level of 0.08% when arrested. Applicant expressed remorse for her "mistake" in driving after drinking, but denied having any substance abuse/dependency issues. Applicant indicated that she now either has a designated driver or does not drink when she goes out.</p>	<p><b>Board Review 04/04/13; Board Action 04/22/13 Executed Consent Agreement and Order:</b> Application approved pending a passing score on the PES examination; probation for 24 months; Clinical supervision for 24 months; Mothers Against Drunk Driving ("M.A.D.D.") meetings for 24 months; 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</p>

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<p><b>Brent E. Case</b> <b>LPC-12277</b> <b>2012-0117</b></p>	<p>Licensee worked at an agency ("Agency") from 10/02 to 02/23/12. A 06/11 email from an individual providing peer support services at Agency ("Peer Support") indicated Licensee left a therapy group he was facilitating to transport a client ("Client 2") to physical therapy and asked Peer support to tell anyone who asked that he was on a crisis call. Peer Support relayed Licensee's request to Director. Agency issued a Corrective Action Plan that indicated Licensee was having ongoing problems with productivity. When Agency CEO ("CEO") and Director met with Licensee regarding an extensive list of caseload management issues, he was defensive and did not understand the seriousness of the situation. Licensee was asked to re-evaluate CASIs that had been scored incorrectly and did not complete the re-evaluations or request for an extension. In 09/11, Licensee was again placed on probation. An Agency billing specialist indicated Licensee's notes on a client ("Client 1") were insufficient to support the duration billed and did not identify who he met with, where he met, or what services were provided. A 02/12 Letter to Licensee addressed ongoing problems of clients not receiving timely visits, unresolved issues involving Licensee's car insurance, documentation deficiencies, productivity problems, potentially fraudulent billing errors, and unethical conduct. In Licensee's 03/06/12 Grievance Letter to Agency, Licensee indicated: ridicule, insults and psychological abuse impacted his job performance; Director was intentionally misleading him; he believed someone put dog feces in his office removed documentation of his sessions from Agency's system. Licensee signed a transportation policy and attended a meeting on the importance of not transporting clients in personal vehicles. Despite this, Licensee was observed with Client 1 in his personal vehicle on 02/23/12 and consequently terminated. Licensee acknowledged during the Board's investigation that he transported Client 1 in his personal vehicle to the post office, choosing not to return to Agency for a company vehicle. Director alleged that Licensee denied the allegations, became irritated and walked out, as supported by Director's 02/23/12 letter to Licensee and by Client 1, who said that Licensee had her duck down to avoid being seen by Agency employees. Licensee denied allegations that he was dishonest, indicating that he "guardedly" admitted to Director that he had violated policy. Client 1 had Licensee's personal cell phone number, indicating a boundary issue. A review of Licensee's personal cell phone records shows regular communications with Client 1 during his employment at Agency, many initiated by Licensee. Licensee reported that his texts with Client 1 were usually to remind him during business hours that she was out of food, but were not documented in Client 1's record be established as therapeutically appropriate. Client 1 reported Licensee continued to text her after his termination, which is reflected in Licensee's phone records that show he initiated contact with Client several times after his termination. There was no legitimate basis for Licensee's continued communications with Client. Licensee indicated he and Client 1 exchanged text messages on 02/24/12 because Client 1 appeared to be in crisis and he called Agency's crisis line about the situation. Licensee affirmed that he did not have any further communications with Client 1 after 02/24/12. Licensee's phone records show he had a number of communications with after 02/24/12, several initiated by Licensee. When shown these records, Licensee denied that he sent the messages and indicated the discrepancy between his recollection and his phone records may be from accidentally pressing "send" instead of "delete" with regard to texts he received from Client 1. Given the Licensee's phone records, and Client 1's statement, Licensee's repeated representations that</p>	<p><b>Board Review 03/07/13; Board Action 03/29/13 Executed</b> <b>Consent Agreement and Order:</b> probation; if engaging in the practice of behavioral health, she shall do so only while working at an OBHL licensed agency; within 12 months, complete 6 clock hours of the NASW Staying Out of Trouble continuing education course or an equivalent preapproved course; within 12 months, shall take and pass a three semester credit hour graduate level behavioral health ethics course; 24 months clinical supervision; 12 months therapy; shall not provide clinical supervision while subject to this Consent Agreement.</p>
<p><b>Wendy S. Kutz</b> <b>LCSW-2236</b> <b>2013-0047</b></p>	<p>Licensee received treatment in 2005 related to a gambling addiction. On 04/28/12, Licensee caused a non-injury minor collision and was charged with DUI after breathalyzer tests resulted in a BAC of .122. Records from the treatment program Licensee completed following her arrest reflect that Licensee was prescribed medication for behavioral health related problems and had been taking, as prescribed, these medications for many years. Licensee's 08/12 treatment discharge plan ("Discharge Plan") indicated that she should participate in a community 12-step program and continue counseling with a provider experienced in addiction recovery. Licensee did not continue with counseling following her discharge, as recommended. In 11/12, Licensee began counseling with an addiction specialist as recommended in the Discharge Plan. Licensee's records reflect that she continues to have alcohol abuse and pathological gambling related issues and may require a higher level of care.</p>	<p><b>Board Review 03/07/13; Board Action 03/27/13 Executed</b> <b>Interim Consent Agreement and Order:</b> Licensee shall not engage in any type of clinical practice or supervise anyone providing any type of clinical services.</p>

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<p><b>Lyn M. Christophersen</b> <b>LISAC-0751</b> <b>2011-0014</b></p>	<p>Licensee provided case management services to Patient ("Patient") and Patient's family at an agency ("Agency 1"). After her 05/14/10 termination from Agency 1 in 07/10, Patient's mother asked for assistance from Licensee regarding Patient's hospitalization ("Hospital"). Hospital records reflect that Patient was admitted as a result of an overdose and was put on suicide watch and could not leave against medical advice ("AMA"). Licensee acknowledged she told Hospital staff that she was Patient's case manager and discussed Patient with the Hospital staff without written authorization to do so. Licensee acknowledged that she did not clarify her relationship with patient or lack of current information and authorization, and as a result Hospital staff assumed Licensee was Patient's current treatment provider. Licensee's failure to provide clear information was inappropriate as Patient was hospitalized for a suicide attempt and not allowed to leave AMA, and staff was unaware the information Licensee provided was not in the context of an ongoing professional relationship. Licensee indicated she felt it appropriate to help them solve this situation, and did not violate any of the rules she had read. Patient committed suicide in 10/10. Licensee was reprimanded in 04/10 for climbing through the window of the home of a suicidal person. Agency 1 noted that contacting the police was the appropriate action and going to the client's home alone, was not advised. Licensee did not ask for supervisor assistance in this situation. Licensee put herself in the position of possibly being harmed or causing more harm in a high-risk situation. Licensee reported she was transporting clients and they would not stop talking, so she told them to "shut the fuck up" and was reprimanded for using profanity towards minor clients. Agency 1 terminated Licensee's employment on 05/14/10. Licensee never acknowledged that she was involuntarily terminated by Agency 1 or that it resulted from her inappropriate conduct. Licensee was hired at another Agency ("Agency 2") on 01/14/11. She received and signed a Correction Action Plan ("CAP") in 03/11 when a co-worker reported that Licensee called her a "bitch" and pulled a knife out of her pocket. Licensee indicated that this exchange was done in a playful and joking manner. Licensee's language and behavior violated Agency 2 policies. On 07/05/11 Licensee physically examined two students when Student 1 appeared with burns. Licensee was advised that she should not examine students but examined another student ("Student 3") on 07/14/11 with bruises. Licensee failed to report this matter to CPS. She again examined Student 3 on 07/26/11 who had a mark on his back and stated his father hit him with a belt. Licensee failed to immediately report this matter to CPS and reported it to a supervisor ("Supervisor") two days later. Supervisor advised Licensee to immediately report the incident to CPS, but Licensee waited until 08/01/11 and failed to follow-up with a written report, as required. Licensee received a CAP noting CPS calls and Incident Reports must be completed promptly and concisely and Licensee is not to examine children or question them about possible abuse as it could damage a CPS and/or law enforcement case. A child's report or visible signs are enough evidence for a report. Licensee refused to sign this CAP and was terminated. Based on a review of records from Agency 1 and Agency 2, Licensee has a demonstrated pattern of impulsivity, over-involvement with clients, poor decision making, and failure to demonstrate appropriate professional behaviors. Licensee has not demonstrated any insight regarding the inappropriate nature of her conduct. On her 07/29/11 LISAC renewal application, under penalty of perjury, Licensee answered "no" to</p>	<p><b>Board Review 05/02/13; Board Action 05/08/13 Order of Revocation.</b></p>
<p><b>Stephanie L. Hight</b> <b>LPC-10323</b> <b>2013-0053</b></p>	<p>From 09/04 to 05/10, Licensee worked at an inpatient civil commitment treatment facility for sexual offenders ("Agency"). In 04/05, Licensee was suspended for 24 hours without pay for accessing sexually explicit content on her Agency computer. A client ("Client") received services at Agency from 08/08 to 12/08. Client reported he and Licensee developed a relationship in 11/08, while Client was residing at Agency, and their relationship developed into an intimate relationship after his 12/08 release from Agency. Client's intimate relationship with Licensee lasted approximately 6 months. Client provided photographs of Client kissing Licensee. During a 01/18/13 investigative interview, Licensee denied that she engaged in an intimate relationship with Client. It is impossible to reconcile Licensee's denial that she engaged in an inappropriate relationship with Client with the photographs. Licensee worked at another agency ("Agency 2") from 04/11 until her termination in 08/12 after Agency 2</p>	<p><b>Board Review 04/04/13; Board Action 05/02/13 Order of Revocation.</b></p>

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<p><b>Herbert R. Warner</b> <b>RLPC-15047</b> <b>2011-0054</b></p>	<p>Licensee submitted his Reciprocal LPC license application to the Board on 01/04/10 with a Verification of Work Experience form completed by a colleague ("Colleague") in support of his application where Colleague certified he had "direct personal knowledge" of Licensee's work history for the previous 5 years and verified that Licensee was engaged in the practice of behavioral health for at least 6000 hours in Washington State from 01/04/05 through 09/22/09. Based on this, the Board issued Licensee's R-LPC license on 08/01/10. During an interview by Board staff, Colleague acknowledged that the information he provided was based almost exclusively on Licensee's representations regarding his private practice. On his license application, Licensee failed to identify his employment at three behavioral health facilities in Washington and his employment at Terros in Arizona, as required. Instead, Licensee misrepresented that he maintained a private practice in Washington. Information Licensee provided on an employment history form at Terros is inconsistent with information provided on his employment application at Cenpatico and both are inconsistent with what Licensee provided on his licensure application, establishing that Licensee has consistently provided inaccurate information regarding his employment history. In 07/07, prior to Licensee obtaining a license in Arizona, the Human Resources Department at Terros sent a "Notice to Cease Communications" to Licensee indicating he was transmitting documents to multiple Terros job sites with various allegations regarding Licensee's first ex-wife's character and background, and requested that he discontinue immediately. In 11/10, Licensee was involuntarily terminated from Cenpatico after he brought a gun to work. A police report indicated Licensee brought a gun to his work in violation of Cenpatico's policy, and the "no weapons" signs posted at the doors, and after being told repeatedly not to do so. The agency security director had asked Licensee if he had a gun with him and he said he did not. Upon a consensual search of Licensee's bag, a loaded revolver was found. Licensee claimed that he forgot that he had his gun with him. In 12/10, Licensee was charged with misdemeanor disorderly conduct regarding this incident and failed to notify the Board within 10 days, as required. The Board was advised of the charges in 04/11 by Licensee's second ex-wife. In 11/10, a complaint was filed with the Board alleging that Licensee misrepresented his employment history on his license application. The Board mailed Licensee a copy of the pending complaint and received Licensee's written complaint response on 02/15/11. Board staff sent another letter to Licensee requesting additional information and was advised that failure to respond to a Board request for information could be considered unprofessional conduct. Licensee failed to respond to the Board's letter and was sent another letter and a subpoena to appear for an investigative interview at the Board's office on 08/09/12. Licensee did not appear for his Board interview or provide the requested information, as required. On 03/13/12, Licensee submitted a change of home address/phone to the Board misrepresenting that he was still employed at</p>	<p><b>Board Review 06/06/13; Board Action 06/12/13 Order of Revocation.</b></p>
<p><b>Becky R. Goudy</b> <b>LAC-13378</b> <b>LASAC-13105</b> <b>2013-0060</b></p>	<p>Licensee began providing services to a client ("Client") at an agency ("Agency") in 2008 with identified behavioral health issues of anxiety, prolonged PTSD, and BPD. During therapy with Client, Licensee documented that Client had transference issues and might have had feelings for Licensee. Client believed that Licensee had feelings for Client. Client struggled with abandonment and relationship issues. Licensee acknowledged that she gave items to Client as therapeutic incentives. Licensee acknowledges that, at Client's request, She drove by Client's home to view Client's Christmas lights. Licensee indicated, during her investigative interview, that she thought that Agency had a policy regarding giving clients gifts/incentives, but was not sure what it was and did not discuss with Agency's clinical director whether, given Client's known issues, it was appropriate to give Client gifts/incentives. Licensee's failure to seek out supervision regarding appropriate therapeutic strategies with a client who continually expressed confusion regarding the client/therapist role was inappropriate. Although Licensee indicated that all of the gifts she gave to Client had a therapeutic purpose, Licensee failed to document, as required, that she gave Client a stuffed animal and toy motorcycle and their therapeutic purpose, or any discussion she had with Client to clarify that the items were therapeutic tools.</p>	<p><b>Board Review 06/06/13; Board Action 06/07/13 Executed Consent Agreement and Order:</b> probation for 12 months, within 12 months 6 clock hours of continuing education addressing behavioral health ethics and boundaries and 3 clock hours of continuing education addressing clinical documentation, clinical supervision for 12 months; 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.</p>

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<p><b>William R. Wolf</b> <b>LCSW-1332</b> <b>2012-0041</b></p>	<p>In 06/08, Licensee began treating a 13-year-old child, ("Son"), who was, involved in a high-conflict custody dispute. Licensee also provided individual and family therapy to Son's father ("Father"). Licensee maintained Son's and Father's clinical records electronically on his computer. In 01/12, Licensee provided his clinical records for Son to the Board. In 01/13, the Board requested the clinical records for Father and was informed by Licensee that his computer crashed and all of his clients' behavioral health records were lost. During his 04/02/13 investigative interview, Licensee acknowledged that he failed to maintain any type of backup protection for his electronic behavioral health records. He did maintain some documentation, such as informed consents for treatment, in hard copy format, however, once he decided to terminate his private practice, he destroyed all of the hard copy behavioral health records he maintained. The progress notes Licensee maintained for Son lacked the following required elements: Duration of time spent providing the behavioral health service, an indication whether the counseling was individual, family, or group and Licensee's signature and date. Licensee failed to</p>	<p><b>Board Review 06/06/13; Board Action 06/07/13 Executed Consent Agreement and Order:</b> Licensee shall not practice under his license. Licensee's license, LCSW-1332, shall by rule, expire on 07/31/14; Licensee agrees not to renew his license; Licensee agrees not to reapply for licensure in Arizona for a minimum of 5 years.</p>
<p><b>Katie Jebraail</b> <b>LAC-Applicant</b> <b>2013-0081</b></p>	<p>Applicant's pharmacy records reflect that she has been filling prescriptions for large amounts of controlled drugs since at least 2007, from multiple physicians through multiple pharmacies. In 2007, Applicant utilized 5 different prescribers and 3 different pharmacies. In 11/07, Provider 5 indicated a clinical impression of "opiate dependence" for Applicant. A 12/07 Walgreens MedMonitor Prescriber Feedback Form indicated Provider 3 was not aware another doctor was prescribing Oxycodone to Applicant. Applicant had 3 different prescribers and 3 different pharmacies in 2008; 7 prescribers and 4 pharmacies in 2009; and 4 providers and 2 pharmacies in 2010. Current pharmacy records as of 2012 reflect 1 prescriber and 2 different pharmacies with prescriptions for Xanax, Oxycodone, Cymbalta. Xanax is a known addictive benzodiazepine. Oxycodone is a known addictive opiate narcotic. A 09/12 Provider 15 progress note indicated Applicant is "still very stressed and anxious." Applicant received several referrals to see a pain management specialist but did not follow up on any of these referrals. On her 05/12 LAC application, regarding her 09/07 DUI arrest, Applicant indicated she was pulled over 2 hours after her last drink with a BAC of .003, and represented that she only took one Xanax on the day of her arrest. Applicant appeared to have deliberately misrepresented her conduct as her BAC was actually .058 and the police report indicates Applicant told Officer that she took 6-7 Xanax with 2 beers before her arrest. Officer found an additional 4 Xanax pills in her pocket. She was only supposed to take one Xanax per day. Applicant's pharmacy records reflect that she was obtaining large amounts of Xanax during this time period. Applicant's urine screen tested positive for Xanax, Celexa and an illegal street drug, Ecstasy. Applicant denied that she ever took MDA/Ecstasy. When asked to identify her medical providers for the last 10 years, Applicant identified 3 providers. Applicant appears to have deliberately misrepresented her medical and prescription history where her pharmacy records reflect over the last 6 years, she has treated with 15 medical providers. When asked to identify any prescription medication taken during the last 10 years, Applicant identified only Xanax and Viibrid. Her prescriptions during this time period included: Oxycodone, Oxycontin, Prozac, Percocet, Vicodin, Lexapro, Flexeril, Zoloft, and Cymbalta. When specifically asked, Applicant denied currently taking any medication for back pain. Pharmacy and medical records clearly reflect that she continues to obtain large amounts of Oxycodone on a monthly basis. When asked why Applicant failed to identify all of her medical providers, as requested, she indicated she didn't consider other doctors she saw to have "treated" her unless they prescribed medications. Applicant's explanation regarding her failure to identify 13 of her 15 medical providers is disingenuous where all 15 providers prescribed her medication. She acknowledged that she continues to drink</p>	<p><b>Board Review 06/06/13; Board Action 06/06/13:</b> LAC application was denied for unprofessional conduct.</p>
<p><b>Debra Raybon</b> <b>LMFT-10371</b> <b>2012-0020</b></p>	<p>See 2012 Adverse Action Report.</p>	<p><b>Board Action 06/07/13:</b> The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 02/15/12</p>

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<p><b>Dianne Andrick</b> <b>LPC-1689</b> <b>LISAC 0372</b> <b>2007-0017</b> <del>2009-0054</del></p>	<p>See 2009 Adverse Action Report.</p>	<p><b>Board Action 06/07/13:</b> The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 11/10/09.</p>
<p><b>Vicktoria Patzer</b> <b>LAMFT-10328</b> <b>2012-0137</b></p>	<p>See 2012 Adverse Action Report.</p>	<p><b>Board Action 06/07/13:</b> The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 09/12/12</p>
<p><b>Marisa B. Spletter</b> <b>LMSW-Applicant</b> <b>2013-0044</b></p>	<p>Applicant acknowledged abusing alcohol beginning in mid-2009 and began participation in Celebrate Recovery. Applicant pled guilty to DUI in 09/10. One month later, she submitted her first Licensed Master Social Worker application to the Board and was denied, in part, due to her misrepresentations regarding her alcohol use and failure to obtain treatment. In 2011, Applicant began participating in AA online and participated in 2 sessions with a licensed substance abuse counselor in 05/12 and 06/12. She submitted her second application to the Board in 08/12 and began participating in AA in person on a weekly basis. Regarding her sobriety date, Applicant indicated since her DUI, she had a drink on 1 occasion after not drinking for 2 years, and was willing to participate in random alcohol testing. Although there is no evidence that Applicant currently has any active substance abuse problems, she has only recently begun AA participation in person. Applicant has indicated that her sponsor from prior participation in Celebrate Recovery ("Sponsor") is her current sponsor regarding her AA participation, but does not attend AA, and is unable to attest to Applicant's actual participation. Sponsor has encouraged Applicant to find a sponsor in AA, yet she has not done so. When Applicant had a recent slip up, she</p>	<p><b>Board Review 06/06/13; Board Action 06/18/13 Executed</b> <b>Consent Agreement and Order:</b> Application approved pending a passage of ASWB examination; Stayed revocation; probation for 24 months; clinical supervision for 24 months; weekly AA meetings; enroll in an approved program and participate in random biological fluid testing; 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.</p>

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<p><b>Arline Lemeszewsky</b> <b>LCSW-3634</b> <b>2011-0009</b></p>	<p>In 07/08, a client ("Client") initiated counseling with Licensee on referral by Client's psychiatrist ("Psychiatrist"). On 07/17/08, Client reported she was depressed and had tried to slit her wrist 3 times in the past year, without telling Psychiatrist. Licensee documented the following: victim of childhood sexually abuse, history of passive suicide ideation, history of cutting arm for attention, and current medication was Ambien. Licensee diagnosed Client with Bipolar Disorder, PTSD, Alcohol abuse, Adult Child of Alcoholic, Personality disorder, borderline traits. Recognized suicide assessment guidelines reflect that these all increase a patient's risk for suicidal behavior. Given this, it was Licensee's responsibility to conduct a suicide risk assessment and develop safety plans as needed. Licensee's records do not reflect that any type of risk assessment was conducted, or safety plan considered. Client signed an authorization for Licensee to communicate with Psychiatrist. There is no documentation in Client's record indicating that Licensee communicated in any way with Psychiatrist regarding Client, or made any attempt to coordinate Client's care. It was incumbent upon Licensee to clearly communicate with Psychiatrist regarding Client's alcohol abuse in order to ensure that Psychiatrist had the information needed to properly monitor Client's medications. This was critical as the manufacturer of Ambien clearly advises to not use with alcohol and persons with past or present addictions should be monitored carefully. When Client initiated treatment, Licensee documented Client's self-reported alcohol abuse issues, including blackouts and binge drinking. Client's records did not indicate that Licensee conducted a comprehensive substance abuse assessment. Licensee conducted 6 individual therapy sessions with Client and did not document that she directly addressed Client's alcohol abuse issues, only indicated that Client's "homework" included exercising "abstinence". On 09/18/08, when a billing issue arose with Client's insurance carrier ("Insurance"), Client asked to discontinue therapy until this was resolved. When she terminated treatment, Client had several serious behavioral health diagnoses and suicide risk factors. There is no evidence that Licensee created any type of written safety plan for Client, provided any crisis line information or contact information for at least 3 other therapists, or advised Psychiatrist that Client had terminated therapy. On 07/18/08, Client signed an Application for Service form that authorized, "the release of any medical information necessary to process claims to any insurer," and a Consent to Release Information form authorizing Licensee to share diagnosis and treatment plan information with Insurance. On/about 09/03/08, Insurance denied Licensee's claims for reimbursement for fees related to Client's treatment and was advised that she had 180 days to submit a written appeal. Licensee determined she needed to submit Client's progress notes with her appeal and neither of the authorizations could be used to release the notes, and another would be required. Client sent Licensee a letter authoring Billing Service to release her progress notes to Insurance. Licensee determined that the letter could not be used because Client authorized Billing Service, not Licensee, to release progress notes. On 04/09/09, Licensee sent Client a form that authorized the release "diagnosis", "assessment", "treatment plan", and "treatment summary" information to Insurance. Client signed the release on 04/15/09 and immediately returned it. On 06/25/09, Licensee submitted an appeal to Insurance with Client's progress notes. On 07/20/09, Insurance advised Licensee that her appeal could not be processed because it was received after the deadline. There is no information in Client's record supporting her assumption that Insurance ever asked for Client's progress notes. Nothing in Licensee's revised release specifically indicates that "progress notes" would be released. When Client returned for treatment with Licensee in 07/08, She signed an "Application for Service" form indicating that she</p>	<p><b>Board Review 09/05/13; Board Action 09/13/13 Executed</b> <b>Consent Agreement and Order:</b> probation; within 12 months, complete 6 clock hours of the NASW Staying Out of Trouble continuing education course or an equivalent preapproved course; within 18 months, shall take and pass a three semester credit hour graduate level behavioral health course in diagnosis and assessment; within 12 months, complete 3 clock hours in clinical record keeping in Arizona; within 12 months, complete 3 clock hours in appropriate billing practices; audits; shall obtain a practice monitor; 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.</p>
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<p><b>Suzanne Schunk</b> <b>LCSW-10194</b> <b>2011-0142</b></p>	<p>Licensee is the Director of Family Support Services at an agency ("Agency"). In 04/10, the Arizona Department of Economic Security ("DES") contracted with Agency to provide services to a family ("Family") consisting of a mother ("Mother"), father ("Father"), and their two children ("Children") through Agency's Factitious Disorder ("FD"), by Proxy Program ("Program"). Licensee supervises Agency's Program. Licensee contends that Agency was to provide services to Family including supervised visitation, case planning, parent skills training and education. Given the unusual nature of services under the DES contract, with reporting requirements back to CPS, it was Agency's responsibility to minimize any potential conflict of interest. Parents' relationship with Agency was not confidential. Their statements and actions were recorded and then reviewed by CPS, a psychologist in California ("Expert Psychologist"), and others, and used in legal proceedings against Parents. Parents objected to the lack of confidentiality, but their disclosures were reported as a lack of cooperation. Licensee did not inform Parents that information obtained by Agency might be used to build CPS' case or advise them that everything taking place during visitation and therapy would be recorded and turned over to CPS or that Licensee would testify against Parents if asked to do so. Licensee acknowledges, on 05/14/10, the "therapeutic team" met with Mother and verbally described Agency's services. Agency did not provide any written information regarding services or maintain documentation detailing information provided. Agency's visitation guidelines were very similar to the CPS visitation guidelines, so Agency staff reviewed Agency's guidelines with Mother verbally. Mother did not receive a copy of the guidelines. Although Agency's visitation guidelines included a place for a parent signature at the bottom attesting that the parent "agree to abide by these rules", Agency staff did not obtain signatures. Mother was verbally asked if she agreed to services. This meeting is typical of Agency's practice. Agency staff never had this conversation with Father. Agency documents reflect that, on 08/17/10, Parents' requested another provider be chosen to provide services to Family. Licensee wrote an email to CPS CM opposing Parents' request. Agency continued to provide services to Family. Around 09/10, Parents requested and obtained a Court order requiring a neutral third party present for all supervised visitation sessions at Agency. Licensee and a psychologist at Agency ("Agency Psychologist") send a letter requesting that the Court Order be vacated based on the supervised visitations and sessions being a therapeutic process and having 3rd party observers, especially persons from the legal community, is counter-productive to this process and implies that the therapists are biased against the parents. Licensee contends that CPS asked Agency to ensure the safety of Children during visits and the services provided to Family were not behavioral health services within a clinical context. Licensee did not engage in the practice of social work or professional counseling or provide any type of psychotherapy or clinical services. Agency communications reflect that in her 08/10 report, Expert Psychologist indicated staff was agreeable to the request that Agency provide "a more intensive therapeutic intervention approach" with Parents. A 08/10 email from Licensee to CPS CM indicated a change in Agency therapists is ill-advised because the "therapeutic process involves relationship building, assessment, goal development and intervention, and closure/aftercare." Agency is "now ready for the goal and intervention phase of the process" and beginning with new therapists will significantly delay the process. An 11/10 document prepared by Licensee and Agency Psychologist indicated that "at this stage of therapy, visits still need to be supervised by mental health professionals who have experience and clinical understanding of the psychological factors that are involved in medical child abuse." Licensee contends that CPS was Agency's client</p>	<p><b>Board Review 09/05/13; Board Action 09/13/13 Executed</b> <b>Consent Agreement and Order:</b> probation; within 6 months, complete 6 clock hours of the NASW Staying out of Trouble continuing education course or an equivalent course; 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.</p>
<p><b>H. Dayton Turberville</b> <b>LISAC-10777</b> <b>2011-0096</b></p>	<p>See 2012 Adverse Action Report.</p>	<p><b>Board Action 09/10/13:</b> The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 01/26/12</p>

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<p><b>Esther Williamson</b> <b>LMSW-Appl</b> <b>2013-0035</b></p>	<p>On 01/10/09, Applicant was arrested for DUI. Regarding the night of her arrest, Applicant indicated she was celebrating a friend's engagement over dinner and drank a margarita. Later in the evening, she had a beer and a "sip of a shot". After the beer, she drank water for about an hour before she drove. Applicant chose to drive because she felt the alcohol had declined in her system. On her way home, she received a phone call and when she reached for her phone her vehicle went into another lane and was pulled over. Applicant was pulled over by the police at 2:09 a.m. and her blood alcohol level was not tested until approximately 1 hour after she was stopped. At Applicant's reported weight, she had the equivalent of 4-5 alcoholic drinks in her system when she was tested. Given the half-life of alcohol in the body, it appears Applicant had significantly more alcohol in her system when she was arrested at 2:09 a.m. She was charged with, and later convicted of, DUI. A BAC of .156% is extremely high and strongly suggests that Applicant has developed a tolerance for alcohol which is typically related to ongoing alcohol abuse. In 1999, Applicant was arrested for Underage Drinking shortly before her 18th birthday. On her 04/13/12 LMSW application, Applicant disclosed the 01/10/09 DUI, but failed to disclose the</p>	<p><b>Board Review 09/05/13; Board Action 09/05/13 Executed</b> <b>Consent Agreement and Order:</b> probation for 24 months; clinical supervision for 24 months; 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.</p>
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<p><b>Dwayne Kruse</b> <b>LMFT-10273</b> <b>2011-0091</b> <b>2012-0035</b> <b>2012-0060</b></p>	<p>Case #2011-0091 In 08/10, a mother ("Mother") and father ("Father") were divorced and in conflict over custody of their 9 year old daughter ("Daughter"). On 08/16/10, Temporary Custody Orders were issued limiting Father to supervised visitation, and ordering Mother to engage Daughter in counseling sessions to address issues of whether or not abuse has occurred and provide a report from the counselor as to the need for continued supervised visitation. Mother subsequently contacted Licensee to initiate services. On 09/04/10, Licensee was scheduled to meet with Father at Father's home. Licensee indicated when Daughter refused to go to Father's home, the intended interview with Father and Daughter together turned into an "impromptu individual meeting in a parking lot" with Daughter. Mother was engaged to a man ("Fiancé") who sat in his own car in the parking lot while Licensee interviewed Daughter in Licensee's car. Licensee did not provide any clinical justification for his decision to interview Daughter in his car in a public parking lot. It would seem difficult to justify the provision of any type of behavioral health service to a young child within the confines of a car and in a public parking lot. Licensee acknowledges he discussed the difference between the truth and a lie with Daughter and discussed the bruise on her leg and showed her a picture of the bruise. Licensee told Daughter that he felt the belt mark could not have been done by Father. Licensee was clear to Daughter that he wanted her to be safe, but he "was also clear that science and evidence in this case did not add up." Licensee's conduct was inappropriate based on the following: The Court involved in Father's and Mother's custody dispute requested that Daughter see a counselor in order to address issues of whether or not abuse has occurred and the child's anxiety in regard to seeing her father and provide a report as to the need for continued supervised visitation. In order to provide the evaluation ordered by the Court, it was reasonable for Licensee to interview, and review information provided by, the parties, form a professional opinion with regard to the credibility of those he interviewed and the accuracy of the information provided, and report his professional opinions and the bases for those opinions to the judge. Instead, after forming an opinion that Daughter's representation that Father hit her with a belt buckle was not credible, Licensee advised Daughter that he did not believe her. When Daughter continued to insist that she was telling the truth, Licensee "challenged [Daughter] to give a different rendition of her story." Following this interaction, Licensee acknowledges that Daughter put her head down and withdrew. It is difficult to understand how Licensee could have reasonably believed there was an appropriate therapeutic basis for such an interaction with Daughter, particularly within the confines of Licensee's car. During the session, a deputy sheriff approached the vehicle. The officer told him that a concerned citizen had reported a strange man was sitting with a little girl for over an hour in the parking lot. Licensee showed the sheriff his credentials, identification, and Daughter's consent for treatment, identified Fiancé' as Daughter's custodian, and described the circumstances leading to Licensee's meeting with Daughter in the parking lot. The deputy sheriff then went to speak with Fiancé. Subsequently, the sheriff's office dispatch told Licensee that there was no record of the incident, and the parking lot was in the Benson police department's jurisdiction. The Benson police department also did not have a record of the incident. Based on that information, Licensee included a statement in his Family Evaluation report ("Report") indicating he believes Fiancé, a "former under Sheriff", asked the deputy sheriff to approach Daughter and Licensee during the parking lot meeting. Licensee's decision to include a highly inflammatory statement about Fiancé in his Report without clear evidence was inappropriate. Mother provided information regarding Father's</p>	<p><b>Board Review 09/05/13; Board Action 09/13/13 Executed</b> <b>Consent Agreement and Order:</b> Stayed revocation; probation; within 12 months, shall take and pass a three semester credit hour graduate level course in family therapy ethics; 24 months 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.</p>
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<p><b>Dwayne Kruse</b> <b>LMFT-10273</b> <b>2011-0091</b> <b>2012-0035</b> <b>2012-0060</b></p>	<p>Case 2012-0035</p> <p>A 05/07 divorce decree gave sole legal and physical custody of a pre-teen boy ("Son"), to his father ("Father"), indicated Son was in need of therapy to re-establishing contact with his mother ("Mother"), and prohibited Mother from having any contact until she resumed treatment for her diagnosed mental health condition and participated in therapeutic visitation with Son. During Father's military deployments, Son stayed with Father's parents ("Grandparents"). In 06/10, Mother was granted limited unsupervised visitation with Son. In 08/01/11, Father committed suicide. On 08/10/11, Father's mother ("Grandmother") took Son to see Licensee at his private practice. Licensee completed an assessment of Son. Following his assessment, Licensee completed a report indicating he was asked to interview Son to assess his current mental emotional state due to his father's recent death, and to evaluate who Son wishes to have as his guardian. Licensee was informed the purpose was that Grandparents would be seeking an emergency ex parte order for the custody of Son. Son disclosed prior sexual and other abuse by Mother. Licensee was made aware that there has been a long custody battle. Before providing any type of services to Son, Licensee needed to take appropriate measures to ensure that Grandmother had legal authority to consent to Licensee's services. Father's suicide left Son without a legal guardian. On 08/08/11, Mother obtained a Court Order granting immediate physical and legal custody of Son to Mother and ordering Grandparents to immediately turn Son over to Mother. At the time Licensee completed his assessment, Grandmother lacked legal authority to authorize this service for Son. Licensee indicated, regarding his decision to assess Son, that Grandparents provided documentation indicating that they had "Power of Attorney." Instead, Licensee's records reflect that Grandparents' attorney faxed a copy of Father's will that appointed Grandmother to be Son's guardian. Father's desire, as expressed in his will, had no legal authority. This was a matter to be determined by the courts. Licensee's description of the documentation provided as "Power of Attorney" suggests that he did not understand the legal significance of the documents upon which he based his decision to see Son. It appears he accepted the will without any effort to confirm whether it, in fact, provided such authority to Grandparents. Following his session with Son, Licensee completed a report that contained a number of statements suggesting that it would not be appropriate for Mother to be given custody and that it was in Son's best interest for Grandparents to be given custody. On 08/10/11, Mother's attorney faxed Licensee a copy of Mother's Ex Parte Order. It appears Licensee was aware of Mother's Ex Parte Order when he completed his report given that he specifically indicated in his report: "[Licensee is] aware that mother has retained a lawyer and has an exparte [sic] granted for custody..." It also appears he was aware that Grandparents did not have custody as the report specifically indicated he was evaluating who Son wishes to have as his guardian and that Grandparents were seeking an emergency ex parte order for custody. Grandparents intended to submit Licensee's report to support their effort to obtain custody. During the assessment session, Son disclosed that he woke up one night when he was younger to Mother touching him inappropriately, and that Mother tried to kill him once. Licensee's records do not reflect that he inquired further or made any type of report regarding Son's abuse allegations. It appears Licensee failed to recognize his responsibility to file such a report. Licensee's informed consent for treatment form lacked required elements. Licensee did not maintain any type of progress note documenting his 08/10/11 session, as required.</p>	<p><b>Board Action See Above.</b></p>
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<p><b>Dwayne Kruse</b> <b>LMFT-10273</b> <b>2011-0091</b> <b>2012-0035</b> <b>2012-0060</b></p>	<p>Case 2012-0060 A 7 year old boy ("Son") has cerebral palsy, is wheelchair bound, and requires substantial assistance with activities of daily living. In 05/10, Son's mother ("Mother") and father ("Father") divorced. In 03/11, Mother had legal and physical custody of Son. Father had visitation with Son every other weekend. Father was in a relationship with a woman, ("Girlfriend"). On or about 03/29/11, Son alleged that a few days earlier he got into an argument with Girlfriend and she purposefully burned Son on the inner thigh with a cigarette lighter. Son had a mark on his inner thigh where he alleged Girlfriend had burned him. Following this alleged incident, Mother obtained an injunction to prohibit Girlfriend from having contact with Son and a Temporary Order suspending Father's parenting time. During an investigation of the alleged incident by law enforcement, Son and Mother made additional allegations, indicating Girlfriend had had been physically and verbally abusive on several occasions, had pointed a rifle at Son in the past, had shown Son nude pictures in a magazine and had touched him inappropriately on one occasion. Girlfriend denied all abuse allegations. Son's primary care provider reported Son's injury was consistent with a superficial burn and could not have been caused by a device on Son's wheelchair. On 05/26/11, Mother initiated Son's counseling with Licensee. The only consent for treatment Licensee maintained authorized him to provide treatment to Son. A Biopsychosocial form completed by Mother indicated Son had experienced physical, emotional, and sexual abuse and neglect by Girlfriend. Son indicated that prior to the burn incident he had fun playing games and going places with Father and Girlfriend. Mother became defensive when Licensee discussed Son's fondness and affection regarding Father and Girlfriend. When Licensee briefly spoke with Son alone, Son talked about wanting a relationship with Girlfriend and about forgiveness. Mother became upset and ended the meeting when Licensee stated that it appeared Son wished to continue a relationship with Girlfriend and Son is ambivalent about how he feels about Girlfriend, almost as if he feels he has to please mother to be upset about the burn. A 07/01/11 session was scheduled with Father and Son. Mother participated in some portion of the session and challenged Licensee's statement that it appeared Son wanted a relationship with Mother, Father, and Girlfriend. Father and Mother argued to the point that Licensee had to separate them. 07/05/11, Mother again participated in at least a portion of Licensee's session with Son. Licensee's documentation reflects that Mother said Son had regressed. Mother was angry and blamed Licensee for allowing Father to participate in a session with Son. 09/16/11, Licensee scheduled a session with Son and Girlfriend. For several days prior to this session, Mother repeatedly communicated to Licensee that Son did not want to go forward with the session. Licensee indicated Son clearly wanted to leave during the session and was fearful of Girlfriend. When she was brought in, Son screamed and cried and had to be taken out. Father came into Licensee's office after Girlfriend left. There was a scene outside the office when Father appeared. Given the complexity of the issues, it was imperative that Licensee work jointly with Mother to clearly define mutually agreeable goals of Son's treatment, explain the treatment methods/interventions he intended to employ, particularly those involving the participation of Father and/or Girlfriend, gain Mother's agreement to the use of those methods/interventions, and develop a written treatment plan where Mother's understanding and agreement was documented via her signature. Licensee did not develop any written treatment planning documentation in this case and there is no indication that he verbally reviewed any unwritten goals and objectives with Mother. The extent of Licensee's plan was written in the "Plan" section of his 05/26/11 progress note, which stated: "See [Son]"</p>	<p><b>Board Action See Above.</b></p>
<p><b>Kathleen Driscoll</b> <b>LPC-1563</b></p>	<p>On 08/19/13, Licensee contacted the Board and verbally reported that she was currently receiving treatment for alcohol-related issues at a substance abuse treatment agency.</p>	<p><b>Board Review 09/05/13; Board Action 09/05/13 Executed Consent Agreement and Order: Licensee agrees not to practice under her license</b></p>

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<p><b>Trisha McMahaon</b> <b>LPC-12450</b> <b>2012-0044</b></p>	<p>Licensee previously worked at an agency ("Agency"). Agency filed complaint against Licensee. Licensee was terminated for reasons relating to fraudulent billing and/or double billing. Agency determined that Licensee "had a pattern of documenting and billing multiple services as if they occurred during the same or overlapping timeframes." Agency's review of Licensee's billing documentation between 07/10-08/11 indicated there were 778 billed service events for Licensee with documented start or end times that overlapped with other billed events. This was 43% of Licensee's total billing. 581 claims that had to be voided or otherwise amended. As a result, Agency voided \$32,358 of Licensee's billings. Agency's research indicated that no other employees engaged in this practice. Staff was trained on Agency's electronic records system ("HMS"), which prompts the entry of a "start time" and "end time." Staff was trained to use "the straightforward meaning of the actual time the service started and the actual time the service ended." Licensee's practice of not reflecting accurate start times resulted in billing for services that did not actually occur. Agency provided Licensee with a copy of a spreadsheet/report demonstrating the overlapping billing. Licensee indicated she "was not aware that [Agency] required its counseling professionals to enter progress notes in 'real time' until her termination..." She "focused her attention on making sure she used the correct billing codes and that the progress notes accurately reflected the services she performed." While she usually entered progress notes "within the required 24 hour period", she billed multiple entries for the same time periods, not realizing that it mattered. She "entered her progress notes in this same manner the entire two years" that she worked at Agency. Licensee's representation that her billing irregularities were inadvertent is not credible. Agency's HMS requires start and end time of all services. There is no legitimate basis for Licensee's acknowledged failure to accurately record the start and end time of services she provided. 43% of the services Licensee documented overlapped with other events she billed for. By billing for overlapping service events, Licensee was able to increase her "productivity" at Agency. Licensee's supervisor at Agency ("Supervisor") alleged that, during a review of Licensee's clinical records after Licensee's was terminated, Agency discovered that Licensee was not completing clinical assessment documentation. A cursory review of Licensee's electronic records would reflect that they were complete. It appeared that Licensee attempted to make her client records look complete, when they were not. Licensee acknowledged that she did not always complete assessment documentation and indicated Supervisor instructed counselors that assessments be completed in 1 hour rather than the normal 2 hour time frame. As a result, some of Licensee's assessment documentation was incomplete. While Supervisor acknowledged that, as a result of workload demands, she instructed counselors to complete assessments in 1 hour, Supervisor also indicated that the time period for these shortened assessments only lasted approximately 3 weeks. Licensee's co-workers at Agency ("Co-Worker"), indicated the confirmed there was a short time-frame in approximately June/July 2011 when counselors were asked to do partial assessments because of a heavy workload. After counselors completed a partial assessment,</p>	<p><b>Board Review 09/05/13; Board Action 09/13/13 Executed Consent Agreement and Order:</b> Licensee's LPC license shall be surrendered. The surrender shall be considered a revocation of her license.</p>
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<p><b>Elizabeth Darland</b> <b>LMFT-0463</b> <b>2011-0046</b></p>	<p>On 09/26/09, a client (Client) presented for treatment with Licensee with depression, low self-esteem, anxiety, and feelings of hopelessness. Client engaged in self-injurious behaviors, including recent episodes of cutting her wrists and taking too many pills, though she denied that she was suicidal. It was Licensee's responsibility to conduct a timely and thorough assessment of Client to properly evaluate risk for suicide and develop safety plans as needed. Despite Client's risk factors, Licensee did not conduct any type of formal risk assessment during her initial assessment. Licensee met with Client again on 10/06/09 for an emergency session. Client talked about being sad and wanting to cut herself and/or take pills and told Licensee that she had "fired" her psychiatrist. Licensee again failed to conduct any type of formal risk assessment. On 10/07/09, Client's former therapist ("Counselor") advised Licensee that Client suffered from depression, anxiety, and panic attacks, had an Axis II diagnosis of Borderline Personality Disorder, and behaviors that included cutting and overdosing on medication. Licensee acknowledges that during a 10/10/09 session, Client stated she felt like killing herself, though this statement was not documented in her session progress note. Licensee again failed to conduct any type of formal risk assessment. Given Client's presenting issues, Licensee's failure to document client's suicidal statement or to conduct and document completion of a thorough suicide risk assessment was inappropriate. In her 10/06/09 progress note, Licensee documented a safety plan whereby Client agreed to call if she felt like hurting herself. During her Board interview, Licensee indicated that it was her understanding of the safety plan that, if Licensee was not available, she would return the call within 24 hours. The safety plan created for Client did not provide any information to clarify the nature and limits of the plan, such as number(s) to reach Licensee, or that Licensee would not always be available. It lacked an alternative plan if Client needed immediate help. Following their 10/10/09 session where Client told Licensee that she felt like killing herself, Client called Licensee at approximately 4:00 pm and requested a return call. Licensee did not respond. Client experienced an anxiety attack and called Licensee 13 more times between 10:39 pm and 12:40 am. Licensee did not respond and was not aware of Client's efforts to reach her until approximately 2:00 am on 10/11/09. As a result of an inadequate safety plan, Licensee did not begin efforts to address Client's safety until approximately 10 hours after Client first attempted to reach her. Licensee took no steps to ensure that she would be available to respond to a crisis if needed, such as using an answering service. Licensee indicated that she decided to terminate her professional relationship with Client when she realized that she was unable to address Client's issues. Licensee had the right to terminate her relationship with Client, but needed to do so in a manner that ensured an appropriate continuation of care for Client, which was particularly important given the nature and severity of Client's symptoms. At a minimum Licensee needed to advise Client of the need to transfer care to another provider, and provide referrals in such a manner as to minimize the risk of harm to Client. Licensee terminated Client's care by sending an email on 10/11/09 advising Client of that, based on Client's failure to call Licensee back between 8:00-9:00 am, she assumed that the "counseling contract" was "broken" and it was advisable for Client to see one of her other counselors and provided several referrals to other possible treatment providers. Licensee's decision to terminate her relationship with Client via email was inappropriate where Licensee's records do not reflect that the need to terminate the therapeutic relationship with Client was discussed or the names of alternative therapists provided prior to 10/11/09 or that she advised Client during their brief 4:20 am conversation that if Client did not call back between 8:00-9:00 am, she would terminate the therapeutic relationship. Licensee</p>	<p><b>Board Action 09/05/13 Consent Agreement and Order:</b> Licensee agrees not to renew her license when it expires on 05/31/13.</p>
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<p><b>David Robinson</b> <b>LAC-2450</b> <b>2013-0039</b></p>	<p>In 01/12, Licensee began treating a female client ("Client") who has Bipolar I Disorder. Client's clinical records indicated: alcohol and benzodiazepine abuse, 07/11 relapse leading to hospitalization, Suicide attempts; most recent suicidal ideation in 08/11, history of violence and threats toward clinical team, depression, mania, paranoia, and auditory hallucinations. Licensee reported that Client had also been a victim of rape. On 07/03/12, Licensee met with Client for an individual session. On 07/05/12, Client reported to Agency case manager ("CM") allegations of sexual advances, that Licensee told her she looked nice with make-up on, asked to sit closer to her, asked if she was having sex with her friend ("Friend"), and informed Client that if she was not having sex with Friend, then she should "at least let [Friend] fondle her." On 07/13/12, Agency supervisor, ("Supervisor") met with Client, who reported that Licensee told her she was beautiful, losing weight, and looked nice with make-up on, and told her to be intimate with Friend and to wear a black negligee on the trip to Sedona with Friend. Licensee asked, "Why, don't you enjoy sex?" and despite Client voicing her discomfort, he continued the discussion. Client reported that Licensee has re-traumatized her and she will never have a male therapist again. Licensee acknowledged, in his 8/12 written statement to the Board, that he attempted to use a Person-Centered approach and only discussed issues raised by Client. In their last session, he "deviated from a non-directive stance in my egregious attempt to normalize [Client's] concerns regarding sexual activity between consenting adults." He made these statements in belief that Client felt she was in a safe place, and that she understood that his unconditional positive regard for her as her therapist motivated his remarks and gestures. The fact that he traumatized Client is a source of personal pain and remorse. Licensee's statement that he felt Client was in a safe place and the implication that due to this, it was appropriate to make sexual remarks towards her, is seriously concerning. In 08/12, Agency issued a Corrective Action Notice which required Licensee to transfer to another co-located site, complete training on ethics and boundaries, and obtain additional training on working with Axis II clients and clients of the opposite sex. On 10/24/12, Licensee was terminated due to failure to complete the required corrective actions trainings. During his 02/26/13 investigative interview, Licensee acknowledged that Client's primary trauma was a rape and he was working to get beyond that rape. He acknowledged making the statements alleged in the 07/06/12 Incident Report and that his comments and suggestions were not appropriate and not about Client. He lost track of Client and psychologically was talking to his daughter ("Daughter"), who is approximately the same age as Client, and also has Bipolar Disorder. His last relationship with Daughter was in 2007 and it was normal for them to discuss her sexual relationships. Licensee wanted to sit close to Daughter, so he asked Client to sit closer to him. He asked Client if she was having sex with Friend because he was thinking about his Daughter's sexual relationships. "You should at least let him fondle you" is not an appropriate statement to make to Daughter or Client. That statement is an expression of Licensee's anger toward Daughter. He acknowledged that he told Client to wear a black negligee on a trip with Friend, which again involved his Daughter and not Client. He asked Client "why, don't you enjoy sex" because he was off course and cannot provide any other explanation. Despite Client indicating she was uncomfortable, he proceeded with the conversation and recalls thinking "good, you should be uncomfortable". Licensee had an alarm go off in his head telling him to stop but surrendered to the situation. He is confident he could prevent future incidents by controlling his thinking. Licensee's conduct appears inappropriate and particularly problematic considering it appears that Licensee experienced counter-transference when working with Client. His statements</p>	<p><b>Board Review 09/05/13; Board Action 09/13/13 Executed Consent Agreement and Order:</b> Licensee's LPC license shall be surrendered. The surrender shall be considered a revocation of his license.</p>
<p><b>Jamie Hestrup</b> <b>LMSW-12217</b> <b>2013-0091</b></p>	<p>On 10/05/07, Licensee made the decision to drive after consuming several alcoholic drinks. Licensee was arrested for Extreme DUI with a BAC of .157%. Given her current weight, that is the equivalent of 5-6 alcoholic drinks in Licensee's system at the time she was tested. On 10/23/07, she pled guilty to DUI Impaired to the Slightest Degree. In her 04/17/13 investigative interview, Licensee indicated that she had waited approximately 4 hours after her last drink to drive and did not feel intoxicated as she was driving home. She will have a few glasses of wine on the weekends, 2 to 4 times per month. Since her 2007 DUI, she does not drive after drinking. Licensee failed to report her arrest to the Board within 10 days, as required. On 05/04/09, Licensee disclosed her</p>	<p><b>Board Action 09/05/13: Order of Censure.</b></p>

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<p><b>Jesus Mata</b> <b>LISAC-10010</b> <b>2012-0009</b></p>	<p>Licensee co-founded a behavioral health agency ("Agency"). Agency is not OBHL licensed. Licensee acknowledges that all of his clients at Agency receive therapy to address gambling addiction issues. As a Licensed Independent Substance Abuse Counselor ("LISAC"), Licensee is prohibited from providing any type of therapy services unrelated to substance abuse/chemical dependency issues. Given his limited scope of practice as a LISAC, his gambling addiction practice violates A.R.S. § 32-3251(10). Licensee asserts that he is qualified to provide this treatment because his substance abuse license qualifies him as a provider under the Office of Problem Gambling ("OPG") standards. OPG standards for qualifying a professional to receive reimbursement for gambling addiction treatment are irrelevant to the issue of whether the scope of practice for a LISAC extends to non-substance abuse related addictions. Licensee did not identify any steps to ensure he was in compliance with his LISAC scope of practice, such as contacting the Board, before he established a private practice focusing exclusively on gambling addiction issues. Licensee's records reflect that he discussed a number of serious behavioral health issues with two clients that were not addiction related. One client's ("Client 1") treatment plan and progress notes reflect that Licensee's treatment addressed Client 1's history of childhood sexual abuse. Another client's ("Client 3") treatment plan and progress notes reflect that treatment addressed Client 3's family of origin and eating disorder issues. Licensee's failure to recognize that these non-addiction related issues were outside his scope of practice as a LISAC and provide appropriate referrals to Client 1 and 3 to a qualified provider appears seriously inappropriate. During their assessments by Licensee, another client ("Client 2") and Client 3 presented with recognized risk factors for suicide. Client 2 indicated he had last thought about suicide within the previous 2 weeks. Client 3 indicated she had last thought about suicide within the previous week. Both indicated that they were currently experiencing both depression and anxiety. Despite the fact that they presented with known risk factors, Licensee did not attempt to obtain any additional information regarding the nature and/or extent of their risk. In accordance with accepted guidelines for suicide risk assessments, once Clients 2 and 3 presented with any known suicide risk factors, a specific risk assessment should have been immediately completed in order to provide the information needed to properly evaluate the level of risk presented. Licensee indicated that he did not inquire further because neither indicated any current suicide ideation or that they had a plan. Licensee's rationale for not completing a thorough suicide risk assessment appears inadequate where: Both clients indicated suicide ideation within the previous 2 weeks and the absence of a plan is not determinative with regard to the extent of the risk. Licensee's failure to complete/document a thorough risk assessment for Client 2 and 3 during his initial assessment was inappropriate. On 07/24/12 and 07/31/12, Licensee and Client 1 created a "safety plan." Licensee did not document any other information regarding the nature or substance of the safety plan and has indicated that he did not retain a copy it. Given that "safety plans" typically involve issues concerning potential safety risks to clients, Licensee's failure to document any information regarding Client 1's safety plan other than its existence was inappropriate. Licensee's records reflect that he conducted a number "family sessions" during his treatment of Client 1 and Client 2. Although Licensee identified "family sessions" involving individuals other than Client 1 and Client 2, it is impossible to determine the nature of these sessions. It is not clear that these other individuals were clients, as Licensee did not have them complete any consent for treatment documentation. Licensee did not document any information clarifying the purpose of their participation in treatment. The consent for treatment documentation that Licensee maintained for Clients 1, 2, and 3 does not</p>	<p><b>Board Review 09/05/13; Board Action 09/13/13 Executed Consent Agreement and Order:</b> Licensee agrees not to renew his license when it expires on 06/30/14. Within 14 days of the effective date of this Consent Agreement, Licensee shall submit a written plan for terminating his private practice for pre-approval.</p>
<p><b>Mary Ann Turner</b> <b>LCSW-10951</b> <b>2010-0018</b></p>	<p>See 2012 Adverse Action Report.</p>	<p><b>Board Action 07/12/12: The stayed revocation was lifted and Licensee's license was revoked, executed order 07/25/13</b></p>

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<p><b>William Baird</b> <b>LASAC-13328</b> <b>2014-0009</b></p>	<p>Licensee has a history of five DUI arrests. Four of the arrests occurred between 12/07 and 01/09. Law enforcement reports for two of these arrests indicated that in addition to alcohol, Licensee had taken Vicodin, and/or Ambien prior to his arrest. In 06/13, Licensee reported a 09/09 sobriety date. In 08/13, Licensee was employed at an agency ("Agency") that provides substance abuse treatment. On 08/16/13, the Board received a complaint from Agency indicating that on 08/14/13, Licensee appeared to be impaired while conducting an Agency intensive outpatient therapy group. Licensee was removed from conducting the group and met with Agency administrative personnel at 1 pm on 08/15/13. Licensee arrived at the meeting "clearly impaired" and stated he could not provide a urine sample. Licensee admitted that he had been using benzodiazepines. Licensee was subsequently terminated. On 08/19/13, Licensee contacted the Board and verbally reported that he had relapsed and had gone to work while impaired. On 8/27/13, Licensee contacted the Board and indicated</p>	<p><b>Board Review 09/05/13; Board Action 09/13/13 Executed Consent Agreement and Order:</b> Licensee's LASAC license shall be surrendered. The surrender shall be considered a revocation of his license.</p>
<p><b>Lindsey Casdorff</b> <b>LSAT-Applicant</b> <b>2013-0095</b></p>	<p>Applicant acknowledged using alcohol occasionally since age 8, using cocaine several times at age 14, and from 14-20 years old using marijuana "consistently almost every day or two". During that timeframe, there was also admitted methamphetamine and heroin use, and at least one 30-day stay in a treatment center for methamphetamine addiction. A substance use test following the birth of her child in 2008 revealed marijuana usage, so the hospital contacted Child Protective Services (CPS). They required that applicant attend substance abuse treatment through an OBHL licensed facility ("Facility"). Applicant completed Facility's program in 2008. In a written statement to the Board, she reported that 05/23/07 was her last methamphetamine use, but medical records reflected additional usage in 2009. Applicant stated that she currently drinks two times a month and is not currently engaging in any formal relapse prevention efforts. The Board found the oral and written misrepresentations regarding the sobriety date from meth was seriously inappropriate, and given the applicant's long term substance abuse history and lack of relapse prevention efforts, her continued alcohol use was</p>	<p><b>Board Action 07/12/13:</b> Applicant's LSAT application was denied based on unprofessional conduct.</p>
<p><b>Justin Ashbridge</b> <b>LAC-Applicant</b> <b>2014-0004</b></p>	<p>In May of 2012, the Board denied applicant's LAC application because of ongoing behavioral health issues that interfered with his ability to function at work/school, his termination from two agencies ("Agency 1" and "Agency 2"), and his misrepresentation to another agency ("Agency 4") regarding his termination from Agency 1. He was also removed from a master's program in 2008, and in 2011 admitted to marijuana and alcohol use. Since that time, he has reported that he is still drinking occasionally, even though he's aware of the warnings on his current prescription medication of the possibility of adverse affects. He discontinued regular therapy with his therapist ("Therapist") in November of 2012 despite his diagnosis of idiopathic anxieties, mild depression, and neurotic anxiety. The decision to stop therapy and continued alcohol use combined with prescription medication is</p>	<p><b>Board Action 09/05/13:</b> Applicant's LAC application was denied based on unprofessional conduct.</p>
<p><b>Abilash Pulicken</b> <b>LAC-Applicant</b> <b>2014-0003</b></p>	<p>From February to May of 2012, applicant was employed by an agency ("Agency") working with residential clients ages 11-17 with behavioral, substance abuse, and psychiatric issues. Applicant was released from Agency's employ because of misconduct involving a lack of boundaries with the clients, unethical behavior, a breach of confidentiality, HIPAA violation, and unprofessionalism. Applicant admitted to his part in the incident which included taking pictures on his iPhone with the clients and emailing them to former clients outside the Agency who eventually posted the pictures on social media revealing some of the clients' names and the identity of the treatment center. His actions violated the rights of minor clients to have their identity and participation in</p>	<p><b>Board Action 08/13/13:</b> Applicant's LAC application was denied based on unprofessional conduct.</p>

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<p><b>Karim Moabi</b> <b>LASAC-Applicant</b> <b>2013-0088</b></p>	<p>On his January 2012 LASAC application, applicant self-disclosed being charged with Attempted Possession of Drug Paraphernalia in June of 2011 at a border patrol checkpoint. He reported that an "empty wrapper" was found in a vehicle he was driving back from California and he was unaware of its presence. During the Board's investigative process, he was requested to get the full police report from the incident, but failed to do so. Instead he provided a written statement on 12/17/12 indicating that the Yuma County Sheriff's Office told him his ticket constituted the police report. When Board staff obtained the actual police report, it revealed that he had originally been charged with Attempted Possession of Marijuana for having (6) 1.1 gram bags of marijuana. Yuma County Sheriff's Office communicated to Board staff that applicant visited their office on 12/06/12 to request a copy of the report and it was mailed to him approximately one week later. The police report also showed his confirmation that the vehicle and marijuana were his. When he was employed at the agency ("Agency") he was working at when he was arrested, he signed employment papers acknowledging his understanding that there was zero tolerance for the use of illegal substances by employees. Agency also had a policy that employees were expected to notify Agency immediately if they were charged or convicted of a list of crimes. "Possession, use or sale of marijuana" and "possession, manufacture, delivery, and advertisement of drug paraphernalia" were both included on the list. Applicant failed to report his 06/11 arrest or 12/11 conviction to Agency. In a 12/17/12 written statement, applicant indicated that he had purchased marijuana to assist with sleep. He had used it a few times and stopped. In an 01/04/13 investigative interview with Board staff, applicant reported that he had used marijuana until late 2010 or early 2011. This was in contradiction to the fact that he had marijuana in his possession in June of 2011. Applicant displayed a pattern of misrepresentation, a lack of</p>	<p><b>Board Action 07/12/13:</b> Applicant's LASAC application was denied based on unprofessional conduct.</p>
<p><b>Mary Demetrovich</b> <b>LMSW-Applicant</b> <b>2014-0014</b></p>	<p>In October 2003, applicant submitted a Certified Master Social Worker ("CMSW") application which was approved in December 2003. On that application, applicant reported that she did not use any illegal substances. In July of 2004, that certification was converted to a Licensed Master Social Worker ("LMSW") license which was subsequently renewed in 2005, 2007, and 2009. On each renewal request, applicant again denied any use of illegal substances. In July of 2002, applicant began working at an agency ("Agency 1"). While at Agency 1, she was counseled for policy violations, work quality problems, inappropriate conduct, and insubordination. She was involuntarily terminated in April of 2008. On her 2009 LMSW renewal, she listed her reason for separation from Agency 1 as "administrative closure". Applicant was arrested in May of 2010 for an offense that required reporting to the Board within ten days, but applicant failed to do so. Applicant allowed her LMSW license to expire on 11/30/11. In April of 2012, she was involuntarily terminated from her position with another agency ("Agency 2"). In January of 2013, applicant submitted a LMSW application to the Board. At that point she disclosed her 05/10 arrest and her 04/08 termination (but still listed the reason as "administrative closure"), but she failed to disclose her 04/12 involuntary termination, instead listing the reason as "conflict of care". Through Board investigation, treatment records showed (and applicant admitted to) continual marijuana use since 1999. With the exception of a period from August 2011 - August 2012 (when she was issued a medical marijuana card), the substance use was illegal. She also acknowledged that she should have reported this on her 2003 CMSW application and subsequent renewals in 2005, 2007, and 2009, and her 2013 LMSW application.</p>	<p><b>Board Action 11/07/13:</b> Applicant's LMSW application was denied based on unprofessional conduct.</p>
<p><b>John Jaksich</b> <b>LAC-Applicant</b> <b>2014-0011</b></p>	<p>On applicant's November 2012 LAC application, he disclosed a long history of alcohol abuse, treatment, and relapse. On his application, he listed his sobriety date as August of 2010. During Board investigation, it was uncovered that he relapsed again in May of 2013 and went to work at a substance abuse treatment center while impaired. There was an additional relapse in July of 2013 and an admission for detox. Applicant discharged from detox center against medical advice, and stated in a Board interview that he was not currently participating in the recommended treatment program.</p>	<p><b>Board Action 11/07/13:</b> Applicant's LAC application was denied based on unprofessional conduct.</p>

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<p><b>David Watts</b> <b>LMSW-Applicant</b> <b>2013-0089</b></p>	<p>Applicant has a criminal history including convictions for DUI in January 2005 (original charge was Extreme DUI for blood alcohol count of .26), Disorderly Conduct - Weapon/Instrument in August 2005 (original charge was Aggravated Assault with a Deadly Weapon), and DUI and Endangerment in September 2009 (original charge was DUI and Unlawful Flight from Law Enforcement). He was also charged with Disorderly Conduct - Disturbance in February 2010 which was later dismissed. On his October 2012 LMSW application, he failed to disclose the Extreme DUI and Disorderly Conduct - Disturbance charge. Board staff requested additional information on his criminal history and his written statement again omitted these two charges. Applicant could not report an exact sobriety date and reported that he no longer attended AA or had a sponsor. He was not engaged in any formal relapse prevention efforts even though most of his criminal charges involved alcohol</p>	<p><b>Board Action 07/12/13:</b> Applicant's LMSW application was denied based on unprofessional conduct.</p>
<p><b>Terri Waibel</b> <b>LMSW-13651</b> <b>2011-0034</b></p>	<p>See 2012 Adverse Action Report.</p>	<p><b>Board Action 12/10/13:</b> The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 07/17/12.</p>
<p><b>Suzanne Schunk</b> <b>LCSW-10194</b> <b>2011-0142</b></p>	<p>See 2013 Adverse Action Report.</p>	<p><b>Board Action 12/10/13:</b> The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 09/13/13.</p>
<p><b>Kristen Ray</b> <b>LAC-13433</b> <b>2012-0149</b></p>	<p>See 2012 Adverse Action Report.</p>	<p><b>Board Action 12/10/13:</b> The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 09/11/12.</p>
<p><b>Tara Boocheck</b> <b>LPC-12785</b> <b>2012-0045</b></p>	<p>See 2012 Adverse Action Report.</p>	<p><b>Board Action 12/10/13:</b> The Board released the Licensee from all terms and conditions of the Consent Agreement and Order dated 03/19/12.</p>
<p><b>Roman Zepeda</b> <b>LISAC-0465</b> <b>2014-0016</b></p>	<p>On 10/07/13, Board received a complaint from a current client ("Client") being treated by Licensee for alcohol abuse and depression stating that Licensee has had sexual intercourse with her on multiple occasions. When questioned, Licensee admitted to having sexual intercourse with Client.</p>	<p><b>Board Review 11/07/13; Board Action 11/08/13 Executed Consent Agreement and Order:</b> Licensee's LISAC license shall be surrendered. The surrender shall be considered a revocation of his license.</p>

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<p><b>Kelly O'horo</b> <b>LPC-14378</b> <b>2013-0079</b></p>	<p>while employed at an agency ( Agency ), Licensee provided counseling to a client ( Client ) from 11/18/11 to 05/22/13. Client owns a chiropractic practice ("GPM"). Licensee received treatment at GPM from 9/10/12 to 12/06/12. Licensee indicated the following with regard to her decision to receive treatment at GPM at the same time that Licensee was treating Client: Client advised Licensee that GPM offered a new type of treatment that could relieve Licensee's pain and chronic headaches, GPM was located in the same town as Agency, at the time, the closest other chiropractor offering this specialized treatment was a 25-minute drive away. Client assured Licensee that Licensee could receive this treatment from other individuals working at GPM, not Client. Licensee discussed the issue with her supervisor at Agency ("Supervisor"), who did not forbid Licensee from entering into a dual relationship with Client. Licensee believed that she exercised appropriate due diligence before making the decision that it was acceptable for her to receive treatment at GPM. However, on five separate occasions, Licensee was treated by Client at GPM. Around the beginning of 11/12, Licensee sought guidance from another counselor ("Counselor A"). Licensee planned to stop receiving care from Client, but Licensee wanted Counselor A to seek advice from a different counselor ("Counselor B") regarding how to best follow through with the termination. Counselor A responded to Licensee within two weeks and indicated that Counselor B thought that Licensee should terminate her chiropractic care at GPM and refer out Client to another therapist On 11/15/12, Licensee documented that Counselor A and Counselor B both thought Licensee needed to terminate her dual relationship with Client and Counselor B advised her to refer Client out to another therapist. Despite having received these recommendations in response to her efforts to clarify her ethical responsibilities, Licensee continued to receive treatment at GPM through 12/06/12. Licensee did not provide any explanation for this delay. Licensee chose not to act on Counselor B's recommendation that she refer Client to another therapist and, instead, continued to treat Client through 05/13. Licensee indicated that she did not follow Counselor B's recommendation because she thought Client was too deep into her family of origin work to stop treatment with Licensee at that point. Licensee acknowledges that she did not maintain a progress note for an 08/29/12 session with Client. Licensee believes that no progress note exists for the 08/29/12 session because the note "didn't save" on the computer program Licensee uses for documentation. It is Licensee's responsibility to ensure that all progress notes entered into an electronic system are properly saved. Licensee acknowledges that she did not have a process for signing her incidental notes.</p>	<p><b>Board Review 11/07/13; Board Action 11/08/13 Executed</b> <b>Consent Agreement and Order:</b> The Licensee's license will be placed on probation for 12 months; complete 6 clock hours of continuing education addressing behavioral health ethics and dual relationships, and 3 clock hours of continuing education addressing current behavioral health documentation standards in Arizona; 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.</p>
<p><b>Jeffrey Schill</b> <b>LAC-13468</b> <b>2012-0102</b></p>	<p>In 12/11, Licensee acknowledged that he was caught consuming alcohol at Agency 1 during work hours. Licensee was drinking heavily during this timeframe. His EAP counselor recommended treatment. Licensee began treatment on 01/23/12, but continued drinking. Licensee completed residential treatment at Agency 2 in 02/12. Agency 2 recommended continued therapy, 12-step meeting attendance several times per week, and completion of an online relapse prevention program. Licensee returned to work at Agency 1 on 03/07/12. Agency 1 has required Licensee to complete random drug screening for 1 year. During the past 13 months, Licensee has attended AA meetings 2-5 times every week, obtained a sponsor, and participated in an online aftercare program. Board and Licensee entered into an Interim Consent Agreement on 06/07/12 suspending his license. Based on information provided by Licensee, it appears that he has established a 13 month period of sobriety.</p>	<p><b>Board Review 06/06/13; Board Action 06/07/13 Executed</b> <b>Consent Agreement and Order:</b> Released Licensee from ICA; Licensee's license will be placed on probation for 24 months; practice only at an OBHL licensed facility; attend individual counseling for 24 months; meet with therapist twice monthly; attend AA meetings 2 times per week; 24 months medication management; \$1,000 civil penalty stayed pending compliance with the terms of this Consent Agreement and Order.</p>
<p><b>Wendy May</b> <b>LASAC-13178</b> <b>2014-0019</b></p>	<p>On 10/29/13, the Board received a complaint from Agency that alleged the following: On 09/30/13, Licensee resigned from Agency. Following Licensee's resignation, Licensee admitted that she allowed Client to stay in her home on some weekends. Client's probation officer ("PO") reported that Licensee helped Client move into his apartment. Licensee was listed as an emergency contact on Client's apartment rental agreement. Licensee acknowledged having a personal relationship with Client.</p>	<p><b>Board Review 11/07/13; Board Action 12/10/13 Executed</b> <b>Consent Agreement and Order:</b> Licensee's LASAC license shall be surrendered. The surrender shall be considered a revocation of her license.</p>

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<p><b>Andrea L. March</b> <b>LMSW-12753</b> <b>2012-0084</b></p>	<p>In 12/10, Licensee was arrested for extreme DUI. Her BAC result was .181. Licensee failed to report her extreme DUI to the Board within 10 days, as required. In 05/11, Licensee reported drinking 2 to 4 "cocktails" twice a month. Board and Licensee entered into an Interim Consent Agreement on 02/24/12 which suspended her license. Since the ICA, Licensee has fulfilled her court ordered sentencing requirements and appears to be stable.</p>	<p><b>Board Review 04/04/13; Board Action 04/22/13; Executed Consent Agreement and Order:</b> Released Licensee from ICA; Licensee placed on probation for 12 months; within 12 months, complete a 3 credit hour graduate level course in addiction counseling; 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.</p>
<p><b>Yvonne Culp</b> <b>LMSW-11341</b> <b>2013-0032</b></p>	<p>In 02/11, Licensee was arrested for DUI. In a 04/11 written statement to the Board, Licensee indicated the following regarding the night of her arrest: Licensee had 2 glasses of wine with appetizers and dinner and then coffee with dessert. After dinner, Licensee went to a friend's house. Licensee had one glass of wine while at her friend's house, but her friend might have "topped it off." During a 08/12 investigative interview, Licensee indicated the following: Licensee acknowledged consuming four glasses of wine between 6:00 p.m. and the time of her arrest at 11:37 p.m. Licensee indicated that "four" would have been the maximum number of drinks that she had all evening. Licensee denied feeling intoxicated or impaired when she tried to drive home. Licensee did not feel impaired before taking two breathalyzer tests and did not agree with the results of those tests. Licensee does not believe she has an alcohol abuse problem and has not discontinued her use of alcohol. Licensee's BAC when she was tested at 12:42 a.m. was .168 and .170. At her current weight, Licensee had the equivalent of 4.5 alcoholic drinks in her system approximately one hour after she was stopped. Given the half-life of alcohol in the body, it appears that Licensee did not accurately report to the Board how much she had to drink prior to her arrest. Licensee's statements that she did not feel intoxicated or impaired before driving suggests that Licensee has developed a high tolerance for alcohol.</p>	<p><b>Board Action 09/17/13 Executed Order and Consent Agreement:</b> Formal hearing was held on September 5, 2013. Licensee's license will be placed on probation for 24 months; within 12 months, complete 3 clock hours of continuing education addressing addictions; monthly attendance at M.A.D.D. meetings; 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.</p>

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<p><b>Jean Collins-Stuckert</b> <b>LISAC-10022</b> <b>2012-0140</b></p>	<p>At the time of the events in the complaint, Licensee was a LISAC in private practice. In 10/11, the Board received a Licensed Master Social Worker application from an applicant ("Client"). Client identified Licensee as a treatment provider. Licensee began treating Client in 09/08. Client's 09/03/08 Presenting Problems Form indicated that she suffered from multiple symptoms including suicidal thoughts. Client did not present any substance abuse concerns. Licensee's 09/08 treatment plan for Client included the following diagnosis: Mood disorder, 309.91 (PTSD), 307.50 (Eating Disorder NOS). Licensee's 07/11 treatment plan for Client included the following diagnosis: 296.90 (Mood Disorder NOS), 307.50 (PTSD), 309.81 (eating disorder NOS), 302.9 (sexual disorder NOS in remission). Neither Client's 09/03/08 Presenting Problems Form or Licensee's 09/08 or 07/11 treatment plans for Client identified any substance abuse related issues. Licensee acknowledged that, in treating Client, she practiced outside of her scope of her practice as a LISAC, but indicated that she did so unknowingly. As an independent therapist in private practice, it is Licensee's responsibility to conduct timely and appropriate assessments of all of her clients. Despite the fact that Client disclosed that she was having suicidal thoughts when she began treatment, Licensee did not record an assessment of Client's suicide risk. Licensee documented that Client reported suicide ideation on the following dates: 09/24/08, 06/22/10, 02/10/11, and 03/14/11. In addition, Licensee documented that Client has several significant suicide risk factors. Despite Client's multiple reports of suicide ideation and the presence of multiple risk factors, Licensee did not record a formal suicide risk assessment during the entire 3.5 years she treated Client. The consent for treatment documentation that Licensee maintained for Client does not include the following required elements: 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. The treatment planning documentation that Licensee maintained for Client does not include a date when the treatment plan shall be reviewed, as required. Although Licensee treated Client from 09/08 to 05/12, the only treatment plans she maintained were dated 09/08 and 07/11. Licensee failed to maintain, at a minimum, annual treatment plans, as required. Licensee's progress notes do not identify the date signed, as required. The written release of information authorizations that Licensee maintained for Client did not include an expiration date not to exceed 12 months, as required. After the Board initiated its investigation, Licensee: Sought supervision from another independently licensed Behavioral Health Professional and completed 7, hour-long supervision sessions addressing topics including the following: clarification of clients appropriate for treatment by a LISAC, deciding which of Licensee's private practice clients were appropriate for transfer, discussion of how to conscientiously dissolve Licensee's private practice, improvement of Licensee's intake forms and psychosocial assessment, including suicide risk factors and documentation skills. Licensee completed 9 continuing education units in Ethics and Substance Abuse and 2 continuing education units in substance abuse and suicide prevention. In 09/12, she dissolved her private practice. As of 10/12, Licensee has been employed as the Director of</p>	<p><b>Board Review 09/05/13; Board Action 10/10/13 Executed</b> <b>Consent Agreement and Order:</b> Licensee's license LISAC-10022 will be placed on probation; within 12 months, complete 3 graduate level credit hours addressing diagnosis, assessment and treatment; 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.</p>
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<p><b>Yolanda Harvey</b> <b>LCSW-12887</b> <b>2012-0064</b></p>	<p>In 03/10, an agency ("Agency") that provides publicly-funded behavioral health services and is licensed by the Office of Behavioral Health Licensure ("OBHL") hired licensee as a Clinical Supervisor. Beginning in late 2011, in accordance with Agency's contract with Cenpatico (a Regional Behavioral Health Authority) Agency began conducting Intake assessments on newly enrolled public behavioral health system clients. Cenpatico mandated that Agency staff members whose job duties included performing Intake assessments be credentialed as Certified Assessors. The Agency was required to implement a Certified Assessor credentialing process. An independently licensed Behavioral Health Professional ("BHP") was required to observe the assessor complete 3 general assessments for them to be credentialed as a General Assessor, and 3 assessments on children ages 0-5 to become a 0-5 assessor. The BHP was required to complete an observation form for each observed assessment. At the completion of the required observed assessments, the Licensee was required to sign an Attestation Form identifying the dates of all completed observed assessments and rating the skill levels in a number of identified areas. Licensee was the only Agency staff member qualified to complete the attestation forms in two southern Arizona locations. Agency depended on Licensee to ensure that non-certified staff successfully completed the observed assessments to become a General Assessor and a 0-5 Assessor. Agency had advised Licensee that Agency staff members who were already Certified Assessors could complete observed assessments of other Agency staff members. If Licensee personally observed an assessment, she was to complete the required observation Form, but if another Certified Assessor ("BHT Certified Assessor") observed an assessment, that individual was to complete the Observation Form and provide it to Licensee for her review, acceptance, and signature. In 08/11, Agency reported to the Board that it had been discovered that, on more than one occasion, Licensee had "falsified Behavioral Health observations in order for staff to be certified to perform assessments". There were several instances found in investigation when Licensee had attested to observations that never took place. There were also instances where Licensee attested to observing assessments on dates/times that it was later confirmed there were no assessments done. Licensee maintained that Agency Director ("Director") decided on a procedure that she was comfortable with...which was allowing other Behavioral Health Technicians (BHT) to do most of the observations. Licensee was mainly responsible for the attestation. As the Independently licensed Clinical Supervisor signing Observation and Attestation Forms for Agency BHTs, it was Licensee's professional responsibility to ensure that she understood and was in compliance with Certified Assessor credentialing requirements. Licensee was allowed to resign in lieu of involuntary termination in 08/11. When she applied with another agency ("Agency 2"), she listed her reason for leaving Agency as, "Resigned for personal reasons, and anticipated restructuring deleting my position". She was hired with Agency 2 as a Long-term Care/Behavioral Health Case Manager. On her 11/11 LCSW license renewal application, she correctly identified her reason for separation from Agency as a resignation in lieu of termination. On a 12/22/11 Disclosure and Authorization Release Form allowing a screening service to perform an</p>	<p><b>Board Review 11/07/13; Board Action 11/08/13 Executed Consent Agreement and Order:</b> Licensee's license will expire by rule on 11/30/13. Licensee agrees not to renew it and will not reapply for a minimum of 5 years. Licensee shall not accept any new clients and will close her private practice within 30 days of the effective date of Consent Agreement.</p>
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<p><b>Ben Gallaway</b> <b>LISAC-0759</b> <b>2010-0128</b></p>	<p>Licensee maintains a private psychotherapy practice ("Practice"). As a licensed independent substance abuse counselor, Licensee's statutory scope of practice is limited to psychotherapy as it relates to persons/families experiencing substance abuse, chemical dependency and related problems. Licensee is prohibited from providing any type of psychotherapy unrelated to substance abuse/chemical dependency issues. Statements on Licensee's website represent that he provides therapy to address non-substance abuse issues, including the following: Drug Addiction, Sex Addiction, Codependency, Grief, Trauma and Couples Issues. Licensee's website listed various "workshops" he provides including the following: "Fat, Sick and in Recovery", "Men's Sexual Addiction Workshop", "Couples Renewal", "Treatment Enhancement", and "Customized Intensive". Licensee indicated the following with regard to the workshops he provides: he can provide psycho-educational services addressing issues falling outside his limited psychotherapy scope of practice because the informed consent for treatment form for his workshops provides as follows: "Our Workshops and Intensives are psycho-educational in nature. We are not an Inpatient or Outpatient Treatment Facility. Due to licensure we adhere to guidelines that govern counselors within our permitted focus in the State of Arizona. Our workshops and intensives are educational and any overnight stay is voluntary." In order to provide psycho-educational services addressing issues falling outside his limited LISAC scope of practice, the burden is on Licensee to ensure that his workshops are limited to psycho-educational activities only. Licensee's website includes statements indicating that his workshops are, at least in part, therapeutic, including the following: "Our workshops are held in a safe &amp; confidential setting...[have] 8 beds only, ensuring a good client-to-counselor ratio...experiential therapy and use of addiction treatment models make for a unique educational experience." The forms Licensee uses for his workshops also include language indicating the services are, at least in part, therapeutic, and the informed consent form Licensee uses for his workshops is nearly identical to the informed consent form used for his therapy clients. Licensee was unable to provide any curriculum or syllabi regarding the psycho-educational material provided during his workshops. Licensee did not maintain any record of the actual services provided to workshop participants. During Board investigation, at least 6 different client files were examined that had no chief complaint of substance abuse. The informed consent for treatment form Licensee uses in his therapy practice lacks the following required elements: purpose of treatment, general procedures to be used in treatment, including benefits, limitations, and potential risks, method for a client to obtain information about the client's records, and a client's right to refuse any recommended treatment or to withdraw informed consent to treatment and to be advised of the consequences of such refusal or withdrawal. None of the records Licensee provided for his therapy clients contain any type of treatment planning documentation even though Licensee treated some of these clients for several years. Licensee's progress notes lack the following required elements: the duration of time spent providing the behavioral health service, whether the counseling was individual</p>	<p><b>Board Action 09/11/13 Executed Order and Consent Agreement:</b> Administrative hearings held at the Office of Administrative Hearings on 3/15/13, 3/18/13, 4/25/13, and 5/30/13. Final Board review on 9/05/13 Licensee's license will be suspended for 24 months; complete a minimum of 12 months of supervised work experience in an agency licensed as an outpatient clinic by the OBHL; Minimum of 12 months of clinical supervision; within 12 months, complete 3 clock hours of ethics training, 3 clock hours of documentation training, and 3 credit hour course in assessment, diagnosis, and treatment planning. Licensee responsible for all Board's costs of hearing.</p>
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