

**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH  
BUREAU OF REGULATORY SERVICES**

In re: George Gorton, C.I.S.W.

Petition No. 941011-58-012

**CONSENT ORDER**

WHEREAS, George Gorton of Gales Ferry (hereinafter "respondent") has been issued license number 001953 to practice as an independent social worker by the Department of Public Health (hereinafter "the Department") pursuant to Chapter 383b of the Connecticut General Statutes, as amended; and,

WHEREAS, the Department alleges that:

1. During October and November of 1993, while evaluating a minor for possible sexual abuse, and in his subsequent treatment of this minor and her brother, respondent failed to maintain appropriate boundaries with both of these children, which boundary violations did not involve physical or sexual contact.
2. The above described facts constitute grounds for disciplinary action pursuant to Connecticut General Statutes Section 20-195p.

WHEREAS, respondent, in consideration of this Consent Order, has chosen not to contest the above allegations of wrongdoing but, while admitting no guilt or wrongdoing, agrees that for purposes of this or any future proceedings before the Commissioner of Public Health (hereinafter "the Commissioner") the above allegations in this Consent Order shall have the same effect as if proven and ordered after a full hearing held pursuant to §19a-9, §19a-14, and §20-195p of the General Statutes of Connecticut.

NOW THEREFORE, pursuant to §19a-17 and §20-195p of the Connecticut General Statutes, as amended, George Gorton hereby stipulates and agrees to the following:

1. That the terms and conditions of probation outlined in the Memorandum of Decision in Petition 930408-58-001, finalized on June 4, 1996, (a true and complete copy of which is attached hereto marked as Attachment "A") are to be extended an additional two years.

2. All correspondence and reports are to be addressed to:

Bonnie Pinkerton, Nurse Consultant  
Department of Public Health  
410 Capitol Avenue, MS #12LEG  
P.O. Box 340308  
Hartford, CT 06134-0308

3. All reports required by the terms of this Consent Order shall be due according to the following schedule:

A. Monthly reports shall be due on the tenth business day of each month.

B. Quarterly reports shall be due the tenth business day of every third month.

4. That he shall comply with all state and federal statutes and regulations applicable to his licensure.

5. That he understands that this Consent Order is a matter of public record.

6. That any alleged violation of any provision of this Consent Order, may result in the following procedures at the discretion of the Department:

(a) The Department shall notify respondent in writing by first-class mail that the term(s) of this Consent Order have been violated, provided that no prior written consent for deviation from said term(s) has been granted.

(b) Said notification shall include the acts or omission(s) which violate the term(s) of this Consent Order.

- (c) Respondent shall be allowed fifteen (15) days from the date of the mailing of notification required in paragraph 6(a) above to demonstrate to the satisfaction of the Department that he has complied with the terms of this Consent Order or, in the alternative, that he has cured the violation in question.
- (d) If respondent does not demonstrate compliance or cure the violation by the limited fifteen (15) day date certain contained in the notification of violation to the satisfaction of the Department, he shall be entitled to a hearing before the Commissioner who shall make a final determination of the disciplinary action to be taken.
- (e) Evidence presented to the Commissioner by either the Department or respondent in any such hearing shall be limited to the alleged violation(s) of the term(s) of this Consent Order.

7. That, in the event respondent violates any term of this Consent Order, respondent agrees immediately to refrain from practicing as an independent social worker, upon request by the Department, for a period not to exceed 45 days. During that time period, respondent further agrees to cooperate with the Department in its investigation of the violation, and to submit to and complete a medical, psychiatric or psychological evaluation, if requested to do so by the Department; and, that the results of the evaluation shall be submitted directly to the Department. Respondent further agrees that failure to cooperate with the Department in its investigation during said 45 day period shall constitute grounds for the Department to seek a summary suspension of respondent's license. In any such summary action, respondent stipulates that his failure to cooperate with the Department's investigation shall constitute an admission that his conduct constitutes a clear and immediate danger as required pursuant to Connecticut General Statutes, sections 4-182(c) and 19a-17(c).

8. That, in the event respondent violates any term of this Consent Order, said violation may also constitute grounds for the Department to seek a summary suspension of his license.
9. That legal notice shall be sufficient if sent to respondent's last known address of record reported to the Licensure and Registration Section of the Division of Health Systems Regulation of the Department.
10. That this Consent Order is effective on the first day of the month immediately following the date said order is accepted and ordered by the Commissioner.
11. That the Department's allegations as contained in this Consent Order shall be deemed true in any subsequent proceeding before the Commissioner in which (1) his compliance with this Consent Order is at issue, or (2) his compliance with §20-195p of the General Statutes of Connecticut, as amended, is at issue.
12. That any extension of time or grace period for reporting granted by the Department shall not be a waiver or preclude the Department from taking action at a later time. The Department shall not be required to grant future extensions of time or grace periods.
13. That this Consent Order and terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum. Further, that this Order is not subject to appeal or review under the provisions of Chapters 54 or 368a of the General Statutes of Connecticut, provided that this stipulation shall not deprive respondent of any rights that he may have under the laws of the State of Connecticut or of the United States.
14. That this Consent Order is a revocable offer of settlement which may be modified by mutual agreement or withdrawn by the Department at any time prior to its being executed by the last signatory.

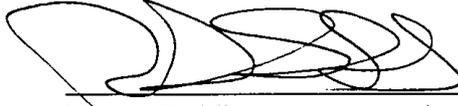
- 15. That respondent permits a representative of the Legal Office of the Bureau of Regulatory Services to present this Consent Order and the factual basis for this Consent Order to the Commissioner. Respondent understands that the Commissioner has complete and final discretion as to whether an executed Consent Order is approved or accepted.
- 16. That respondent has the right to consult with an attorney prior to signing this document.



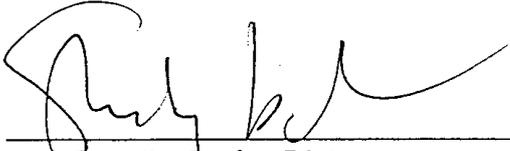
George Gorton, have read the above Consent Order, and I stipulate and agree to the terms as set forth therein. I further declare the execution of this Consent Order to be my free act and deed.

  
George Gorton, L.C.S.W.

Subscribed and sworn to before me this 27<sup>th</sup> day of December 1996.

  
~~Notary Public~~ or person authorized  
by law to administer an oath or affirmation

The above Consent Order having been presented to the duly appointed agent of the Commissioner of the Department of Public Health on the 31<sup>st</sup> day of December 1996, it is hereby ordered and accepted.

  
Stanley K. Heck, Director  
Legal Office

# ATTACHMENT A

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STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES  
BUREAU OF HEALTH SYSTEM REGULATION  
DIVISION OF MEDICAL QUALITY ASSURANCE

George Gorton, CISW  
Certification No. 001953  
8 Forest Lane  
P.O. Box 504  
Gales Ferry, CT 06335

Petition No. 930408-58-001

## PROPOSED FINAL DECISION

### PROCEDURAL BACKGROUND:

On October 11, 1994, the Commissioner of Public Health and Addiction Services appointed this Hearing Officer to hear this case, and to recommend findings of fact, conclusions of law, and a proposed order upon the conclusion of the hearing.

The Department of Public Health and Addiction Services ("Department") brought a Statement of Charges against George Gorton, CISW ("Respondent") dated June 8, 1994.

The Statement of Charges alleged in one count that the Respondent violated §20-195p of the Connecticut General Statutes by negligent, incompetent, or wrongful conduct during the course of therapy provided to a client.

Prior to the initiation of the instant charges, the Department offered the Respondent the opportunity to attend a compliance conference scheduled on December 28, 1993, to demonstrate that no adverse finding against him should be noted regarding his Social Worker Certification.

The Department served the Notice of Hearing and Statement of Charges on the Respondent by abode service. An answer to the Statement of Charges was filed on behalf of the Respondent by his counsel on June 24, 1994.

The administrative hearing was held on November 8, 1994, in accordance with Connecticut General Statutes, Section Chapter 54; and Regulations of Connecticut State Agencies §19-2a-1, et seq. The Respondent appeared at the hearing with his attorney, Robert Walzer, Esq. Judith Lederer, Esq. represented the Department. Subsequently notice was taken of certain documents which were included in the record without objection.

This Proposed Final Decision is based entirely on the record and sets forth this Hearing Officer's recommended findings of fact and conclusions of law, and proposed order.

FINDINGS OF FACT:

1. Dr. Gorton is a Certified Independent Social Worker listed with the Department, certification number 001953.
2. During July 1992 through August 1992, Dr. Gorton was employed as a Social Worker in counseling Mr. and Mrs. Kerr, at his office, in Gales Ferry, Connecticut.

Allegations and Evidence With Regard to the First Count:

3. In the First Count, the Department alleged that the treatment provided to Mrs. Kerr by the Respondent was below an acceptable standard of care in one or more of the following ways:
  - a. he failed to maintain appropriate boundaries between familial and individual therapy; and/or
  - b. he failed to maintain proper records on this patient; and/or
  - c. he failed to develop a preliminary diagnosis and treatment plan in a timely fashion; and/or
  - d. he breached client confidentiality.
  
4. In Paragraph 3(a) of the First Count of the Statement of Charges the Department alleged that the Respondent failed to maintain appropriate boundaries between familial and individual therapy. During the period of July 22, 1992, through August 17, 1992, the Respondent provided counseling services to Mr. and Mrs. Kerr either individually or as a couple. Counseling services were provided to Mr. Kerr alone from approximately August 28, 1992, through January 21, 1993.
  
5. Mrs. Kerr testified that there had been no discussion between her, Mr. Kerr and the Respondent "about anticipated goals and therapy plans."

6. On or about August 26, 1992, counseling services shifted from the couple to an individual, Mr. Kerr. Mrs. Kerr testified that she stopped seeing the Respondent a few days before the 26th of August although the Respondent's notes indicate he spoke with Mrs. Kerr via telephone on August 26, 1992.
  
7. Mrs. Kerr testified that on two occasions, the couple's son Shaun, accompanied his mother on visits to the Respondent's office. The actual purpose of the son's visit is not clear although in the counseling notes of the Respondent dated July 23, 1992, he makes reference to "seeing" the son at some future time. The purpose of which is not stated but certainly the implication for therapeutic purposes is clear as he references the son's dealing with the "loss of his father". Although the counseling notes of July 23, 1992, do not reflect the son's presence, the Respondent testified that the son was present in his office during the visit. The son was present not for purposes of evaluation of the child but rather as a matter of convenience to his mother, with the added benefit of observing the child's interaction with the parent. Any observation of such an interaction with the parent that may have been made does not appear in any counseling notes. Mrs. Kerr testified that the Respondent told her "he couldn't see anything wrong with Shaun following his evaluation." The second session attended with the child's mother is not reflected in the counseling notes but could possibly have been on 8/13/92. There was no reason to bring a child into those sessions.

8. Mrs. Kerr spent much of the time in therapy in a very upset state with no clear purpose of what she wanted from therapy. She vacillated back and forth whether she wanted her husband home or not. She "did not want a divorce" and wanted to resolve the marital conflict.
  
9. It became clear early in therapy that a common objective for the couple was not possible. Ms. Edell stated that her review of the counseling notes indicated that the husband felt the marriage was over and alliances with both individuals as a couple is not possible under such circumstances. In circumstances where each individual has a different goal and different expectations from therapy, a joint counseling session with both parties is needed. Such a session provides for an opportunity to confront each partner with their differences and discuss possible resolution of these differences. A decisive session of this type never took place. A recommendation for one of the couples to transfer to another therapist was not made. Mr. and Mrs. Kerr saw pastoral counselors during the time they were in therapy with the Respondent, but at no time did the Respondent "recommend somebody else to deal with the marital situation."
  
10. The necessary boundaries between familial, individual and possible marital therapy were not maintained in an appropriate fashion. The respondent failed to properly assess the purpose of each client in

seeking therapy. There was no attempt to clarify their objective. The respondent's plan for therapy was not stated. The clients were never advised by the respondent regarding what they might expect from therapy and there was no distinction in planning therapy for both individuals as a couple or as single entities. How the respondent planned to proceed in counseling was lacking.

11. Subsequent to the August 26, 1992, telephone conversation between the Respondent and Mrs. Kerr. Mrs. Kerr terminated therapy with the Respondent but did not provide official notification to that effect. The Respondent's notes indicated that sessions with Mr. Kerr continued until January 21, 1993, and that the respondent believed his 'patient' was the family to the very end. Clearly there was no recognition of the absence of a therapeutic working relationship between the therapist and the patient, Mrs. Kerr, either as an individual or as part of the couple. In situations where the client ceases contact with a therapist, the therapist should attempt to contact the client for purposes of appropriate action and if telephone contacts fail, a letter should be sent. The Respondent continued to view the "family" as his patient figuring that "things could change".

12. A therapist/patient contract is an agreement of how the two people or the family and a therapist will work together. It need not necessarily be written but at least should be reflected in the notes. Since the reasons for seeking therapy were never really clearly explored, a therapeutic alliance between these two people could not and did not take place. Eventually, the transition from the treatment of the couple to one member of the couple was inevitable. It probably was not possible for anyone to treat these two people together as a couple at that point in time. The Respondent probably became aware of this and the need to make a decision regarding couple counseling very early on - perhaps as early as the very first session.
13. The only ground rules the Respondent gave the couple were "around confidentiality". He also advised them that physical violence would be reported and advised them they would receive assignments. He further advised them of his role in the event there was an involvement of either party with another person and his responsibility to bring that out in therapy if he had knowledge of such a situation.

14. It is clear that at some point counseling shifted from the couple to an individual however this was never acknowledged by the Respondent. He failed to acknowledge a necessary change in his role as therapist when Mrs. Kerr withdrew from therapy and his 'patient' shifted from the couple to Mr. Kerr.
15. In Paragraph 3(b) of the First Count of the Statement of Charges, the Department alleged that the Respondent failed to maintain proper records on this patient.
16. Records of counseling for Mrs. Kerr or Mr. Kerr span the period of time from July 22, 1992 to January 21, 1993. The therapy note entered for July 22, 1992, identifies the "New Patient" as Wanda Kerr with "husband James D. Kerr" in parentheses. This would lead the reader to think the patient was an individual although testimony provided throughout the hearing by both the complainant and the Respondent support that the entity in therapy was both the husband and wife until about August 26, 1992.
17. Another unclear entry in the counseling notes is the entry of August 10, 1992, by the Respondent, "She talks too long and too much." This entry appears to be the assessment and impression of the Respondent, however, as testified to by the Respondent himself, "That was coming from her husband."

18. The counseling record of July 23, 1992, reflected that Mrs. Kerr said "...she doesn't remember anything at all about her father." The next two sentences go on to say that "...there was a good chance her father would have tried to sexually abuse her if they were alone. Because many times when she would be with him he would be trying to kiss her, and she felt these were very improper kisses." There is no notation or explanation in the record regarding these conflicting statements. According to the record no clarification was sought or given. Ms. Kerr indicated that she "saw him a few times a year" when she was growing up but had not seen him in many many years.

19. The therapeutic notes should include the discussion of elements of the therapeutic contract and the "client's response" to those elements. The Respondent's counseling notes did not include any reference to elements of a therapeutic contract. The counseling note of July 29, 1992, was lacking what the Respondent was counseling Mr. Kerr about. The Respondent's reference to his concern "about the child" is not clear and Ms. Edell verified the need to state why and document that. The reason for the concern was not stated nor was there any reference to attempting to obtain more information to substantiate the concern or move away from it. What exactly the concern was did not appear anywhere.

Clinical thinking being formulated was not documented. There was no reasoning documented in terms of how the therapist planned to work with this couple. Regarding the use of the lay term, "A lot of stuff is going down," there was no translation of that into a clinician's thinking and how to deal with what was happening between the two of them.

20. References to therapy by the Respondent were unclear. He wrote, "She's in a state of denial and is refusing therapy." What avenue of treatment he tried with the patient was not stated. Nor was his plan and how she subverted that. His reference to refusing therapy does not explain if the patient was refusing to come in or, having a hard time working with some of the suggestions. Explanations regarding her ability to use therapy should have been documented. Patient response to therapy and the clinical interpretation of a patient's refusal or difficulty in accepting therapy is also necessary in record documentation. These types of behaviors have some clinical meaning, and in this case, the meaning was not documented.
  
21. The end of a therapeutic relationship should be documented indicating why the decision had been reached, what was shared with the client, what the client's response was, and what plans were made for the client. In the event a client should refuse to come in, notification attempts should be made even if necessary to do so by a letter. Actions taken by a therapist should be documented and stated in the record. The record was lacking those critical entries.
  
22. A clinician is responsible for the documentation of information being collected, thoughts about what that information means and assessment. The accumulation of this information and synthesis of the same is assistive in bringing the clinician to the development of a plan or strategy for dealing with the patient.

23. The purpose of the presence of Mr. Kerr in therapy was not clear since it was implied he didn't want to be in the marriage. The Respondent never inquired of Mr. Kerr if he wanted to terminate the marriage. Regarding Mrs. Kerr, the respondent did not try to determine the conflicts she was experiencing and set a course of therapy accordingly. There was a lack of the formulation of clinical thinking.
  
24. Ms. Constanzo testified regarding the counseling notes, "...I think that there are some things in there that hit me the wrong way,..." and "I think that the writing probably doesn't reflect his own thinking as much as if he..." and "...I think the notes to me would be more notes that the Respondent perhaps would have used for himself and not intended for professional..." The counseling notes did not support the Respondent's testimony that he always viewed the couple as the primary therapeutic entity.
  
25. The Respondent stated regarding his counseling notes "well, a lot of times when I put down things I don't put down anything I'm going to do."
  
26. The Respondent's counseling notes included language which had no professional meaning such as "the same old shit is going on and on" and "just a lot of garbage". These references were not followed by any clarifying statements, therefore had no therapeutic basis in documentation of counseling therapy.

27. In Paragraph 3(c) of the First Count of the Statement of Charges, the Department alleged that the Respondent failed to develop a preliminary diagnosis and treatment plan in a timely fashion.
  
28. The Respondent described his development of the plan as an "ongoing thing, evolving what my objectives are, what's their goals. So it vacillates back and forth sometimes..." His plan for Mrs. Kerr was for her to go to New York City, go to the Naval Hospital, take a trip to Puerto Rico, and have her mother-in-law come and live in with her for a while. During this testimony he also admitted that in a letter he wrote to Investigator Roy of the Department, he did state "Because of the short time I spent with Mrs. Kerr, I was unable to form a treatment program for her." "Due to the short duration of therapy with Wanda Kerr, I was unable to set in motion any projected treatment plan."
  
29. On August 7, 1992, the Respondent administered the MMPI (Minnesota Multiphasic Personality Inventory - 2 test to Mrs. Kerr). The resulting profile of this test was an indication of her personality functioning at that time. The "Diagnostic Considerations" of this test indicated that individuals with the profile exhibited by Mrs. Kerr "may receive a diagnosis of Somatoform Disorder in a Passive-Dependent Personality." This diagnosis did not appear as a consideration in any of the counseling notes, nor did any other. The "Treatment Considerations" of this test indicated that "Any

psychological intervention with her will need to focus upon her negative family feelings if treatment progress is to be made." There was no evidence of this type of focus in the Respondent's counseling notes.

The Respondent testified regarding this treatment consideration of the MMPI, "The only thing I never really had a chance to do some of this work, because most of the time she was in, she was very, extremely upset and she would be crying for the sixty minutes, so we never really had a chance to focus and get work other than to just help her and nurture her along with some of the issues about the new baby coming, Shaun, etcetera." He also felt that the MMPI had a role in his diagnosis and treatment of Mrs. Kerr, "...and it will basically give me a diagnosis of the person,..." The counseling therapy notes of 8/10/92, two days after the MMPI report was printed, do not reflect any nurturing of Mrs. Kerr. Rather, they reference a need for "teaching them some communication skills" but again there is no direction, instruction, nor reference to how the "teaching them some communication skills" was going to happen.

30. Mrs. Kerr did not get the help and the skills that she needed to receive in order to deal with the situation, and stated that in working out a plan, or in offering a solution, the only thing the Respondent proposed was for her to leave and go with her family.

31. The Respondent was unable to set in motion any projected treatment plan. There had not been an evaluation of exactly what point the patient was at in her crisis. She was clearly distressed, but there was no plan established to address that. There was no assessment of whether she was becoming psychotic, or suicidal. Hospitalization was a plan, however, there was no therapeutic plan for the couple. The patient did not receive the care that she required at that point. In the counseling of the entity (Mr. and Mrs. Kerr, the couple) many serious issues remained unexplored, including the Respondent's frustration with the client and a plan for how to deal with it.
32. There had been sufficient opportunity to establish a diagnosis and subsequent treatment plan even through those things are always subject to change as therapy progresses. It is not necessary that a diagnosis stay with a patient forever, however, the establishment of one is critical to therapy. This leads the therapist to the formulation of a plan for how to deal with what he/she thinks is happening. The reference to "...refusing therapy" in the Respondent's notes, brings up another question. When a patient is having a hard time accepting the therapist's attempts to help them, a clinical interpretation of that behavior should be considered. An alternate plan might require development to deal with that. What the Respondent's "strategic plan" in dealing with this couple who had completely different objectives was remains unknown.

33. In paragraph 3(d) of the First Count of the Statement of Charges, the Department alleged that the Respondent breached client confidentiality.
34. On September 11, 1992, the Respondent sent a letter to Attorney Bruce Chamberlain who was counsel for Mr. Kerr at that time, and indicated that he was writing to support Mr. Kerr's effort to get temporary custody of Shaun Kerr who was then two and one-half years old. He stated that due to Mrs. Kerr's emotional state and pregnancy he felt this would be the more appropriate placement. The specifics of Mrs. Kerr's emotional state were not divulged in this letter nor were any elements of her history and emotional manifestations mentioned.
35. The Respondent had expressed concern for the well being of the two and one-half old child, Shaun on several occasions as reflected in counseling notes.
36. References to Mrs. Kerr's highly anxious state and physical problems associated with her pregnancy of seven and one-half months appear throughout the Respondent's counseling notes. The Respondent was concerned regarding the physical condition of Mrs. Kerr and her ability to sustain the third trimester of pregnancy and still be able to lift and carry her two and one-half year old child. He indicated

that his concern for the fetus outweighed his obligation to maintain confidentiality regarding Mrs. Kerr's counseling. He was also concerned regarding the possibility of Mrs. Kerr considering suicide in her highly emotional state. (The MMPI test taken by Mrs. Kerr did indicate the possibility of her contemplations of suicide).

37. Although the personal situation of the couple and the lack of an established plan with some objective all added to a chaotic situation, it was very clear that the Respondent was concerned about the welfare of the children.
38. On August 10, 1992, Mrs. Kerr signed a release form authorizing the Respondent to reveal information relative to her diagnosis and treatment. The release form did not in any way restrict who the information could be released to.
39. By Mrs. Kerr's own admission there were Naval Base military personnel who knew she had sought professional assistance for her marital problems. In fact, she had been referred to the Respondent by "Family Services on the base" and was required by the church (Mormon Religion) to "continue in a counseling relationship with church members" while in counseling with the Respondent.

Discussions and Conclusions of Law:

40. In the absence of any state regulation with regard to the conduct and practice of social workers, the prevailing standard may be found from the National Association of Social Workers (NASW) standards for the practice of clinical social work and code of ethics. (The Respondent is a member.) These standards are designed to guide clinical social work practice and state regulatory agencies; provide information to insurance carriers and others and; inform consumer groups.
  
41. Clinical social work is defined by NASW as the professional application of social work theory and methods to the treatment and prevention of psychosocial dysfunction, disability, or impairment, including emotional and mental disorders. According to the NASW definition, clinical social work services consist of assessment, diagnosis, treatment, including psychotherapy and counseling, client-centered advocacy, consultation, and evaluation.
  
42. The Department sustained its burden of proof that the treatment provided to Mrs. Kerr by the Respondent was below and acceptable standard of care with regard to paragraph 3(a) of the Statement of Charges:

He failed to maintain appropriate boundaries between familial and individual therapy.

- a. The Respondent failed to maintain appropriate boundaries between familial and individual therapy. A contract with the patient was never established, and the expectations and limitations of therapy were not identified by the Respondent with the exception of confidentiality, the exclusion of secrets of infidelity and acts of physical violence being reportable. The issues were not brought out for clear discussion. When it became very clear that due to differences in client objectives, the couple could no longer be treated as an entity, the Respondent did not recognize the limitations of therapy and appropriately act upon those limitations in his management of the couple.
- b. NASW Code of Ethics 11. The Social Workers Ethical Responsibility to Clients F.6., sets forth the primacy of the social worker responsibility to the client. It requires the social worker to provide clients with accurate and complete information regarding the extent and nature of services available to them.
- c. The Respondent violated this standard as documented in the findings of 3(a) of the Statement of Charges.

43. The Department sustained its burden of proof that the treatment provided to Mrs. Kerr by the Respondent was below an acceptable standard of care with regard to paragraph 3(b) of the Statement of Charges:

He failed to maintain proper records on this patient.

- a. The records maintained on this patient lacked clarity and in some instances were misleading to the reader. They were deficient in content, lacked documentation of the specifics of therapy and the patient's response to same. Clinical interpretation of patient responses were absent from the record and in a couple of instances there was the use of unprofessional language.
  
- b. The prevailing standards for any patient or client record are that it be clear, comprehensive, accurate, and reflect the patient which it is intended to give an account of, including assessments, impressions, objectives, therapeutics, patient responses and the clinical interpretation of those responses.

NASW Standard for the practice of Clinical Social Work, revised 1989., Standard 8., is: Clinical Social Workers shall establish and maintain professional offices and procedures. This standard requires Clinical Social Workers to maintain records of clients that are accurate and substantiate service.

Sections 19a-14-40 and 19a-14-41 of the Regulations of Connecticut State Agencies, set forth the definition and purpose of medical records, information to be included in those records, the purpose of such information and, professions responsible for the maintenance of appropriate medical records including social workers.

The Respondent violated the NASW Standard for the Practice of Clinical Social Work, revised 1989., Standard 8, and Sections 19a-14-40 and 19a-14-41 as documented in the findings of 3(b) of the Statement of Charges.

44. The Department sustained its burden of proof that the treatment provided to Mrs. Kerr by the Respondent was below an acceptable standard of care with regard to paragraph 3(c) of the Statement of charges:

He failed to develop a preliminary diagnosis and treatment plan in a timely fashion.

- a. Although the Respondent stated that the MMPI test taken by Mrs. Kerr on August 7, 1992, would give him a diagnosis of the person, there is no diagnosis of this patient by the Respondent anywhere in materials submitted during the hearing. The MMPI report produced "Diagnostic Considerations" with a specific notation contained in the document that the report was intended to serve as a useful source of hypotheses about clients. The notation also advised that the descriptions, inferences and recommendations contained within the report needed to be "verified by other sources of clinical information."
  
- b. Although the Respondent testified that the development of a plan was an "ongoing thing" there were no established goals or objectives. There was no demonstrated plan of therapy for this patient even after the MMPI results indicated the need for a focus on the patient's negative family feelings if there was to be a therapeutic effect for this person. Finally, the Respondent himself admitted that he had not formulated a treatment program for Mrs. Kerr and had not set in motion a treatment program.

c. NASW Standard for the Practice of Clinical Social Work, revised, 1989., Standard 2., is: Clinical Social Workers shall have and continue to develop specialized knowledge and understanding of individuals, families, and groups of therapeutic and preventive interventions. It requires the social worker to possess specific areas of expertise in order to be effective in clinical intervention. Areas referenced in this standard include the knowledge to "obtain, analyze, classify and interpret social and personal data, including assessment and diagnosis."

45. The Respondent violated this standard as demonstrated in the findings of 3(c) of the Statement of Charges.

The Department did not sustain its burden of proof that the treatment provided to Mrs. Kerr by the Respondent was below an acceptable standard of care with regard to paragraph 3(d) of the Statement of Charges:

He breached client confidentiality.

The Respondent had a release form properly signed by the patient. His concerns for the welfare of the patient, her seven and one-half month fetus and two and one-half year old child were documented in the counseling notes and reinforced through testimony. Connecticut General Statutes Section 52-146q allows an exemption to confidentiality in instances of possible substantial risk of imminent physical injury by the person to himself or others.

The Respondent did not violate this statute as documented in the findings of 3(d) of the Statement of Charges.

SUMMARY:

46. Based on the record in this case, the above findings of fact, and conclusions of law, I respectfully recommend to the Commissioner that he make a finding of:

- a. Lack of maintenance of appropriate boundaries between familial and individual therapy; and
- b. failure to maintain proper records on this patient; and
- c. failure to develop a preliminary diagnosis and treatment plan in a timely fashion.

I also respectfully recommend to the Commissioner that he dismiss the allegation that the respondent breached client confidentiality.

ORDER

47. In accordance with Sec. 20-195 CGS, the following is recommended:

1. Letter of reprimand;
2. Imposition of a Penalty of three hundred dollars (\$300.00).
3. Two year suspension as a Certified Independent Social Worker listed with the Department of Public Health; the suspension stayed is to be contingent upon monitoring, supervision and educational attendance as indicated below.

4. Enrollment and attendance in professional education seminars specific to the responsibilities of independent social workers in those areas which are the basis of the suspension; e.g. social workers ethical responsibility to clients; maintenance of records of clients that are accurate and substantiate services to those clients; and specialized knowledge and understanding of individuals, families and groups and of therapeutic and preventive intervention.
5. Two years of professional supervision by a Certified Independent Social Worker at the Respondent's expense. That is the inspection, critical evaluation and direction over the services of the Respondent. Supervisory activities shall include, but not be limited to, case presentation, and direct observation. The supervised work experience shall include fifty hours of direct supervision within a twelve month period with a minimum of twelve hours per quarter. Documentation of the supervisory review by the C.I.S.W. shall be submitted to the Department on a quarterly basis in a format approved by the Department.
6. Failure to comply with the educational and monitoring requirements shall result in the stay being lifted and suspension imposed.

Respectfully submitted,

  
\_\_\_\_\_  
Irene DiPace  
Hearing Officer

1-8-96  
Date