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STATE OF WISCONSIN

BEFORE THE SOCIAL WORKER SECTION

EXAMINING BOARD OF SOCIAL WORKERS, MARRIAGE AND FAMILY THERAPISTS AND PROFESSIONAL COUNSELORS

IN THE MATTER OF THE DISCIPLINARY

PROCEEDINGS AGAINST

SANDRA M. HELPSMEET, C.I.C.S.W. Case No. LS0002091SOC

RESPONDENT.

FINAL DECISION AND ORDER

The parties to this action for the purposes of Wis. Stats. §227.53 are:

Sandra M. Helpsmeet, C.I.C.S.W.
2550 Gregorson Drive
Eau Claire, WI 54703

Social Worker Section
Examining Board of Social Workers,
Marriage and Family Therapists and Professional Counselors
P.O. Box 8935
Madison, WI 53708-8935

Department of Regulation and Licensing
Division of Enforcement
P.O. Box 8935
Madison, WI 53708-8935

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Marriage and Family Therapist Section. The Section has reviewed this Stipulation and considers it acceptable.

Accordingly, the Section in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Sandra M. Helpsmeet (formerly known as Sandra M. Hansen), Respondent, date of birth May 15, 1949, is certified by the Social Worker Section of the Wisconsin Examining Board of Social Workers, Marriage and Family Therapists and Professional Counselors as an independent clinical social worker in the state of Wisconsin pursuant to certificate number 3130 which was first granted December 13, 1994.

2. In 1988, Respondent received a masters degree from the University of Wisconsin – Stout.

3. Respondent's last address reported to the Department of Regulation and Licensing is 2550 Gregorson Drive, Eau Claire, WI 54703.

4. On September 25, 1991, Ms. A first sought treatment for symptoms of depression from Respondent at a clinic in Eau Claire.

5. On September 30, 1991, Respondent created a treatment plan for Ms. A which was approved by Respondent's supervising psychiatrist. That treatment plan contained a diagnosis of depressive disorder, not otherwise specified, and indicated that Ms. A would receive individual psychotherapy from Respondent 2 to 3 times per month. Treatment goals were specified as:

- Clarify emotional reality including personal [?].
- Attenuate depression.
- Explore relationship between boundaries and sense of self.
- Strengthen support system.

6. Respondent provided individual psychotherapy to Ms. A on October 9, 16, 30, November 13, 20, 27, and December 4, 1991. A treatment plan of December 9, 1991, which was approved by Respondent's supervising psychiatrist on December 30, contained the same diagnosis and mode and frequency of treatment as the previous plan. It also contained the same treatment goals and added: "facilitate resolution of grieving".

7. Respondent provided individual psychotherapy to Ms. A on December 13, 19, 27, 1991 and January 3, 1992. During the January 3, 1992 session, Respondent began working with Ms. A on relaxation and meditation skills. At that session, Respondent also provided Ms. A with relaxation tapes and written instructions to practice with between sessions.

8. Respondent provided individual psychotherapy to Ms. A on January 8, 15, 23, February 7, 13, 21, 27, March 4, 18, and 23, 1992. A note of the March 18 session indicates Ms. A had followed Respondent's recommendation and attended a weekend treatment group at Derwood's Glenn for "adult/child issues." The note also says: "I think this gives an opportunity to do some more imagery work and also to focus specifically on some of her core issues."

9. The treatment plan of April 7, 1992, which was also approved by Respondent's supervising psychiatrist, contained the same diagnosis, treatment goals and mode and frequency of treatment, as the last plan. Respondent provided individual psychotherapy to Ms. A on April 8, and the note of that session indicated that Ms. A appropriately called her childhood family experience "emotional and spiritual rape."

10. Respondent provided individual psychotherapy to Ms. A on April 22, May 1 and May 8, 1992. At the May 8 session, they did primarily imagery work, and the note of a May 15 session says that Ms. A "had a lot of feelings come up as a result of the imagery work we did."

11. Prior to May 29, 1992, there is no mention in any of Ms. A's treatment records of Ms. A having even a suspicion that Ms. A had been sexually abused as a child. Respondent's note of her May 29, 1992 session with Ms. A says that Respondent became aware of elements of post traumatic stress disorder in Ms. A as Ms. A continued to remember and recognize what had happened to her. The note also says:

> "[Ms. A] has been jogged in her awareness by the booklet I had given her written by abuse survivors about the therapy process. She asked if it was really possible for a person to not remember things that had happened. She also had been taken aback when she looked at the abuse continuum and realized that nearly everything in the section on emotional abuse had happened to her and that several of the things in the section on sexual abuse had happened to her. She was both horrified and shocked to recognize that she's been sexually abused and also relieved in that it explained to her some of her experience and she felt a bit less crazy. . . .I gave her lots of acceptance and validation for her feelings. . . . I told her about the sexual abuse group and asked her to think about that."

12. At the time Respondent was providing psychotherapy to Ms. A, Respondent had no experience working with clients with recovered memories and had no adequate training in working with such individuals.

13. At no time during the period Respondent provided treatment to Ms. A did Respondent caution Ms. A that the content of the apparent memories of childhood sexual abuse may or may not be accurate representations of what had occurred in Ms. A's childhood. A minimally competent psychotherapist would have provided Ms. A with such a caution.

14. In the next treatment note of June 5, 1992, Respondent wrote that Ms. A "was able to tell me that she's ready for more directiveness and for more interaction and processing."

15. In the treatment note of June 12, 1992, Respondent wrote that Ms. A had agreed to participate in the sexual abuse survivors therapy group on June 23.

16. On June 19, 1992, Respondent discussed with Ms. A the diagnostic criteria for post traumatic stress disorder (PTSD) and changed Ms. A's diagnosis to PTSD and depression. The new diagnosis was based upon the memories of child sexual abuse Ms. A reported at that time.

17. From June 23, 1992 to May 3, 1993, Patient A attended once weekly group therapy for victims of sexual abuse co-facilitated by Respondent and a social worker-therapist at the clinic in Eau Claire.

18. Respondent provided Ms. A with individual psychotherapy on July 8, 1992 and noted that Ms. A was having many body memories of sexual abuse by her father.

19. Respondent also provided Ms. A with individual psychotherapy on July 13, 23, 29, and August 5, 1992. Respondent had been encouraging Ms. A to visit her "inner child" and, on

August 5, Ms. A described having problems doing that. On that date, Respondent taught Ms. A an imagery protocol which allowed Ms. A to remain aware of her adult self at the same time that she "sees" her child. At an August 13, 1992 individual session, Respondent and Ms. A agreed to schedule some 2 hour sessions to do experiential work. Respondent had an individual session with Ms. A on August 19.

20. On August 21, Ms. A was seen at the clinic by a psychiatrist who changed antidepressant medications from Prozac to Pamelor. The psychiatrist observed that he was "really quite startled" to see Ms. A in a condition of constant jitteriness of her legs and arms to the point that it almost made the psychiatrist uncomfortable. The psychiatrist noted that he was "frankly surprised that she can get anything out of therapy at this time." He also gave Ms. A a prescription for Xanax for her heightened anxiety.

21. Respondent provided individual psychotherapy to Ms. A, which included the continued emergence of new memories of child sexual abuse, on August 28, September 2, 3, 10, 16, 25, 30, October 8, 14, 22, 29, and November 5, 1992.

22. The November 10, 1992 treatment plan created for Ms. A, which was approved by Respondent's supervising psychiatrist, increased the individual psychotherapy by Respondent to 4 times per month. It also added the group psychotherapy 4 times per month to be provided by Respondent and a social worker-therapist, which Ms. A had already been receiving since

June, 1992.

23. Respondent provided Ms. A with individual psychotherapy on November 5, 19, December 3, 9, 18, and 31, 1992. On January 6, 1993, Respondent's supervising psychiatrist changed Ms. A's diagnosis to adjustment disorder with depressed mood.

24. Respondent provided individual psychotherapy to Ms. A on January 6, 1993. On January 13, because Respondent was not available and because Ms. A had been having almost continuous flashbacks through the weekend, Ms. A saw the social worker-therapist for

1 and 1/2 hours of individual therapy. Ms. A then saw Respondent for individual psychotherapy on January 15 and saw Respondent and the psychiatrist together on January 19, 1993. The psychiatrist diagnosed major depressive episode, recurrent.

25. Respondent provided Ms. A with individual psychotherapy on January 19 and 21, 1993. The note of the January 21 session says:

> "As we talked the flashback that [Ms. A] has been struggling with so much lately was stimulated and she got into process with the little part of her going through the victimizations, the survivor part of her trying to promote her putting it all away and the adult part of her trying to stay on top of all this. She ended up, when speaking from the child part of her, saying that her father would threaten her that if she didn't be quiet he would kill her. After she had said this she stopped suddenly and shifted into the present adult part of her able to look at and appreciate what that meant to her as a child to hear that threat. It was a new piece of information for [Ms. A], and one that horrified her but also brought considerable clarity to what she has been experiencing kinesthetically and emotionally."

26. During an individual session on February 5, 1993, Respondent explained to Ms. A that Ms. A needed more support than could be given on an outpatient basis and recommended inpatient treatment. Ms. A was resistive to inpatient treatment and Respondent agreed to provide individual psychotherapy 2 times each week. Some of the psychotherapy sessions became 90 minutes to 2 hours in length and some included the social worker-therapist as a co-therapist. Individual sessions took place on February 9, 12, 15, 17, 18, 23, and 26. On February 26, 1993, Respondent again suggested that Ms. A enter inpatient treatment and Patient A again refused.

27. At an individual session on March 3, 1993, Respondent and the social worker-therapist again recommended inpatient treatment because Ms. A's flashbacks were almost continuous and caused an elevated level of anxiety. Ms. A refused inpatient treatment. There were additional individual sessions on March 5, 9, and 10, 1993. In the treatment note of

March 9, Respondent wrote:

"[Ms. A] continues to struggle with really accepting that the abuse that she experienced happened. . . . I spent a lot of time validating where she is, congratulating her for being able to tell her present truth, and encouraging her to believe her experience."

28. Until March 16, 1993, all of Ms. A's reports of having been sexually abused as a child involved only her father as the perpetrator. During an individual session with Respondent on March 16, 1993, Ms. A began reporting memories of ritualistic sexual abuse by more than one person. Respondent did not caution Ms. A that the content of the apparent memories of childhood ritualistic sexual abuse may or may not be accurate representations of what had occurred in Ms. A's childhood. A minimally competent psychotherapist would have provided Ms. A with such a caution.

29. The treatment plan of March 18, 1993, which was approved by Respondent's supervising psychiatrist, increased to 8 times per month the individual psychotherapy Respondent was providing Ms. A. The only additional goal was to assess further therapeutic needs.

30. Respondent provided Ms. A with individual psychotherapy on March 18, 23, 26, 31, April 2, and 6, 1993. The social worker-therapist saw Ms. A for individual psychotherapy on April 7 and both therapists saw Ms. A on April 9, 1993. During this period, Ms. A reported more "memories" of a group of people participating with her father in sexually abusing her as a child. The reports included killing animals and the drinking of its blood. By April 9, Respondent was noting that based on the reports by Ms. A "very clear satanic abuse is evident."

31. On April 16, 1993, Ms. A was seen in individual psychotherapy by the social worker-therapist for three hours. Ms. A, Respondent and the social worker-therapist had decided that the two therapists would offer Ms. A sessions several times per week between the two of them.

32. An undated, unsigned treatment plan, in Respondent's handwriting, in Ms. A's medical records indicated that individual psychotherapy was to increase to 15 to 20 times per month and was to be provided by Respondent and the social worker therapist. There is no indication in the treatment record that the plan was approved by Respondent's supervisor. It listed the treatment goals as:

1. Re-experience memories on all levels.
1. Review patterns of memories.
2. Pool knowledge about memories.
3. Incorporate finished memories.

33. Beginning in April 1993, on a routine basis Respondent and the social worker-therapist had telephone conversations with Ms. A late at night outside normal work hours. Some telephone conversations between Respondent and Ms. A lasted six to eight hours. Respondent stated that Respondent attempted to "talk [Patient A] down" and "ground" Patient A during these telephone calls.

34. Individual psychotherapy sessions by Respondent or the social worker-therapist increased to 11 in April of 1993, 13 in May of 1993, 16 in June of 1993, and 20 in July of 1993. Most of the sessions were at least 2 hours in length with some 4 hours in length. During July, Ms. A began cutting herself.

35. During August of 1993, Ms. A began to have suicidal thoughts, but would not consider inpatient treatment. Individual psychotherapy sessions by Respondent or the social worker-therapist increased to 22 in August of 1993. Most of the sessions were at least 2 hours in length with some 4 hours in length.

36. On September 7, 1993, Respondent changed Ms. A's diagnosis to dissociative identity disorder, not otherwise specified. Individual psychotherapy sessions by Respondent or the social worker-therapist increased to 22 in September of 1993. Most of the sessions were at least 2 hours in length with several 4 hours in length.

37. From April to October 1993, Ms. A's reports of "memories" of childhood satanic ritualistic sexual abuse increased and became more horrific, including the dismembering and sacrificing of babies. At no time did Respondent question the accuracy of the "memories" or caution Ms. A that they may not be accurate representations of what had occurred to Ms. A in her childhood. A minimally competent psychotherapist would have provided Ms. A with such a caution. Instead, Respondent supported and encouraged the reports as accurate memories.

38. In September and October 1993, Ms. A spent weekends at the homes of Respondent and the social worker-therapist. Respondent and Ms. A slept together in the same bed so that Respondent could reassure and ground Ms. A when Ms. A had nightmares.

39. At that time, Respondent and the social worker-therapist did not want to leave Ms. A alone on weekends and one or the other would take Ms. A with her if they were going to be gone from the area. Ms. A attended a

conference in Madison, Wisconsin with Respondent, and Respondent took Ms. A with her to a retreat center near Fond du Lac, Wisconsin and they spent the weekend together.

40. Ms. A had 15 individual psychotherapy sessions with Respondent or the social worker-therapist in October and again in November of 1993. Most of the sessions were at least 2 hours in length with some 3 and 1/2 hours in length.

41. Respondent documented in Ms. A's treatment record neither the extensive telephone calls nor the contacts outside of the office. Nor did Respondent make her supervisor aware of them. Respondent did not make her supervisor aware of the frequency or length of the psychotherapy sessions with Ms. A.

42. The clinic where Respondent provided Ms. A with psychotherapy services is a general medical clinic with a psychiatry department. It maintains notes of the dates of psychotherapy sessions in a patient's general medical chart, but has little other information about those sessions in that chart. The clinic maintains a separate psychiatry department chart with detailed session notes. There are notes in each chart for every session Respondent or the social worker-therapist had with Ms. A. The notes in Ms. A's general medical chart do not indicate the length of sessions, but most of the notes in the psychiatry department chart do indicate the length of the sessions.

43. After November 23, 1993, Respondent provided all individual psychotherapy sessions to Ms. A. The social worker-therapist and Ms. A wanted to become friends and it was decided that the social worker-therapist would no longer provide therapy to Ms. A in order to avoid a dual relationship.

44. On December 1, 1993, the clinic management became aware of the extent of the contacts Respondent and the social worker-therapist were having with Ms. A.

45. On December 3, 1993, following the clinic's investigation of Respondent's practice, Respondent was issued a written warning by clinic management for providing therapy to Ms. A in a way the Psychiatric Supervisor had deemed independent of his guidance, direction and support. The clinic determined that no other discipline was appropriate.

46. Steps were then taken by the clinic to insure that there would be appropriate supervision of Respondent's practice and appropriate client care by Respondent. The clinic established the following guidelines for Respondent:

a. All therapeutic contacts with clients, inside and outside of the clinic including phone calls, shall be documented in the client's chart.

b. Biweekly supervision meetings shall be scheduled with a specified psychiatrist with particular focus on SAS (sexual abuse survivor) clients. All clients shall be discussed after every five hours of therapy as outlined in the clinic's department of psychiatry utilization review standards.

c. Treatment plans, diagnosis and therapeutic support plans on all clients shall be reviewed as outlined in the utilization review policy for the clinic's department of psychiatry.

d. All persons currently being treated with psychotropic medications shall be reviewed with the supervising psychiatrist. The psychiatrist will be informed who is currently providing the medications and attempts shall be made to have the clinic's department of psychiatry psychiatrists provide medication coverage, as appropriate.

e. Any therapy attempts that may be considered "unusual" or "nontraditional" by the specified psychiatrist shall be reported and discussed with the psychiatrist before implemented with clients.

f. Computer lists of all active clients shall be brought to each supervision visit for review by the supervisor.

g. All clients shall be charged the usual rate unless differences are negotiated with the supervisor of the clinic's department of psychiatry or the supervising psychiatrist.

h. She shall discuss with the clinical supervisor issues such as: developing working relationships with quality inpatient programs; when to use local hospitalization and how to manage it. She shall consider the possibility of additional outside supervision about some issues, such as multiple personality disorder.

i. Weekly meetings shall be held with the supervisor of the clinic's department of psychiatry to improve the timeliness of dictation and the management of client schedule.

j. Shall attempt to reduce the frequency of visits for current clients to free up time for clients who

need more timely follow-up.

47. Respondent modified her practice to comply with the clinic guidelines and continues to follow those guidelines in practice.

48. Respondent had 7 psychotherapy sessions with Ms. A in December of 1993; 3 sessions in January, 1994; 2 sessions in February; 3 sessions in March; 3 sessions in April; 1 session in May and a termination session in June of 1994.

49. The Section and the Department of Regulation and Licensing have received no other complaints regarding Respondent.

50. Respondent's annual performance evaluations at the clinic for the period September 1993 through October 1999 indicate that Respondent met or exceeded the clinic's standards each year. The most recent evaluation includes the following comments by her supervisor:

> "Sandra is recognized as very competent, ethical and is respected by peers and supervisor for clinical/professional/interpersonal skills. A role model in ability to clarify group needs/differences in respectful way. Seen as dedicated to exceptional patient care while still supporting the many system changes over past year. Integrity also apparent in her continued mindfulness of boundary/transference issues. Truly an asset to our department, both to staff and patients."

51. Respondent has completed the following continuing education since late 1994:

a. 09/20/94, 3.1 hours, "Rituals and Imagery."

b. 10/14/94, 6 hours, "New Directions in Treatment of Sexual Trauma and Dissociative Disorders."

c. 10/20/94, .1 hour, "Physiology of Addictions."

d. 10/28-29/94, 12 hours, "Short Term Therapy for the Long-Term Patient."

e. 12/05/94, .1 hour, "Psychological and Psychiatric Management of Chronic Pain."

f. 02/16/95, .1 hour, "Assessment and Treatment of Post Traumatic Stress Disorder."

g. 03/16/95, .1 hour, "Update on Mental Health Statutes, Confidentiality, and Ethical Issues."

h. 05/05-6/95, 12 hours, "Possibility Therapy with Adults Who Were Sexually Abused as Children."

i. 05/18/95, .1 hour, "Guided Imagery and Immune System Function: Summary of Research Findings."

j. 10/19/95, .1 hour, "Adult ADHD: Assessment."

k. 02/18/96, completion of 17 hours, "Eye Movement Desensitization and Reprocessing, Level I Training."

l. 03/21/96, .1 hour, "Brief Therapy."

m. 04/18/96, .1 hour, "Adolescence: A Portrait of Normal Development."

n. 09/29/96, completion of 14 hours, "Eye Movement Desensitization and Reprocessing, Level II Training."

o. 10/11/96, 2.5 hours, "Abreactions in the EMDR Process."

p. 10/17/96, .1 hour, "Behavioral Health Rounds, Postpartum Depression Update."

q. 01/16/97, .1 hour, "Behavioral Health Rounds, Anxiety Disorders Update."

r. 02/20/97, .1 hour, "Behavioral Health Rounds, Autism and the Pervasive Developmental Disorders."

s. 04/18/97, 2.5 hours, "EMDR & Couples Counseling."

t. 05/15/97, .1 hour, "Benzodiazepines: Use and Misuse"

u. 07/26/97, 2.5 hours, "Strategies for Embodiment in EMDR Processing."

v. 01/15/98, .1 hour, "Behavioral Health Rounds, Short Term Psychological Treatment of Panic Disorders."

w. 01/24/98, 2.5 hours, "Blending EMDR & Schema-Focused Therapy: Finding Targets Associated with Core Personality Structures."

x. 02/19/98, .1 hour, "Behavioral Health Rounds, The Many Faces of Grief in Death."

y. 04/16/98, .1 hour, "Behavioral Health Rounds, The Chronically Depressed Patient in the Office Setting."

z. 04/25/98, 2.5 hours, "Beyond the Cognitive Interweave: Use of Metaphors, Dreams, Art & Imagery in EMDR"

aa. 07/10-12/98, sponsored by the Eye Movement Desensitization and Reprocessing (EMDR) International Association:

- "Current understanding of the Psychobiology of Trauma" – 1.5 hours.
- "Riding the Wave" –1 hour.
- "Advanced Clinical Seminar: Innovation and Integration in EMDR Based Diagnosis, Technique, Teaching, Performance Enhancement and Creativity" – 4.5 hours.
- "Clinical Applications of EMDR in the Treatment of Adult Survivors of Childhood Abuse & Neglect" – 4.5 hours.
- "It's Never Too Late to Have a Happy Childhood: Using EMDR to Create and Install Essential Experiences" – 3 hours.
- "Exploring the Boundaries" – 1 hour.
- "Trust, Intimacy and Sex: An Integrated Approach" – 1.5 hours.

CONCLUSIONS OF LAW

1. The Social Worker Section of the Wisconsin Examining Board of Social Workers, Marriage and Family Therapists and Professional Counselors has jurisdiction over this matter pursuant to §457.26, Wis. Stats.

2. The Social Worker Section of the Wisconsin Examining Board of Social Workers, Marriage and Family Therapists and Professional Counselors has authority to enter into this stipulated resolution of this matter pursuant to §227.44(5), Wis. Stats.

3. That Respondent, by engaging in the conduct described in the Findings of Fact, has performed services for which Respondent was not qualified by education, training or experience, which is unprofessional conduct as defined by Wis. Adm. Code § SFC 20.02 (1) and subjects Respondent to discipline pursuant to § 457.26(2)(f), Stats.

4. That Respondent, by engaging in the conduct described in the Findings of Fact, has committed gross negligence in practice, which is unprofessional conduct as defined by Wis. Adm. Code § SFC 20.02 (22) and subjects Respondent to discipline pursuant to § 457.26(2)(f), Stats.

5. That Respondent, by engaging in the conduct described in the Findings of Fact, has committed negligence in practice in more than one instance, which is unprofessional conduct as defined by Wis. Adm. Code § SFC 20.02 (22) and subjects Respondent to discipline pursuant to

§ 457.26(2)(f), Stats.

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED:

1. That the certificate of Sandra M. Helpsmeet, ICSW, to practice as an independent clinical social worker in the state of Wisconsin is hereby SUSPENDED for a period of at least two years, effective immediately.

2. That Respondent may petition the Section for the termination of the suspension, after two years, under the following terms and conditions:

a. Respondent shall, at Respondent's own expense, have undergone an assessment by a mental health care provider experienced in assessing health care providers who have violated professional- client boundaries, who has not treated Respondent.

b. The practitioner performing the assessment must have been approved by the Section, with an opportunity for the Division of Enforcement to make its recommendation, prior to the evaluation being

performed.

c. Respondent must provide proof sufficient to the Section that Respondent can practice with reasonable skill and safety of patients and public.

d. If the Section determines to end the suspension, Respondent's certificate shall be limited in a manner to address any concerns the Section has as a result of the conduct set out in the findings of fact and to address any recommendations resulting from the assessment, including, but not limited to:

i. Psychotherapy, at Respondent's expense, by a therapist approved by the Section, to address specific treatment goals, with periodic reports to the Section by the therapist.

ii. Additional professional education in any identified areas of deficiency.

iii. Restrictions on the nature of practice or practice setting or requirements for supervision of practice, by a professional approved by the Section, with periodic reports to the Section by the supervisor.

e. Respondent shall appear before the Section on an annual basis, if requested by the Section, to review the progress of any treatment and rehabilitation.

3. Any request for approval of an evaluator, therapist, supervisor or educational program required by this order shall be mailed or delivered to:

Department Monitor

Department of Regulation And Licensing

Division of Enforcement

1400 East Washington Ave.

P.O. Box 8935

Madison, WI 53708-8935

4. If Respondent believes that the Section's refusal to end the suspension is inappropriate or that any limitation imposed or maintained by the Section under paragraph 2 is inappropriate, Respondent may seek a class 1 hearing pursuant to §227.01(3)(a), Stats., in which the burden shall be on Respondent to show that the Section's decision is arbitrary or capricious. The suspension or limitations on Respondent's certificate shall remain in effect until there is a final decision in Respondent's favor on the issue.

5. Violation of any term or condition of this Order, or of any limitation imposed under paragraph 2 above, may constitute grounds for revocation of Respondent's certificate as an independent clinical social worker in Wisconsin. Should the Section determine that there is probable cause to believe that Respondent has violated the terms of this Order, or any limitation imposed under paragraph 2 above, the Section may order that Respondent's certificate be summarily suspended pending investigation of and hearing on the alleged violation.

6. Respondent shall bear all costs incurred as a result of satisfying this Order.

The rights of a party aggrieved by this Decision to petition the Section for rehearing and to petition for judicial review are set forth on the attached "Notice of Appeal Information".

Dated at Madison, Wisconsin this 9th day of February, 2000.

_____

Cornelia Gordon-Hempe

Chairperson

Social Worker Section