BEFORE THE MINNESOTA

BOARD OF SOCIAL WORK

In the Matter of
the Social Work License of
Daniel F. Carle, L.I.C.S.W.
License No. 03245

STIPULATION AND ORDER

IT IS HEREBY STIPULATED AND AGREED, by and between Daniel F. Carle, L.I.C.S.W. ("Licensee"), and the Minnesota Board of Social Work ("Board") as follows:

1. During all times herein, Licensee has been and now is subject to the jurisdiction of the Board, from which he holds a license to practice social work in the State of Minnesota.

FACTS

2. For the purpose of this stipulation, the Board may consider the following facts as true:

a. From approximately June 1986 to March 1992, Licensee provided therapy to client #1 (D.O.B. 5/3/70). Licensee also provided therapy to members of client #1's family between 1977 and 1992. Client #1 sought therapy for depression and suicidal thoughts and Licensee diagnosed her with an adjustment disorder. In the course of providing therapy to client #1, Licensee failed to maintain appropriate professional boundaries, engaged in unprofessional conduct, failed to maintain appropriate client records, improperly billed client services, breached confidentiality, failed to maintain objectivity, and mismanaged the therapy as demonstrated by the following:

1) In approximately early 1992, Licensee told the clerical staff intimate and extensive details of client #1's alleged sexual abuse and other issues for which she was in therapy. The private data Licensee provided regarding client #1 was not necessary to enable staff to perform their jobs. The clerical staff found the information extremely

disturbing and reported Licensee's conduct to the clinical director as inappropriate behavior and a breach of client/therapist confidentiality.

2) In early 1992, client #1 told Licensee she was hospitalized for surgery. Licensee told the clerical staff that the surgery on client #1 would be performed without an anesthetic. When they stated that was not possible, Licensee repeated that the surgery would be done without it. Licensee also stated that client #1 was on a special code status so no one would know she was in the hospital.

3) Licensee instructed clerical staff to interrupt him at any time, including during other clients' sessions, to take calls from client #1 or her nurse "Jennifer." Licensee allowed client #1 to call him at any time of the day or night. Licensee gave client #1 his phone number while he was vacationing in Cancun, Mexico.

4) Licensee spoke with "nurse Jennifer" on at least six occasions about client #1. Licensee did not attempt to obtain a release from client #1 before speaking with "nurse Jennifer."

5) On March 3, 1992, at a clinical meeting, Licensee stated that client #1 had phoned him as frequently as four times per day seven days a week, including calling Licensee while he was on vacation in Cancun. Licensee even left during the meeting to take a call from client #1.

6) Licensee discussed client #1's condition with another client, client #2. On one occasion, while passing through the waiting area, client #2 referred to client #1, asking, "How's that client of yours in the hospital?"

7) A staff member raised the following concerns with Licensee regarding client #1's treatment:

a) client #1's working diagnosis;

b) the purpose of the phone calls night and day;

c) questions regarding why only one contact person at the hospital (nurse "Jennifer") could provide Licensee with information about client #1's condition

and why Licensee had not obtained a signed release to speak with the nurse about client #1's condition;

d) Licensee's appearance of being over-involved with client #1 to the point of having impaired objectivity;

e) boundary concerns related to client #1 visiting Licensee's home on weekends;

f) the physical impossibility of client #1 or any human being surviving the number and types of surgeries and cardiac arrests that she reported to Licensee;

g) the plausibility of client #1's story about her recent hospitalization and whether client #1 and the nurse were one and the same person;

h) whether Licensee had missed diagnosing client #1 with Multiple Personality Disorder or was caught in a fantasy created by client #1.

8) Licensee responded to these concerns by saying the other clinical staff members did not understand the complexity of client #1's situation. Licensee stated he did not doubt the validity of client #1's story and that she was recovering from surgery. Licensee stated client #1 fits the diagnosis of Post Traumatic Stress Disorder but Licensee saw her diagnosis as "shame." For insurance purposes, Licensee gave client #1 the diagnosis of Adjustment Disorder. Licensee told the Attorney General's Office investigator that his working diagnosis for client #1 throughout her treatment was depression.

9) At a clinical meeting on March 17, 1992, the clinical director reported that he had spent two days sorting out client #1's case as Licensee presented it. During the meeting the following occurred:

a) The clinical director reported he had not been able to corroborate that client #1 was a patient at the hospital she named. He stated he called client #1's apartment and she answered the phone. Client #1 then admitted to creating the whole hospitalization story.

b) Other staff members stated this case would never have gotten out of hand if Licensee had followed protocol with regard to diagnosis, treatment planning, clinical consultation, and obtaining a release to share information.

c) It was also mentioned that client #1 had been a guest at Licensee's home, including an overnight visit, on more than one occasion during the past few months.

d) Licensee admitted being embarrassed and completely caught up in client #1's case to the point of not being able to hear the opinion of any other therapists. Licensee assured staff members it would never happen again.

10) Licensee terminated therapy with client #1 after Licensee met with client #1 and she confessed to making up the stories. However, Licensee's termination report indicated that client #1 completed goals.

11) Licensee told the investigator that with respect to client #1 pretending to be "nurse Jennifer," he fell for it hook, line and sinker. Licensee also told the investigator that client #1 was "smarter therapeutically" than Licensee was because she knew how to get what she needed from Licensee.

12) Licensee admits that client #1 stayed in his home on one occasion and states that he did not provide therapy to her while she was at his home. Licensee stated it seemed to be the human thing to do, to keep client #1 from killing herself. Licensee described this as a "tender time," and that he and his wife comforted client #1 while she cried and then tucked her into bed. Licensee failed to initiate any accepted crisis intervention and had no plan if client #1 deteriorated while in his home.

13) With respect to client #1 Licensee told the investigator, "I would do it all over again, but my value system is very different from contemporary systems."

14) Licensee failed to keep appropriate records, improperly billed the insurance company, and provided free sessions to client #1 as follows:

a) Licensee did not bill client #1 for a session on April 10, 1989.

b) Licensee did not bill client #1 for six sessions between March 1991 and May 1991.

c) In January 1992 Licensee billed an insurance company $115 each for phone consultations on the following dates: 1/3/92; 1/7/92; 1/9/92; 1/10/92 and 1/12/92. An explanation of benefits form indicates that these phone consultations were billed as psychiatric outpatient visits. Licensee told the investigator that the January phone consultations were with "nurse Jennifer." Licensee stated he informed "Jennifer" he would have to bill their conversations as consultations on client #1's case and "Jennifer" agreed to this. Licensee said his secretary did the billing and Licensee did not know anything about the telephone consults being listed as outpatient office visits. There are no progress notes in client #1's chart to correspond with these dates of service.

d) Licensee billed client #1 for sessions on weekends held at his home. Licensee did not prepare any progress notes for these weekend sessions. Billing records list the following four sessions which fell on a Saturday or Sunday: 2/22/92, 2/23/92, 2/29/92 and 3/1/92.

e) On April 17, 1992, Licensee wrote a letter to client #1 stating, "You raised some questions in your letter regarding the charges that were sent to you. My intention . . . is to bill you only for those six sessions. You may disregard the January charges intended to cover your deductible. . . . The total bill should be for six sessions only for $690."

f) There are no progress notes for the following dates billed as therapy sessions:

8/28/90	9/16/91	12/16/91
11/12/90	9/23/91	12/23/91
7/29/91	9/30/91	1/31/92
8/12/91	10/2/91	2/21/92
8/15/91	10/10/91	2/22/92
8/19/91	10/21/91	2/23/92
8/26/91	11/7/91	2/28/92
9/3/91	11/14/91	2/29/92
9/9/91	11/21/91	3/1/92

b. From 1983 to 1992 Licensee provided therapy to client #2. Client #2 sought therapy for anxiety, depression, and suicidal ideation and had a history of alcohol dependence. Earlier, Licensee had provided therapy to client #3, client 2's female companion. Licensee failed to maintain appropriate professional boundaries with clients #2 and #3, engaged in unprofessional conduct, failed to maintain adequate client records, and engaged in inappropriate billing practices as demonstrated by the following:

1) On approximately May 8, 1990, Licensee wrote a letter on client #2's behalf in which Licensee threatened that legal action would be taken against client #3 for blackmail and extortion if she did not stop her activities against client #2 after their break-up. Licensee gave the letter to client #2 to use. Licensee told the investigator that "human sense sometimes overrides technical ethics" and Licensee felt he needed to write the letter to prevent client #2 from committing suicide. Licensee stated he wrote the letter with a lot of thought and would do it again.

2) A March 4, 1991 letter to Licensee from client #3 references the letter Licensee wrote and describes her outrage at his statements about her since she had been his client first. The letter also asked why Licensee had not sent the client's records as requested.

3) On November 19, 1991, during a clinical staffing regarding client #2, staff members discussed Licensee's multiple levels of involvement with client #2 and

recommended that the client be referred to a therapist nearer his home to better accommodate client #2's need for frequent and ongoing outpatient treatment.

4) While client #2 was receiving therapeutic services from Licensee, Licensee and his wife used client #2's cabin on several occasions, once using it for a party.

5) Licensee continued to provide therapy to client #2 until September 1992 when Licensee retired from the center.

6) Licensee failed to maintain adequate records for and improperly billed client #2 as follows:

a) Client #2 paid cash in advance for his therapy, often paying $1,000 to $1,500 up front for his care. Ledger cards indicate that throughout client #2's treatment with Licensee, he paid for sessions in advance, often resulting in a credit balance of hundreds of dollars on his account. Licensee told the investigator he wished all of his clients would have paid in advance.

b) Between January 1987 and May 1990 ledger cards indicate that Licensee had 18 therapy sessions with client #2. There are no corresponding progress notes for these sessions.

c) Client #2's chart contains no progress note to correspond with a session billed for August 27, 1990.

d) Client #2's chart contains no progress notes for the following dates on which sessions were billed in 1991:

1/14/91	10/21/91
4/23/91	11/12/91
8/27/91	12/3/91
9/5/91	12/10/91
9/30/91	12/17/91
10/8/91	

e) Client #2's chart contains no progress notes for the following dates on which sessions were billed in 1992:

1/7/92	3/3/92
1/14/92	3/10/92
1/28/92	3/24/92
2/4/92	3/31/92
2/11/92	9/17/92
2/19/92	9/28/92

c. From 1988 to 1991 Licensee provided therapy to client #4 for marital and family issues. Licensee saw client #4 for individual sessions and also had joint sessions with client #4 and her husband. Client #4 worked with a female therapist at the center on issues related to past sexual abuse, anxiety, depression, her mother's death, and her children's illness. Licensee failed to address client #4's transference issues appropriately and failed to maintain accurate client records, as demonstrated by the following:

1) Progress notes for sessions between April 11, 1988, and June 13, 1988, are signed by Licensee's wife but the billing ledger lists Licensee as the treating therapist.

2) On July 25, 1988, Licensee's summary note for client #4 states, "It is my impression that [client #4] is transitioning from her fantasized affair with me to a realistic relationship with her husband."

3) On August 8, 1989, Licensee wrote, "It is important that she confide in a woman regarding her fantasies about me so she can finish the development of her own sexuality. There may be a time where it may be advisable they see [clinical director] for marital therapy."

4) On September 13, 1989, client #4's female therapist noted the following: "Spoke of romantic attachment to former therapist, DFC. Experiencing shame in association with these feelings. Reports that she feels 'frightened' of bumping into her former therapist. Associates this primarily with the guilt she experiences in enjoying seeing him."

5) On September 14, 1989, client #4's female therapist noted the following: "She took time and spoke about feeling confused and angry with her former

therapist. Is angry because he didn't 'do something' to help her understand or get rid of the attraction she felt for him. Experiencing shame about these feelings."

6) Licensee stated he and client #4 parted on good terms and that she gave Licensee a small gift which is displayed in Licensee's home. Licensee stated that he accepts at face value all gifts and cards which clients give him.

7) A note in client #4's file from the clinical director states, "9/27/89, 10/4/89 sessions to be retyped." There are no progress notes for these dates. The billing ledger indicates that Licensee saw client #4 for sessions on those dates.

d. Beginning in October 1988 Licensee provided therapy to client #5 and her husband for communication problems in their marriage. Client #5 had a history of depression, suicidal ideation, and psychiatric hospitalizations. Licensee failed to maintain complete records for client #5 as demonstrated by the following:

1) Billing ledgers indicate Licensee billed for sessions on the following dates for which there are no corresponding progress notes:

2/21/90	5/26/92
2/26/90	6/9/92
3/23/90	
5/24/90	
11/12/90	

e. In 1990 Licensee provided family therapy to client #6. Licensee's wife also provided therapy to client #6, related to her son. Licensee failed to maintain adequate records on client #6 as follows:

1) Client #6's chart contains no treatment plan.

2) Client #6's chart contains no progress notes for the following therapy session dates listed on the billing ledger for which Licensee was the therapist listed: 11/15/90; 4/23/91; 5/23/91 and 1/13/92.

f. A number of clients attended Licensee's daughter's wedding. Licensee stated he had a good time at the wedding and the clients also probably had a good time.

g. Licensee provided marital therapy to client #7, a woman, and to her husband in 1982 and for approximately twenty sessions during 1985 and 1986. When client #7 and her husband divorced, the husband sought an annulment from his church. The following occurred:

1) In 1996, Licensee testified before the church Tribunal about client #7 without her consent and also provided records about her.

2) The Tribunal's first Definitive Decision states:

> a) The counsellor [sic], Dan Carle, M.S.W. A.C.S.W., and witness in this case, gave these insights into these two people . . . . [Client #7], according to [Licensee], is very manipulative and controlling. She demanded that she be in charge and have things her way in all things. She is so intent on being the controller that she will fabricate situations to meet her needs . . . .
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> [Licensee] goes on to say [client #7] was and is incapable of marriage. He states that if marriage is seen as two people being able to give support, love and companionship to the other, [client #7] is unable to do that. Her statements of "fact" must be weighed against reality. At the same time, [Licensee] indicates that if one was to meet [client #7], and listen to her, she is very convincing and can and will manipulate anyone to believe her.
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> b) [Licensee] indicates that it was in fact [client #7] who eventually chose to end this marriage with a civil divorce. He indicates that if [client #7] had not insisted on the divorce . . .

3) In a letter to the Board dated November 5, 1997, Licensee denied giving testimony:

> I provided no information, written or oral, to the Tribunal, regarding [client #7] other than to acknowledge that she was the wife of [her husband] . . . The Tribunal's inquiry . . . is restricted to the [husband]. No information pertaining to [client #7] was solicited from me, nor was any provided.

h. General recordkeeping problems include the following:

1) Licensee sometimes went for several months without preparing written progress notes for sessions with clients. Licensee would then do massive dictation and prepare summaries of sessions. When questioned by clerical staff, Licensee stated that it was strictly a formality for Licensee to comply with recordkeeping standards.

2) Peer review forms noted consistent problems with Licensee's charting. For example, intake forms, treatment plans, goals, and progress notes were incomplete or missing.

i. Licensee's primary employment no longer involves practicing social work.

STATUTES

3. The Board views Licensee's practices as inappropriate in such a way as to require Board action under Minn. Stat. § 148B.26, subd. 1(1) and (2) and Minn. R. 4740.0310, subps. 1, 4, 4.F., 4.G., and 5 [Emergency]; and Minn. R. 8740.0310, subps. 1, 4, 4.D., 4.E. and 5.A., and Licensee agrees, for purposes of Board proceedings only, that the conduct cited above constitutes a reasonable basis in law and fact to justify the disciplinary action.

REMEDY

4. Upon this stipulation and all of the files, records and proceedings herein and without any further notice or hearing herein, Licensee does hereby consent that until further order of the Board, made after notice and hearing upon application by Licensee or upon the Board's own motion, the Board may make and enter an order as follows:

a. Licensee shall **surrender** his license to practice social work in Minnesota. All state licenses and certificates shall be surrendered to the Board within five days of service of this order.

b. Licensee shall immediately cease to advertise or otherwise hold himself out in any manner as being a licensee in this state.

c. Upon Licensee's surrender of his license to practice social work in Minnesota, the Board agrees to close its files in this matter.

d. Should Licensee reapply for licensure in Minnesota, the Board may reopen its investigation.

5. In the event the Board at its discretion does not approve this settlement, this stipulation is withdrawn and shall be of no evidentiary value and shall not be relied upon nor introduced in any disciplinary action by either party hereto except that Licensee agrees that should the Board reject this stipulation and if this case proceeds to hearing, Licensee will assert no claim that the Board was prejudiced by its review and discussion of this stipulation or of any records relating hereto.

6. Licensee has been advised by Board representatives that he may choose to be represented by legal counsel in this matter. Although aware of his right to representation by counsel, Licensee has knowingly and expressly waived that right.

7. Licensee waives any further hearings on this matter before the Board to which Licensee may be entitled by Minnesota or United States constitutions, statutes, or rules and agrees that the order to be entered pursuant to the stipulation shall be the final order herein.

8. Licensee hereby acknowledges that he has read and understands this stipulation and has voluntarily entered into the stipulation without threat or promise by the Board or any of its members, employees, or agents. This stipulation contains the entire agreement between the parties, there being no other agreement of any kind, verbal or otherwise, which varies the terms of this stipulation.

DANIEL F. CARLE, L.I.C.S.W.
Licensee

Dated: Apr 8, 1998

ORDER

Upon consideration of this stipulation and all the files, records, and proceedings herein,

IT IS HEREBY ORDERED that the terms of this stipulation are adopted and implemented by the Board this 15th day of May, 1998.

MINNESOTA BOARD OF

SOCIAL WORK

THOMAS M. McSTEEN
Executive Director

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