Box 2325
Florence, Arizona 85232-2325
January 24, 2004

Arizona Board of Psychologist Examiners
1400 West Washington, Suite 235
Phoenix, Arizona 85007

Re: Unprofessional Conduct
Ethics Violations

McCauley, Pamela #1949
Arizona Department of Corrections
1110 W. Washington Avenue, Suite 310
Phoenix, Arizona 85007
(602) 364-2912

Golde, Jeffrey #3421
Health Services
Cook Unit
P.O. Box 695
Florence, Arizona 85232
(520) 868-0201

Holly-Reps, Sherry #1254
Arizona State Prison Complex-Eyman
P.O. Box 695
Florence, Arizona 85232

Dear Arizona Board of Psychologist Examiners:

From the EPPP all psychologists know that the purpose of licensing and regulating psychologists is for the safety of the public. This complaint is directly related to our responsibility as psychologists to protect the public.

Attached is a copy of documents in support of my claim of violations in ethics and in exerting undue influence upon a supervisee regarding responsibility, control, oversight and review [32-2061.A.13.(q)and(y)]. These are copies of my copy of the PACE entry in my ADOC Personnel File and my response.

I requested a copy of the original complaint by Dr. Jeff Golde; nonetheless, Dr. Holly-Reps, my direct supervisor, declined to give a copy of that written complaint to me. It appeared that Dr. Golde had either taken a complaint from an inmate patient and had typed it up or had joined with his inmate patient in writing a complaint about me.

On the day I was observing the Parole Board hearings for the first time, I was summoned to call Counseling and Treatment Services Program Director Dr. McCauley. Dr. McCauley called to inform me that because of what I wrote in my PACE response, she was going to

have to address some clinical issues with Dr. Golde. I informed Dr. McCauley that I would have preferred that Dr. Golde would have confronted me informally face to face as required by the APA Code of Ethics before writing it up and taking it to Dr. Holly. But as he had not allowed me the opportunity to clarify issues with him, I had not approached Dr. Golde informally.

Moreover, I do not believe that these are matters that may be addressed informally due to Dr. Golde's violation of the APA Code of Ethics that requires an attempt at informal resolution prior to making a formal complaint. More importantly, it would have been beneficial for all involved to clarify the actual issues prior to escalating the false elements of the complaint into a written report.

Therefore, I wish to cite a violation of the American Association Code of Ethics, the standards that dictate the behavior of psychologists and distinguish psychologists from all others. Furthermore, when I called my immediate supervisor Dr. Holly to inform her of the telephone conversation with Dr. McCauley, Dr. Holly indicated that Dr. Golde had approached Dr. McCauley first with the complaint. It was intimated that Dr. McCauley ordered Dr. Holly to write up a PACE complaint and place a negative entry in my file. I will concede that I have no idea of exactly what was said to whom and in what order.

Accordingly, as Psychologist McCauley failed to redirect Dr. Golde to address me on an informal basis, I find Dr. McCauley also to have violated that provision of the APA Code of ethics as well. Even though we are working in a military styled bureaucracy, having and using the APA Code of Ethics and abiding by them would avoid much misunderstanding and the unnecessary escalation of complaints.

However, then is a more grave offense:

I felt pressured, and my master's level colleague concurred independently and expressed concern that I was being pressured to write this inmate patient a clean bill of health without the benefit of being able to fully assess the inmate patient, to make this star graduate of the Sex Offender Treatment Program not-SMI. As the inmate is fast approaching the date when he may appeal to the parole board, it appears he is attempting to minimize anything that might preclude his release, including his mental health status and history.

As a licensed psychologist, I am aware that I may NOT sign off on any work for which I have NOT assumed supervisory review, control and authority according to the Arizona Statues. Nonetheless, the Policies and Procedures of the ADOC appear to be contrary to the Rules and Regulations that govern our license as psychologists in Arizona. Therefore, I seek Board clarification on this matter.

According to ADOC Policy in the Mental Health Technical Manual written by Dr. Lutz and Dr. McCauley (April 1, 2000) under Local Procedure 4.1.3.2:

> The actions of the treatment team . . . shall be arrived at by consensus.

This appears in contradiction to the ADOC organizational chart, which places psychologists at the head of the treatment teams and in contradiction to the Rules and Regulations under which our licenses are held, the Rules and Regulations that govern psychologists' licenses. Moreover, I was not afforded the time necessary to make a reasonably certain decision regarding the inmate's Severely Mentally Ill status. Nor should I have been pressured to make the inmate not SMI by the psychologist who had been treating him over a long period of time, who was more familiar with and knew the inmate patient better. And, especially not by a professional who had the authority to make such a determination and sign off on it himself as a psychologist.

These are delicate matters that may only be understood by other psychologists. Accordingly, I respectfully appeal to the board to review these matters and place my confidence in the Board of Examiners to decide and direct us to improve services for inmate patients and for the safety of the public at large.

Sincerely,

John Taylor Kent, Ph.D.
Psychologist

ENCLOSURES seven pages

NOTE TO PACE

December 22, 2004

EMPLOYEE COMMENTS

The accounting and comments from the outset are not accurate.

Regarding the therapeutic suggestion of charting one's own course, the question of what one would do if one met Buddha on his path is a long standing therapeutic and motivational query. I did not invent it. In fact, Dr. Arthur Freeman (Beck, Freeman & Associates, Cognitive Therapy of Personalty Disorders, 1990) readily employed it in training. And I have heard it elsewhere.

Upon review of the data base, I observed that the inmate had not been seen in accordance with the SDS Standards. Therefore, I scheduled this inmate patient in order to comply with the standards. Both the master's level therapist and administrative assistant told me Dr. Golde was the only one to see this inmate in therapy and that Dr. Golde did not want anyone else to see this inmate. This smacked of an inappropriate proprietary relationship; however, I needed to assure that we were in compliance with the standards as it is my responsibility. The inmate was not "referred to me for me to change his SMI status.' Rather, I initiated the scheduling of the appointment and saw the inmate.

However, after scheduling the inmate, Dr. Golde came in for his weekly scheduled day at Cook Unit. I consulted with Dr. Golde informing him that I had scheduled this patient, and then Dr. Golde told me he wanted me to make the inmate NOT SMI. I felt an inordinate pressure from Dr. Golde to change this inmate's SMI status. When I suggested to Dr. Golde that since he knew the inmate, and moreover since he wanted the inmate's SMI status changed that he [Dr. Golde] should be the licenced psychologist signing off on this action as (1) I did not have the opportunity to observe the inmate over time and, more importantly, (2) the inmate did not meet the usual criteria under which we psychologists at DOC practice, Dr. Golde pressured me further to change the inmate's status anyway.

This inmate patient did not meet the typical minimal criteria under which we practice. This inmate had not been successfully off psychiatric medications for a period of at least six months and, in my opinion, and as is the prevailing practice within DOC, it was premature to change the inmate's Mental health score from a 3 to a 2 under such circumstances.

I was informed, perhaps incorrectly, that this was the number two graduate in the Sex offenders's Program and that he is schedule for a review by the parole Board and has a fast approaching released ate. He is a short timer. When I suggested to Dr. Golde that he should be the one to change this inmate's SMI status because he had seen him and knew him best, Dr. Golde urged me to sign off on making the inmate not SMI. I felt a pressure from Dr. Golde to sign off on this inmate-- to, in effect, give him clean bill of health.

The inmate also pressured me to change his SMI status. Because I did not know the inmate and

because I was ill that day, and due to the seriousness of the possibility of changing this inmate's SMI status, I ended up spending more time than usual with that inmate. Also the inmate took as much time as I was willing to give him as he had an agenda and a goal. In the process I learned quite a bit about this inmate and my sense is that inmate may NOT have benefitted from the Sex Offender's Treatment Program and may in fact remain dangerous to the public.

I assessed the inmate's gains and respect for the SOTP by asking the inmate to explain the program he had graduated. I know nothing of the program. Part of the complaint was that I disagreed with the diagnosis. How was I to make this inmate NOT SMI if his Bipolar Disorder diagnosis was not in question? Another part of the complaint was that I questioned the "philosophy" of the SOTP program. While I have been vocal in seeking out information about the program, it has not been forthcoming. Moreover, how can I disagree with the philosophy of a program when I do not know the philosophy of that program?

During the PACE entry time with Dr. Holly, she, too, emphasized that I should have changed this inmate's SMI status to no longer SMI. She said it should not have taken as much time as I gave it to change the inmate's status. When I vocalized that I did not know the inmate and that the inmate did not meet our usual minimum criteria to be changed from SMI to non-SMI, Dr. Holly informed me that 'Dr. Golde was no longer practicing general services on the unit.' It was implied that I was to make the change in status on an inmate who had not met the minimal criteria by which we practice: He had not been off psychiatric medications for at least six months and there was no indication that he did not need counseling services.

While treating the inmate, he continued to talk even when I became ill abruptly and had to rush for the sink. There was time to excuse neither myself nor the inmate. It was a brief period of time for my stomach upset, certainly not prolonged. I cleared my throat of minimal material. It was not fun. It was not pleasant. But I knew over the weekend that I was sick and I knew I was the only psychologist to cover the entire Eyman complex that Monday. However, because I had agreed to cover for another psychologist in advance, I went to work ill.

In fact, the FHA was present at Cook Unit Medical and I inquired as to how he thought I should handle it when I was sick and I knew there was no one else to cover. Rod Norris remarked, "You tough it out." Rather than be applauded for my dedication to the team and my service, my sacrifice, I am being given a disciplinary PACE entry.

Notwithstanding, because I was able to give that much time to the inmate and observe the inmate patient under those circumstances, because he never stopped talking about himself even while I hit the sink and vomited, my provisional impression is that this inmate may have a 301.5 Histrionic Personality Disorder, Manipulative Subtype (Millon) and as such is not a candidate for psychotherapy. Moreover, because of the failure of the inmate to brag about the program he had just completed and his inability to explain the program to me, I surmise that the inmate may not have been treated successfully. Rather, the inmate's talents in manipulation precluded him from successful treatment. In other words, had he been assessed by myself or a competent psychologist, the inmate may not have been considered for treatment. He certainly would not have received priority consideration for placement. Should there have been a waiting list, this

inmate may have been placed at the bottom as an unlikely candidate for therapy.

I could not sign my name onto this inmate's plans for early release and place the public safety in jeopardy.

Finally, when my master's level colleague informed me of her concerns that I might change the inmate's status from SMI to no longer SMI, I listened. And I learned. She said that she was hoping the inmate might tell me himself: He committed his offense while in a manic episode.

From my knowledge of the literature (Goodwin and Jameson), the classic manic episode occurs once every two years. Therefore, six months is insufficient to determine whether or not the person has Manic-Depressive Illness and thus qualifies for SMI status. In other words, six months is an inadequate test for the possibility of a Bipolar Type I Disorder. One must be observed over a significantly greater period of time.

Moreover, since the inmate had plenty of opportunity to establish rapport with me and since he did not seek to work openly and honestly with me, I concluded that the SMI status should remain positive.

It saddens me to think that a fellow psychologist would pressure me to make his star pupil no longer SMI when he probably knows that the inmate represents a risk. It saddens me that my fellow psychologist and my supervising psychologist would both intimate that I failed by not changing the status of this inmate patient. I dare say that the treating psychologist may be too invested in himself and in his program to admit that this inmate may still be a danger to the public. Why does he not sign off on the change in SMI status himself since he knows this inmate so well? Could it be that he is overly and inappropriately invested in the graduate of his program?

Moreover, I have a complaint against my colleague: If I suspected a fellow professional of knocking my program, I would approach him or her myself directly and inquire on an informal basis first before taking this to a higher lever. I would do this because it is required by the American Psychological Association's Code of Ethics–Our Code of Conduct that defines what we do and who we are as psychologists The APA Code of Ethics requires that one psychologist approach another psychologist and seek to resolve ethical issues informally before making a formal complaint. Dr. Golde did not do this and as a result we have a gross misunderstanding–at my expense, of a disciplinary PACE entry.

More to the point, I do not think that Dr. Golde believes I knocked his program or he would have confronted me. Rather I think that Dr. Golde may be overly invested in his inmate patient graduate and may have taken this shot at me in retaliation for my having failed to follow his directive to make his prized student no longer SMI. Or perhaps his officemate down the hall in Central Office may have influenced him.

John Taylor Kent, Ph.D.
Psychologist II

ARIZONA DEPARTMENT OF CORRECTIONS

Performance Factors - Comments

Note to PACE

RATER COMMENTS

12/22/04 Dr has come to my attention that in response to a request to decide whether or not to terminate SMI status Dr Kent had a 2½ hr session and then had a 1½ hr session in response to inmate's request to review his record. During these sessions Dr Kent repeatedly discussed various topics such as dentists, testosterone and menopause. He repeatedly asked the inmate what he would do if he smoked Buddha, then told the inmate "No, you would kill him". Dr Kent repeatedly fell asleep in the sessions, told the inmate he disagreed with the

EMPLOYEE COMMENTS

The opening comments are not accurate, I saw this inmate because his regular provider had not seen him within the time frame specified in the new DO 5 standards. It was a mental health session rather than an assessment.

ARIZONA DEPARTMENT OF CORRECTI .S

Performance Factors - Comments

Note to PAGE - pg 2

RATER COMMENTS

diagnosis and that I he disagreed with the philosophies and techniques used in the Sex Offender Program. At no time reported that Dr Ext vomited on the sink while seeing the inmate, then had the inmate step in the room. Dr Ext later he was sick, did not vomit much but felt better after and kept the inmate there because he was meeting the inmate's needs, not his own.

EMPLOYEE COMMENTS

The inmate continued to talk nonstop. I attended to the inmate's needs rather than my own. It was urgent, I cleared my throat, washed my face briefly and wiped my face clean. I knew I was sick and I went to work because I was going to be the only psychologist during Eyman

RATER COMMENTS

Note to PACE - pg 3

— Dr Lent has been instructed to have brief sessions of about 30 minutes, that he does not have time to [redacted] psychotherapy, must use a Cognitive Behavioral Therapy approach, and is encouraged to use a group approach of Mind Over Mood.

— Dr Lent has been instructed to focus on the referral question, not other topics

— Dr Lent has been directed not to fall asleep in session - this is a safety issue.

EMPLOYEE COMMENTS

As a member of the Association for the Advancement of Behavioral Therapy (AABT), the leading association for the advancement of CBT. I practice CBT which is a type of psychotherapy. I will limit sessions to 30 minutes

RATER COMMENTS

NOTE TO PACE - pg 4

- Dr Egot has been instructed not to discuss the 30P program in a negative way with inmates and that he must evaluate and do each regarding diagnosis.

12-22-04

EMPLOYEE COMMENTS

In report writing I sought to learn from a "successful" inmate patient about the program I never was describe. This inmate is upset because I did not do as he asked and he has presented a twist on facts in order to split staff.