psychNEWS

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PSYCHOLOGY UNPLUGGED?

a message from the chair

Jane E. Perrin, Ph.D.

Just imagine: an Iraq War veteran is a double amputee and suffers from posttraumatic stress disorder. He is afraid to leave his house as a function of his PTSD, and transportation is especially difficult because of his physical disability. The nearest psychologist who treats PTSD is two hours away. After three sessions with the psychologist, the client announces that the travel time and the discomfort associated with getting to the sessions are so great that he will have to discontinue his treatment. The psychologist offers to conduct treatment via web camera, the client agrees and therapy continues.

Although this case is fictional, variations on this scenario are playing out across the country. Many psychologists applaud the use of technology in making psychological services more accessible to persons with mental illness. Some traditionally underserved populations, such as prisoners, people who have physical disabilities, people who live a considerable distance from a psychologist and people whose mental illness requires a psychologist with specialized training may particularly benefit from teletherapy. Additionally, telepsychology may have valuable applications for emergency assessments and involuntary commitments, and may be less expensive for clients when compared to face-to-face sessions.

But, how effective are electronic techniques in the practice of psychology, what are the intrinsic challenges of infusing technology into the clinical setting, and what are psychologists doing to address these challenges? These and other issues were discussed at "Psychology Unplugged: How Technology Impacts Regulation," a conference in Seattle sponsored by the Association of State and Provincial Psychology Boards (ASPPB). Martha Storie (Executive Director of the North Carolina Psychology Board and Secretary-Treasurer of ASPPB), Randy Yardley, M.A. (Staff Psychologist of the NCPB), and I represented North Carolina at the conference, and came away with enriched perspectives.

Effectiveness of distance psychological services

Some practitioners at the conference argued that electronically transmitted sessions would interfere with nonverbal communication that is normally an important component of assessment and treatment in face-to-face sessions. In contrast, others pointed out that clients may be more willing to disclose certain information through written communication, or if they have the screening afforded by webcam. Catholic confessionals have, of course, made use of this principle for centuries.

Ideally, psychologists could turn to empirical research for guidance in deciding whether to employ electronic technology in their practice. We learned at the conference that published studies are limited, however. The difficulty in measuring the efficacy of psychotherapy is well known. Efforts to compare the relative merits of teletherapy with face-to-face therapy have additional, complex challenges. Consider the wide array of client demographics, psychological disorders, evidence based treatments, types of electronic communications and measures of success that would need to be considered in this type of research. Many clinicians who use information technology in their practices use a hybrid of face-to-face treatments and telepsychology. What is the appropriate balance? Moreover, current research has questionable application to future electronic applications and technologies. Remember, ten years ago, Facebook, Skype and iPads did not exist. Who knows what technology will be commonplace in another decade?

Ethical considerations

Participants at the ASPPB conference appeared to agree that psychologists who use email, chat rooms, Twitter, webcams and other electronic tools in their practice are held to the same ethical standards as psychologists who practice face-to-face therapy. However, in order for a psychologist to adhere to ethical principles such as obtaining a client's informed consent for treatment, the psychologist must be well-educated about the clinical and ethical risks of telemental health services. To avoid doing harm to clients, psychologists need to take steps to minimize hazards. Speakers discussed many of the potential ethical perils associated with telepsychological services. Some of them seemed fairly apparent, such as the vulnerability of client information. We were reminded that intrusions on privacy can occur in the transmission of electronic information, both at the client's computer/electronic device, as well as at the psychologist's. Although passcodes and encryption can make intrusions on privacy difficult, these protections are not panaceas. For instance, how should a psychologist handle a client's family member who wanders into the room where the client is engaging in therapy via Skype?

Some risks are less obvious. Because interstate and international psychological

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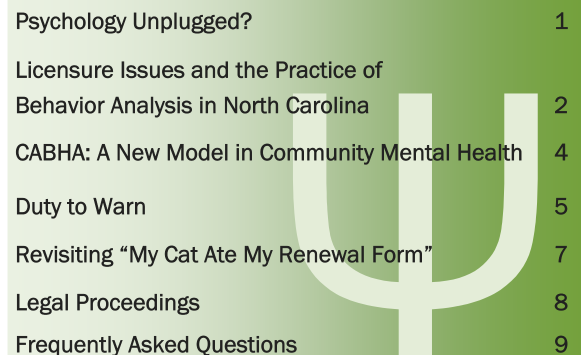

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services are possible through telecommunications, psychologists need to develop cross-cultural sensitivities that may not have been pertinent to their traditional local practices. Mandatory educational requirements for cultural competency have been discussed in recent years by ASPPB. These courses have new significance in light of the growth of telepractice.

North Carolina Psychology Board's 2005 Advisory Statement about provision of services via electronic means

Martha Storie presented a summary of the advisory statement generated by the NCPB, which can be found at http://www.ncpsychologyboard.org/policy.htm. In addition to referring psychologists to pertinent sections of the APA *Ethical Principles of Psychologists and Code of Conduct* (2002), the statement provides significant guidance to psychologists who are considering incorporation of distance services in their practices. The Board asserted, *"The practice of psychology occurs both where the psychologist who is providing the service is located and where the individual (patient/client) who is receiving the service is located."* North Carolina psychologists should therefore determine whether telepractice is allowed in the jurisdiction in which the client lives, and whether the psychologist needs to be licensed in both jurisdictions. In light of the complexity of issues related to distance psychological services, our advisory statement is only a first step. Relative to most states, though, the NCPB appeared to be ahead of the curve in anticipating concerns related to telepractice.

Future directions

Graduate students in attendance at the conference reported that telepsychology is not taught in their programs. They are relying on peers for counsel on challenges such as how to maintain ethical boundaries with clients while also participating in social networking sites. Clearly, academic faculty will need to become sources of guidance on these issues as well as telehealth issues in the near future. Likewise, psychology boards need to develop acumen about information technology in order to create and enforce rules about the use of electronics in psychological practice. Because of the cross-jurisdictional potential for distance practice, cooperation across regulatory bodies will be essential. Efforts are already underway by ASPPB, the National Register and the American Psychological Association to address distance psychology matters that transcend jurisdictional boundaries.

ASPPB Executive Director Stephen DeMers, Ed.D., noted that "Psychology Unplugged" was like a Rorschach, because it could be interpreted as the profession gone berserk, or the profession detached from technological advances. Regulatory boards, as well as experts in information technology, law and psychology will need to contribute their expertise to ensure that new approaches are implemented in an ethical, efficacious manner. With responsible guidance, telehealth technologies may advance our field in interesting and previously unforeseen ways.

LICENSURE ISSUES AND THE PRACTICE OF BEHAVIOR ANALYSIS IN NORTH CAROLINA

Thomas J. Thompson, Ph.D.
Former Board Chair, currently at Murdoch Developmental Center in Butner, NC

In North Carolina, behavior analysis and behavior therapy have long been part of the definition of the practice of psychology, under N.C. Gen. Stat. § 90-270.2(8). In fact, the Association of State and Provincial Psychology Boards (ASPPB) includes behavior analysis and therapy in its definition of the practice of psychology in both its current Model Act for Licensure and its proposal for the next revision of the act. Specifically, ASPPB's definition of the practice of psychology includes, but is not limited to "…counseling, psychoanalysis, psychotherapy, hypnosis, biofeedback and behavior analysis and therapy." All state Psychology Boards are members of ASPPB and typically review the association's recommendations for use in their state practice acts.

Behavior analysis is the scientific study of behavior. The term "behavior analysis" was coined by B. F. Skinner, who is generally considered the founder of the field. Skinner is perhaps the best known learning theorist of the twentieth century. The field is also highly indebted to the work of Russian physiologist Ivan Pavlov whose study of the digestive system won him a Nobel prize in 1904, and led to the description of the conditioning of physiological reflexes, or classical conditioning.

Skinner (1935) observed that there were two different models for learning or conditioning. Behavior was either controlled by antecedent, eliciting stimuli (respondent or classical conditioning), or by consequent stimuli (operant conditioning). Since 1957, the *Journal of the Experimental Analysis of Behavior* has set the standard for laboratory research in operant conditioning. In 1968, the *Journal of Applied Behavior Analysis* began publication. In the first issue, Baer, Wolf and Risley (1968) defined the term "applied behavior analysis." In summary, *applied* defines a subject matter that is important to people and society, *behavioral* defines the reliable quantification of physical events, and *analysis* defines the ability to convincingly demonstrate the variables which control the behavior. In recent years, additional journals have been published to develop the field covering areas of clinical and theoretical importance as well as practitioner issues.

As indicated previously, many licensing acts refer to behavior analysis and therapy. There is a difference between the two, and the Association for Behavior Analysis International (ABAI) provides the following distinction:

"…the terms are not synonymous. Behavior therapists tend to accept the underlying assumptions of behavior analysis. However, they tend to use Pavlovian procedures and focus on problems involving covert behavior, such as anxiety disorders, depression, and unwanted thoughts and feelings. Applied behavior analysts tend to use procedures based on operant procedures and tend to focus on overt (publicly

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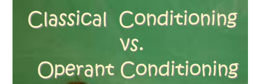

observable) behavior."

Since the 1960s, the field of behavior analysis has, in fact, demonstrated significant applications to the improvement of human behavior. Much of the early application was directed toward persons with developmental disabilities, a population chosen perhaps for both the obvious needs relating to learning, and the availability to be systematically studied in congregate living environments. Over time, great advances have been made both in the ability to enhance adaptive behavioral repertoires and to reduce significant, often life-threatening maladaptive behaviors in this population. The last 40 years have seen significant contributions of applied behavior analysis in other areas including: organizational management, education, health, addiction, clinical behavior analysis, behavioral medicine, brain injury rehabilitation, and sports psychology. North Carolina has made significant contributions to the field of behavior analysis including research in the areas of developmental disabilities (Murdoch and J. Iverson Riddle Developmental Centers), education (UNC-Charlotte), basic research in learning (UNC-Wilmington), and student education (East Carolina University and UNC-Wilmington).

Interest in the application of behavioral interventions in the treatment of autism spectrum disorders (ASD) has skyrocketed in the past 10 years. While the application of these behavioral intervention treatment principles to ASD is not new (Lovaas, 1987; McEachin, Lovaas, and Smith, 1993), its popularity has soared for at least two reasons. First, the number of children known to have ASD has increased dramatically since the 1980s. Second, highly intensive treatment programs using behavior analytic principles have reported dramatic success in some individuals with ASD. At least 16 states have adopted legislation mandating health insurance companies to provide coverage for behavioral treatment for children with ASD. Currently, the North Carolina legislature is considering one such bill. Benefits are already being provided to active duty military families in North Carolina through their insurance benefit program. With the prevalence of ASD and the intensity of supports needed to address it, there is a great need to identify qualified providers.

Given the success of interventions based in behavior analytic principles, one group qualified to meet this need would be applied behavior analysts. An important distinction should be made, however, between the theoretically based treatment planning and evaluation done by highly qualified professionals and the work that non-licensed paraprofessionals might do in the intensive daily therapeutic interactions (such as discreet trial training, pivotal response training, etc.) that are an essential "hands-on" part of treatment programs. It is important to give a name to this activity which is not the analysis of behavior, but rather is an intervention strategy carried out by trained technicians as prescribed by professionals. A common term would be "behavior intervention", and a newer term is "behavioral care". This distinction is not a rhetorical exercise, but rather a critical decision point in defining credentials for service providers. In common parlance, a person might say that the technician who is providing prescribed interventions is "doing behavior analysis" with a client. This is inaccurate, and would imply that the non-licensed person is practicing psychology. Such activity, under the supervision of a Licensed Psychologist or Psychological Associate, would be considered the provision of ancillary services pursuant to N.C. Gen. Stat. § 90-270.21 and Board rule 21 NCAC 54 .2801-.2806.

In 1998, the Behavior Analyst Certification Board, Inc. (BACB), was established to develop, promote, and implement an international certification program for behavior analyst practitioners. The BACB certifies behavior analysts at the doctoral and master's levels and associate behavior analysts at the bachelor's level. This certification certainly helps identify persons with skills relevant to the needs of clinical populations, including persons with ASD. Unfortunately, it can create confusion for persons with one of these certifications who wish to work in a state that defines behavior analysis as the practice of psychology.

According to the North Carolina Psychology Practice Act, in order to practice psychology, which includes behavior analysis and therapy, one must be licensed by the Psychology Board, or otherwise exempt pursuant to N.C. Gen. Stat.§ 90-270.4. Persons exempted from psychology licensure who can practice psychology include school psychologists licensed by the N.C. Department of Public Instruction (DPI), but only while serving as regular salaried employees of DPI or local boards of education, students or interns as part of a course of study, persons licensed to practice psychology in other states for up to five days per year, and qualified members of other professional groups licensed or certified *under the laws of this State,* who render services within the scope of practice as defined in the statutes regulating those professional practices.

In North Carolina then, a person who possesses a Board Certification in Behavior Analysis who is not licensed as a psychologist, or exempt as stated above, could provide ancillary services or behavioral care under the supervision and/or employment of a licensed psychologist or psychological associate, but could not otherwise legally practice behavior analysis. Psychologists may become aware of persons who are practicing behavior analysis illegally. If you become aware of someone who is doing so, you should make the person aware that this is a prohibited act according to the licensing law (N.C. Gen. Stat. § 90-270.16) and may constitute a Class 2 misdemeanor (N.C. Gen. Stat. § 90-270.17). Also, be aware that any licensee aiding or abetting the unlawful practice of psychology by any person not licensed by the Board may be found by the Board to have violated the Code of Conduct under N.C. Gen. Stat. § 90-270.15(a)(8).

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CABHA: A New Model in Community Mental Health

John Esse, Ph.D.

In an article I wrote in the February 2008 edition of this newsletter (Vol. 15, No. 1), I addressed concerns of the Psychology Board regarding certain job descriptions and service definitions within the evolving mental health system in North Carolina. These primarily related to issues of quality and accountability. The Board was subsequently encouraged by learning of the development of a Staff Qualifications Workgroup within the State's Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS). A major thrust of that group has been to develop a sounder, more comprehensive framework for assessing competencies and establishing skill standards for various categories of professionals who work within myriad private provider organizations; these are the organizations that essentially replaced the network of publicly operated local mental health centers originally spawned by the Community Mental Health Act of 1963. However, this Workgroup has now postponed plans to disseminate its work product due to current system stresses. Another action by the State was to establish tiered rates for reimbursement for community support services based upon the individual qualifications of the staff providing the service, and included a category for licensed qualified professionals. To some degree, this decreased the incentive to use non-licensed staff to perform functions that, arguably, should only be provided by someone who has more advanced training/experience and is licensed by (and thus accountable to) a professional board. Such efforts notwithstanding, continuing problems with variability in quality/accountability, particularly in the provision of community support services, have plagued public policy makers within the Legislative Oversight Committee of the General Assembly and the State's Department of Health and Human Services (DHHS). Some of DHHS's most recent responses to this dilemma have been to transition community support to other defined services and to establish the basis for a new service provision entity called the Critical Access Behavioral Health Agency (CABHA).

A CABHA description can be found at http://www.dhhs.state.nc.us/MHDDSAS/cabha/. This new type of agency is geared toward providing mental health and substance abuse services only, not developmental disabilities services; it may be a for profit, not for profit, or public organization. The essential goals are to ensure population-appropriate clinically competent services based on a comprehensive assessment and to reduce clinical fragmentation within the mental health system. CABHAs will receive state-wide three-year certification following completion of a multi-step application process, culminating with an on-site review by Local Management Entity (LME) licensed staff, along with a team from DMH/DD/SAS and the Division of Medical Assistance (DMA). To become certified, a CABHA must have staff to fulfill the functions of medical director, clinical director, and quality management/staff training director. Of note for psychology is that the clinical director, whose duties include supervising all non-medical direct care staff, designing treatment protocols for the agency, and ensuring appropriate assessments, can be a licensed psychologist or a licensed psychological associate.

Services provided by a CABHA must include the core functions of comprehensive clinical assessment, medication management, and outpatient therapy, as well as at least two other approved services consistent with the age/disability of the population served. Case management will also be a core function provided by CABHAs (for both Medicaid and State funded mental health and substance abuse clients) once this service is approved by the federal Centers for Medicare and Medicaid Services (CMS). Case management will be paid on a monthly case rate at a level that should help pay for some of the clinical leadership staff that are required. Meanwhile, a number of other services may continue to be delivered by other providers who are not CABHA-certified.

The announcement of this system re-design has drawn criticism from those who oppose the change or who urge a slowing of the process. There are, for example, concerns about the significant medical oversight requirements from both a practical perspective (e.g., given the cost and scarcity of experienced psychiatrists and other physicians) as well as substantively in terms of the degree to which the medical director functions do or do not require a person with medical training (e.g., oversight of quality management initiatives). There have also been concerns expressed about the impact on many small providers who will not be able to meet the requirements, and thus may be barred from providing the core services, with such impact being particularly salient in more rural communities. It is an open question as to whether some services originally designated as CABHA-exclusive core functions will be allowed to be subcontracted to smaller providers, either by a CABHA or by an LME. In any case, one likely result of CABHA implementation will be fewer providers and consolidation of services among larger providers in the system.

Most advocates and stakeholders seem to agree that fundamental change is needed, and that the reform process up until now has been flawed. The system at present is too fragmented with a lack of continuity of care for consumers. Further, the much-publicized prior overbilling abuses and involvement of insufficiently trained/credentialed staff in relation to community support services by some private providers unfortunately spoiled the integrity of the care environment for those dedicated agencies doing a good job with well-qualified professionals.

The hope of state officials is that this major paradigm shift in how core services are delivered, i.e., by CABHAs, to those who have traditionally been seen as public sector clients, will result in better training/credentials and oversight/accountability of the staff providing those services. Meanwhile, by virtue of the requirement for each CABHA to employ a clinical director, opportunities should open up for psychologists to play a key leadership role in increasing the likelihood of such enhancements.

Finally, as a sidebar, I wish to mention that part of the bigger picture is the State's intent to expand use of the 1915b/c Medicaid Waiver for MH/DD/SAS beyond one LME (i.e., PBH). This is a model wherein "Medicaid-funded services for mental health, substance abuse, and developmental disabilities are provided on a capitation basis" within a given geographic area (http://www.dhhs.state.nc.us/dma/lme/MHWaiver.htm). In addition to following outcomes related to the imminent implementation of the CABHA model, advocates and other stakeholders will be closely following the impact of additional LMEs being selected to participate in the State's Medicaid Waiver, especially in this era of scarce resources.

DUTY TO WARN

Sondra C. Panico

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The North Carolina Psychology Board, on occasion, receives inquires about a psychologist's obligation to warn others about the potential for harm by his/her client/patient. The purpose of this article is to discuss what is required of a psychologist to protect others from harm, otherwise known as the "duty to warn." The North Carolina Psychology Practice Act incorporates the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2002) by reference.

Standard 4.05 of the *Ethical Principles of Psychologists and Code of Conduct* states:
(a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.

(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or *where permitted by law* for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) *protect the client/patient, psychologist, or others from harm*; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose.

Therefore, when disclosure is mandated by law, then revealing confidential information is required, such as in the case of child abuse, neglect, or elder abuse or neglect. Further, N.C. Gen. Stat § 8-53.3, states that the psychologist-patient privilege is not grounds for failing to report suspected child abuse or neglect or for failure to report a disabled adult to the appropriate county department of social services. When not mandated by law, Standard 4.05 states that if it is permitted by law, a psychologist discloses confidential information to protect the client/patient, psychologist, or others from harm. As discussed in this article, it appears that such disclosures under certain circumstances are permitted by North Carolina law.

Chapter 122C of the North Carolina General Statutes:

If you are a psychologist working in a facility which meets the definition of "facility" under N.C. Gen. Stat. §122C-3(14), as set forth below, and you are a "responsible professional," then you may disclose confidential information to protect others from imminent danger or if there is a likelihood of the commission of a felony or violent misdemeanor.

N.C. Gen. Stat. § 122C-55(d) states: A responsible professional *may* disclose confidential information when in his opinion there is an imminent danger to the health or safety of the client or another individual or there is a likelihood of the commission of a felony or violent misdemeanor.

N.C. Gen. Stat. § 122C-3(32) defines "responsible professional" as: an individual within a facility who is designated by the facility director to be responsible for the care, treatment, habilitation, or rehabilitation of a specific client and who is eligible to provide care, treatment, habilitation, or rehabilitation relative to the client's disability.

The definitions/obligations under Chapter 122C of the North Carolina General Statues apply, if the psychologist is working in a facility that meets the definition of "facility" under Chapter 122C , as follows:

N.C. Gen. Stat. § 122C-3 (14) defines "facility" as: (14) any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers, and includes:

a. An "area facility", which is a facility that is operated by or under contract with the area authority or county program. For the purposes of this subparagraph, a contract is a contract, memorandum of understanding, or other written agreement whereby the facility agrees to provide services to one or more clients of the area authority or county program. Area facilities may also be licensable facilities in accordance with Article 2 of this Chapter. A state facility is not an area facility;

b. A "licensable facility", which is a facility that provides services to individuals who are mentally ill, developmentally disabled, or substance abusers for one or more minors or for two or more adults. These services shall be day services offered to the same individual for a period of three hours or more during a 24-hour period, or residential services provided for 24 consecutive hours or more. Facilities for individuals who are substance abusers include chemical dependency facilities;

c. A "private facility", which is a facility that is either a licensable facility or a special unit of a general hospital or a part of either in which the specific service provided is not covered under the terms of a contract with an area authority;

d. The psychiatric service of the University of North Carolina Hospitals at Chapel Hill;

e. A "residential facility", which is a 24-hour facility that is not a hospital, including a group home;

f. A "state facility", which is a facility that is operated by the Secretary of the Department of Health and Human Services;

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g. A "24-hour facility", which is a facility that provides a structured living environment and services for a period of 24 consecutive hours or more and includes hospitals that are facilities under this Chapter; and

h. A Veterans Administration facility or part thereof that provides services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers.

As a result, if a psychologist is employed in a facility that meets the definition of a facility under N.C. Gen. Stat. § 122C-3, which is a very broad and inclusive definition, and the psychologist is the responsible professional, then he may disclose confidential information under N.C. Gen. Stat. § 122C-55, if in his opinion there is imminent danger to the health or safety of the client or another individual or there is a likelihood of the commission of a felony or violent misdemeanor. This statute may also apply to psychologists who are in sole or group private practice, given the broad definition of facility. Again, this is a permissive statute, not mandatory.

Applicable Case Law

In the landmark case, *Tarasoff v. Regents of University of California*, 17 Cal. 3d 425, 551 P. 2d. 334, 131 Cal. Rptr. 14 (Cal. 1976), the California Supreme Court held that once a therapist determines, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger.

In North Carolina, the duty to warn foreseeable victims of serious danger from a patient, as held in *Tarasoff*, is not the law. As a result, a therapist is not required to warn potential victims of danger by his patient, however, there is no law that prohibits a therapist from doing so. In *Gregory v. Kilbride*, 150 N.C. App 601, 565 SE 2d 685, (2002), the North Carolina Court of Appeals held that a psychiatrist does not have a duty to warn third persons. In *Gregory*, the patient made numerous threats to kill his wife, but the psychiatrist, Dr. Kilbride, determined that he did not meet the requirements for involuntary commitment. Once the patient was released he shot and killed both his wife and himself. The plaintiffs argued that Dr. Kilbride breached a legal duty to warn the wife of her husband's dangerous condition. The Court of Appeals held that, unlike the court in *Tarasoff*, North Carolina does not recognize a psychiatrist's duty to warn third persons.

However, in *Davis v. N.C. Department of Human Resources*, 121 NC App 105, 112, 465 S.E. 2d 2, 12 (1995), the North Carolina Court of Appeals recognized an exception to the general rule that there is no duty to warn, when a person has been involuntarily committed for a mental illness, in which case there is a duty placed upon the institution to exercise control over the patient with such reasonable care as to prevent harm to others at the hands of the patient.

As a result, except in the case of involuntary commitment, since the *Ethical Principles of Psychologists and Code of Conduct* (APA 2002), Chapter 122C of the North Carolina General Statutes, and present North Carolina case law, do not mandate a duty to warn, but also do not prohibit such a duty to warn, it is left up to the psychologist to determine whether he/she should warn third persons and, if so, how to do so. The psychologist will need to balance confidentiality requirements with the protection of potential victims of harm.

Some considerations, taken from statute and case law, when deciding whether to warn (not meant to be an exhaustive list):

1. Was the person who made the threat an actual patient;
2. Would the patient consent to your warning (in which case you would not have to violate confidentiality);
3. Did the patient make the threat in your presence;
4. Was the threat made against an identified individual;
5. Do you believe the threat to be a serious threat of harm to another individual (for example, does the person have an identified plan, means to act on such a plan, etc.);
6. Do you believe the threat to be of a felony or violent misdemeanor;

It is important to carefully document any disclosure, how you disclosed (in person, letter, email, telephone, etc.) and to whom (potential victim, potential victim's family, law enforcement, etc.), when you made the disclosure (date and time), and who made the disclosure (you or staff person).

The *Tarasoff* case is helpful in considering how to warn third persons and suggests that you warn the actual potential victim, or if you are unable to reach the potential victim, someone who can warn the potential victim. It further suggests that you only disclose the confidence when necessary to avert danger to others, and even then to do so discreetly and in a way that would preserve the privacy of the patient to the fullest extent possible consistent with preventing the threatened danger. *See Tarasoff,* 17 Cal. 3d at 441.

NOTE: This article was prepared for the North Carolina Psychology Board by Sondra Panico, Assistant Attorney General and Counsel to the Board. It has not been reviewed and approved in accordance with procedures for issuing an Attorney General's opinion. Nothing in this article is intended to serve as legal advice and you may wish to consult with an attorney for specific legal advice about any of the issues raised in this article.

RE-VISITING "MY CAT ATE MY RENEWAL FORM" AND "FOLLOW-UP ON THE CAT"

Original versions by Craig Iversen, Ph.D., then Board Chair
Revised for publication by Randy Yardley, M.A.

In a not so tongue in cheek fashion, Dr. Iversen described in articles for the newsletter in the early 1990's the not so creative ways that licensees had found to get themselves into trouble with the Board when a few simple preventive measures could have been taken to avoid such problems. Things have certainly gotten better since that time. The fact that the Board has more staff and is able to provide more responsive service to applicants and licensees has reduced some of the difficulty about which Dr. Iversen wrote at that time. Unfortunately, despite the effort that the Board expends to keep licensees informed about changes in Board Rules under the North Carolina Administrative Code, the many pieces of correspondence (including email) that are sent to those who are recalcitrant about responding, and the various pieces of information provided in the now regularly published newsletter, Dr. Iversen's words from back in the day still ring true during the current times for some individuals. So, to repeat the list of problem behaviors commented on by Dr. Iversen, please read on:

Don't bother to read your mail (including email). As many of you know, this is a license renewal year, which means that by October 1, all licensees must send a check and renewal application to the Board to maintain their licenses. It is also the year in which, at the same time you renew, you must submit documentation of having met continuing education (CE) requirements. Notices will go out in August, and a not so small select few will not have informed the Board about changes of address, so they will have the not so useful excuse of saying that the mail never got to them or the US Postal Service took too long to forward their mail, which is why their renewal fee and CE documentation are being submitted late. There are others who will not be inclined to open their mail, but eventually do so, in some cases, well past the deadline or only when the late notice is sent out to the select few. It will not matter to the Board what the excuse is, late will cost somewhat more than being on time.

Surprisingly there are those who fail to open other mail from the Board, or who avoid picking up certified mail, possibly in the misplaced hope that the Board will give up and go away. Second notices for some things, e.g., being late on CE information, are sent out by regular US Mail. Third notices never are, and they appear in the form of certified mail, return receipt requested. Know that if you have certified mail from the Board to which you do not respond, you have upped the ante in the direction of potential disciplinary action. And finally, for those who are really unresponsive, the Board will sometimes employ either a private process server or the sheriff's office to deliver important mail to licensees, and we hear that they will show up all hours of the day and night when you least expect them.

While the Board, as everyone seems to have done these days, has begun to rely more on technology in the form of email communication, failure to respond to this form of communication is simply another way not to respond to Board communications in an appropriate manner, which creates similar problems for the applicant or licensee.

Ignore deadlines. As Dr. Iversen articulated, "This recommendation is clearly a corollary of Rule #1 above and an almost fail-safe method for gaining the Board's attention. It also leads almost directly to Rule #3, one of my personal favorites."

Ask for special dispensation. In Dr. Iversen's words: "For the most effective use of this Rule, it is almost necessary to assume that I, personally, and with total disregard for legal requirements and precedents, set totally arbitrary deadlines for your individual convenience. Then, all you have to do is call the Board's office with great urgency, explaining that you've been to Moldavia for the past eight months, and ask that a conference call of the Board be conducted so you won't have to reapply for your revoked license because you have to be at your favorite aunt's house this weekend."

Although this description of potential circumstances was a bit of contrivance on his part, Dr. Iversen's words ring true to this day. The reality is that the Board makes every attempt to act fairly and reasonably when asked to veer from its normal course. It will not veer from that course, however, unless it has good reason to do so and only if it has the flexibility provided under law and the previously mentioned rules. The Board certainly recognizes that deployments by the military to Iraq and Afghanistan, automobile accidents on the way to take an exam, and unexpected early deliveries of babies are disruptive in many ways, but, for the most part, the excuses or reasons that applicants and licensees routinely present to avoid obligations and standard expectations are not so grave. The best thing to do is (this is a mixed metaphor, I know) to bite the bullet, and take your medicine. In other words, consider requesting special dispensation only if your circumstances truly support such a request, and recognize the potential limitations for the Board to honor such a request.

RENEWAL TIPS

- Make sure that the contact information the Board has on file for you is current. Email, fax or mail the Board a change of address.
- Mail your renewal application to the Board, faxed renewals are not accepted. Renewals must be postmarked by October 1, 2010.
- All licensed psychological associates must also submit a supervision report for each work setting along with the renewal application.
- For this renewal cycle, licensees may only count CE obtained between October 1, 2008-October 1, 2010.
- Remember to complete the CE Attestation Form (located on the back of your renewal form). See page 8 for more information about CE.
- Make sure your renewal application is completed correctly and that you have included your renewal fee with your form. Incomplete or incorrect renewal applications will be returned.

LEGAL PROCEEDINGS

During the period of time from January 1, 2010, through May 31, 2010, the Board reviewed and closed 25 investigative cases involving psychologists in which it found either no evidence of probable cause of a violation or insufficient evidence to issue a statement of charges, and reviewed and closed three cases involving non-psychologists. In addition to issuing remedial action in three cases, the Board took the following action:

Sharon S. Burton, M.A. - FINAL DECISION on remand was approved on February 17, 2010. The Board affirmed its decision to REVOKE Ms. Burton's license to practice psychology. The Board concluded that, based upon the evidence presented regarding the appropriateness of the Board's sanction, the sanction it imposed in its Final Decision dated November 30, 2006, was appropriate and supported by the evidence. The Board added to the conclusions of law in its November 30, 2006 decision, the conclusion that Ms. Burton also violated N.C. Gen. Stat. § 90-270.15(a)(12). Ms. Burton shall pay the costs of the previous disciplinary proceeding in the amount of $2,850 and of this disciplinary action in the amount of $600.00.

Demetri Paul Drosinis - ORDER was signed on March 24, 2010, by The Honorable J. Gentry Caudill, Mecklenburg County Superior Court Judge, granting the PERMANENT INJUNCTION sought by the Board against Mr. Drosinis. Mr. Drosinis is enjoined from representing himself to the public to be a psychologist in any medium and from offering to practice psychology or practicing psychology.

John A. Gorman, Ph.D. - CONSENT ORDER was approved and signed on March 12, 2010. Dr. Gorman admits that the described conduct constitutes violations of N.C. Gen. Stat. §§ 90-270.15(a)(10), (a)(11) & (a)(15), of the North Carolina Psychology Practice Act, and Standards 3.05(a), 3.06, 10.06 & 10.10(a) of the *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2002). Based on the unique circumstances of this matter, Dr. Gorman shall VOLUNTARILY RELINQUISH his license to practice psychology and the Board shall accept his relinquishment. After May 15, 2010, he shall not engage in the practice of psychology at any time in the future in any State or jurisdiction. Further, he must remit $300.00 in costs. This ORDER constitutes action against Dr. Gorman's license pursuant to N.C. Gen. Stat. § 90-270.15(b).

James A. Powell, Psy.D. - CONSENT ORDER was approved and signed on January 21, 2010. Dr. Powell admits that the described conduct constitutes violations of N.C. Gen. Stat. §§ 90-270.15(a)(14), & (a)(15) of the North Carolina Psychology Practice Act, and Standard 9.01(a) of the *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2002). Dr. Powell's license is REPRIMANDED. He must issue a signed and dated written retraction of a diagnosis which he assigned to a patient, stating that the diagnosis was made in error because it was not supported by the information which he had available to him, and he must remit $300.00 in costs.

Michael Streppa, Psy.D. - ORDER OF SUMMARY SUSPENSION was approved and signed on March 8, 2010. The suspension became effective on March 9, 2010, and shall remain in effect until the Board issues a Final Decision in this matter or until the parties enter into a Consent Order that is a final determination in this matter. Dr. Streppa's conduct, if proven, violates several provisions of the NC Psychology Practice Act and *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2002), including Standard 10.05, which is the absolute prohibition on engaging in sexual intimacies with a patient.

Michael Streppa, Psy.D. - CONSENT ORDER was approved and signed on May 5, 2010. The Board finds that the described conduct constitutes violations of N.C. Gen. Stat. §§ 90-270.15(a)(10), (a)(11), (a)(15), (a)(20) & (a)(21) of the North Carolina Psychology Practice Act, and Standards 3.04, 3.05(a), 3.08 and 10.05, and 10.08(a) of the *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2002). Dr. Streppa's license is REVOKED and he must remit $300.00 in assessed costs.

License #:
Last Name: (Enter the last name of the individual you are searching for, i.e., Smith, Jones, etc.)
First Name: (Enter the first name of the individual you are searching for, i.e., Jane, Mary, etc.)
City: State: Zip:
Submit Reset

NOTE: License verification is available on the Board's website and includes whether or not Board action has been taken on a license.
To search for License Verification:
Click on License Verification located on the sidebar.
Enter the relevant information.
Click Submit.

CURRENT CE REQUIREMENTS:

18 Hours Every Two Years

CATEGORY A

9 Hours Minimum Required

3 hours from Category A must cover ethical and legal issues within the professional practice of psychology.

If you can answer yes to all of the following questions, an activity is considered acceptable for Category A.

- Is the program sponsored or co-sponsored by the Board, the APA, an APA-approved sponsor, or by NC AHEC?
- Does the program specifically identify psychologists in the target audience?
- Are contact hours specified by the sponsor?
- Does the program cover ethical and legal issues within the professional practice of psychology or assist you in maintaining and upgrading skills and competencies within your scope of practice?
- Does the program provide a certificate upon completion?

CATEGORY B

9 Hours Maximum Allowed

No Sponsorship Requirements for Category B

Category B activities must either cover ethical and legal issues within the professional practice of psychology or assist you in maintaining and upgrading skills and competencies within your scope of practice as a psychologist.

FREQUENTLY ASKED QUESTIONS

I am a licensed psychologist, who has recently been asked to supervise a licensed psychological associate who tells me that he is approved to receive level 3 supervision. How do I confirm this information?

One of the first and most important responsibilities for a supervisor of an LPA is to verify his/her licensure and supervision level. A supervisor may do this several different ways. The easiest way to verify this information is online at the Board's website www.ncpsychologyboard.org. Click on the "License Verification" link located on the sidebar and enter the relevant information for the licensee. You can verify licensure, confirm an LPA's supervision level and find out if a licensee has received Board action. This information is regularly updated by the Board. When the LPA's information is displayed on screen, you will see either "1," "2," or "3" beside the Supervision Level. You may click on each of the numbers for an explanation of the different levels of supervision. Please be aware that an LPA is only able to receive Level 2 or 3 supervision after making application and receiving written confirmation from the Board that the LPA's application for reduced supervision was reviewed and approved. If an LPA informs you that he/she has been approved for reduced supervision, but you are unable to confirm this information on the Board's website, please contact the Board office. You may also call the Board office to verify licensure and/or a licensee's level of supervision with Board staff. While there is no charge for web or telephone license verification, pursuant to 21 NCAC 54 .1605(10), there is a $10.00 charge assessed for each written license verification obtained from the Board office, whether submitted individually or on a list.

I provide services to children in my practice, and I often treat children whose parents are divorced. If I am treating a child whose parents are divorced, do I need to obtain both parent's consent to treat the child?

Providing psychological services to a child whose parents are separated or divorced can be very complex. Often, one parent will enlist the services of a psychologist without notifying the other parent. The Board receives numerous complaints from parents who were unaware that their child was even seeing a psychologist and are upset that the psychologist did not ask for their consent before providing treatment. Unless there is some reason not to include one parent, you should always make reasonable attempts to obtain the consent and cooperation from both parents before providing any type of psychological services to a child. In many instances, one parent will have primary custody and that parent is responsible for making decisions regarding the child's health. In that case, it would be crucial for you to contact the parent who has primary custody to obtain his/her permission in order for you to offer any type of services to the child. If the parent who contacts you has primary or joint custody, that parent may be able to seek services without the other parent's consent. However, it is your responsibility to determine what the custody agreement stipulates by having the parent provide you with a copy. You need to carefully review the requirements regarding medical services and make note of what both parents are required to be notified of. If one parent is hesitant to provide his/her consent, and such consent is required, you may need to schedule a meeting to discuss the services you would be providing and to find ways to incorporate the decisions of both parents into the child's treatment.

I am a provisionally licensed psychologist and have completed my post-doctoral year requirement. Am I now permanently licensed and able to practice without supervision?

Just because you have completed your post-doctoral year does not mean you are permanently licensed. There is an application process to move from provisional to permanent. After you have completed your post-doctoral year, you must complete the Provisional to Permanent Application Form (available online on the Board's website). Additionally, pursuant to G.S. 90-270.20(b), any permanently Licensed Psychologist who provides or offers to provide health services to the public must also be certified as a health services provider psychologist (HSP-P). Therefore, you must submit a Health Service Provider application as well. Once you make application, a specialized report form, which is *not* available on the Board's website, will be sent to your supervisor to document your post-doctoral year. The standard supervision report cannot be used to document your hours of supervised experience. Please be advised that, until you receive written confirmation from the Board that you are permanently licensed, you must continue to receive one hour of face-to-face supervision during any week in which you engage in the practice of psychology, per the contract you have on file with the Board.

BOARD MEETINGS

UPCOMING

JULY 21-23, 2010

SEPTEMBER 22-24, 2010

DECEMBER 1-3, 2010

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CENTRAL OFFICE

Address: 895 State Farm Road
Suite 101
Boone, NC 28607

Phone: 828-262-2258

Fax: 828-265-8611

E-mail: info@ncpsychologyboard.org

Website: www.ncpsychologyboard.org