NO Reply

From: Alice Moore <alicemoore0428@gmail.com>
Sent: Monday, November 4, 2019 3:45 PM
To: NO Reply
Subject: Proposed rule change 21 NCAC 54.2008 End career-long supervision for LPAs

Dear Board Members,

I write this letter to ensure my experiences are taken into consideration during the deliberation related to the proposed rule change 21 NCAC 54.2008 End career-long supervision for LPAs.

I finished my Masters in Counseling Psychology in 1990 while living in Massachusetts and was first licensed in NC in 1993. I certainly considered other education and training disciplines but I was most interested in clinical training and expertise in order to be prepared for a career as a psychotherapist. Had stayed in Massachusetts, I would have continued my education at the Massachusetts School of Professional Psychology. My education in psychology is a good match for my professional strengths which include perception, analysis and understanding of interpersonal dynamics. I have always worked in challenging settings and even now, my practice is focused primarily on individuals with complex trauma, and specifically with co-morbid diagnoses of PTSD and Bipolar D/O, and individuals with recent hospitalizations and/or histories of suicide attempts. I work closely with two local psychiatric hospitals and their partial hospitalization programs.

I have had a number of wonderful clinical supervisors (LPs) to satisfy my supervision requirements with the NC Psychology Board. I have valued and enjoyed my supervision sessions over the last 25+ years. They have been smart. experienced clinicians and academicians. I would be remiss if I did not highlight, however, an ongoing issue for many LPAs, including myself.

While the LPs I have worked with have been heavily trained in research as well as personality development, assessment, tests and measurements, psychopathology and treatment interventions, there is a frequent gap in expertise that has been filled by many LPAs. That is in the following areas:

- current evidenced based practices that meet best practice models with insurance panels and local Behavioral Health Organizations;
- Assessment and protocols for treating patients with SI/HI and Domestic Violence, inpatient and outpatient;
- Family systems theories and related treatment and legal resources;
- newer specialized treatment models (i.e., DBT, CBT-TR, ACT, MBBT)
- changes in public mental health practice in NC (LMEs, CABHAs, BHOs and the impact on individual practitioners)

Because of these gaps, I have regularly been in supervision sessions where I am educating the LP regarding guidelines, political and ethical implications for practitioners and clients/patients. I have regularly received feedback from LPs related to the above areas that sounds like, "*Wow, I really learned something today." or "Thanks for this information, this is really something I should know."* So the idea that LPAs have needed expertise from LPs for the duration of their careers is simply not true and inconsistent with the specialized work many LPAs are doing that LPs simply are not.

Another concern shared with LPs over the years is their realization that the mental health service providers has expanded greatly with LCSWs, LMFTs and LPCs (all of whom can practice independently early in their careers) and that they have changed the market for mental health treatment. Insurance panels have changed their paneling based on their licensure practices whereby it is difficult for LPAs to be on panels other than BCBS. Certainly this has been cost effective for the insurance providers to reimburse at a lower level for Masters level practitioners. What is a concern however, is the consensus that these other programs are clinically inferior to the knowledge and experience obtained

through psychology programs. I have heard this feedback from all LPs I have worked with over the years. This is particularly concerning when individuals receiving services through Medicaid or IPRS funding are encountering providers who lack keen assessment skills and are diagnosing clients with poor clinical formulation and those diagnoses follow them for many years, often contaminating the treatment process and medications prescribed. This should be concerning for all psychologists in NC.

Fewer and fewer students are drawn to psychology because of the licensure process which means not just fewer master level practitioners in psychology but fewer Ph.Ds as well. This trend is providing fewer clinically sound and lesser-trained practitioners Again, this is a problem for all of us.

I know that plenty of other LPAs have submitted comments related to the statistics of available LPAs and LPs across the rural populations and within state funded facilities, hospitals and prisons. These positions are vital and they would simply remain unfilled if not for LPAs and the Psychology Board has an obligation to care about these implications.

Thank you for considering these comments,

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