



PSYCHOLOGY'S SERVICE TO THE MILITARY

a message from the chair

Jane E. Perrin, Ph.D.

North Carolina does not mandate psychologists to receive education in cultural competency, but all of us would agree that our ethics code says this is an important aspect of responsible practice. Principle E, Respect for People's Rights and Dignity, and Standard 2.01, Boundaries of Competence, in the *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2002) specifically address this responsibility. If you're like me, you hadn't thought much about the cultural knowledge required for working with members of our military. A recent Southeastern AHEC program, *Military Family Issues**, raised my consciousness. I realized that most of us who practice Psychology in North Carolina have a duty to learn about life in the armed forces because of the likelihood that we will provide services to military personnel, veterans of the military, and/or their significant others.

Roughly one in ten North Carolinians is a veteran. North Carolina has the fourth largest percentage of veterans in the United States and one of the highest rates of citizens who have been deployed in the current wars in Iraq and Afghanistan. All of the branches of the military have bases in North Carolina. Fort Bragg in Fayetteville has the largest census of any United States Army base in the world. Camp Lejeune in Onslow County is the largest Marine installation on the East Coast. Womack Army Medical Center at Fort Bragg is the second largest military hospital in the country. Although members of the Army, Marines, Navy, and Air Force are concentrated at North Carolina's military bases, those associated with the National Guard and Reserves are spread throughout the state.

One of the speakers at *Military Family Issues*, Harold Kudler, MD, Associate Director of the Veterans Administration's Mid-Atlantic Mental Illness Research, Education, and Clinical Center told me, "The huge military subculture is invisible. It doesn't expect to be understood in the civilian world. This creates a national blind spot."

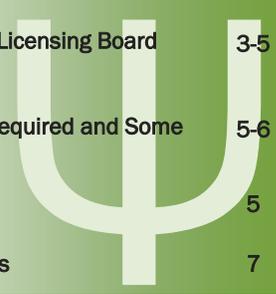
Presenters at the conference emphasized that military culture can have salubrious effects on service persons and their families. Contrary to their stereotype, Vietnam veterans have enjoyed greater financial success and higher educational levels than their cohorts who did not serve in the military. Families of military personnel often learn to be adaptable and independent. They may have special appreciation for one another as a consequence of their frequent moves and the sometimes prolonged absences of their service member. Military children are exposed to people with diverse ethnic and religious backgrounds, which may result in their acquiring social sensitivities. They may develop confidence and maturity from their experiences.

However, there are also stressors associated with life in the military that affect service members and their families. Attendees of the conference were sensitized to the presence of psychological issues in the armed services that are unrelated to combat. For instance, we learned that service members living on base who have substance abuse issues may fear that they will lose their security clearance, which may equate to their family's paycheck, if they self-report to mental health professionals. Spouses who live on military bases are often expected to assume a role equivalent to the rank of their service member, even though that may not be desirable to the spouse. Socializing among military spouses creates special challenges, because confidences to spouses of service members with higher or lower ranks can have negative consequences for the family member in the military. Spouses with civilian jobs not uncommonly learn that their service member has been transferred to another military base, which may require their own sudden relocation and thus result in unemployment and financial hardship. Combat-related events certainly take their emotional toll, as well. "Blackouts" are days when all communication is blocked on a military base until the family of a deceased service person is notified. Anxiety is understandably rife on those days, as rumors fly and everyone anticipates bad news. Notably, the presenters did not even get around to discussing the psychological effects of actual war casualties and injuries on the service member's family.

We were told about how deployment can have a different impact on each member of the family, depending on their age and relationship with the service person. In the pre-deployment phase, members of the armed forces often feel the need to accelerate plans. For example, it is not uncommon for them hastily to wed. Because these marriages begin with the departure of one of the spouses, they may become unstable. During deployment, spouses can develop resentments that they are handling family crises alone. The service person may develop relationships and have experiences that they feel their spouse would not understand. Post-deployment can include numerous stressors, ranging from the service person's feeling unneeded in well-functioning family routines that have not included him or her, to unemployment, to the family's not knowing how to relate to someone who may be grief-filled, preoccupied, or otherwise affected by serving in war.

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According to the Surgeon General's *Mental Health Advisory Team Final Report* (November 2006), of the 2.1 million service members who have served in the wars in Iraq and Afghanistan, 75% have been in situations in which they felt they could be seriously injured or killed; 62-65% have known people who were seriously injured or killed; and more than 33% have experienced an event in which they felt intense fear, helplessness, or horror. These individuals are clearly at risk for psychological problems associated with trauma exposure.



Mental health disorders are the second most common health concern, after hearing problems, of the 1.25 million veterans who have served in the current wars who are eligible for VA services. The *Report of the DoD Task Force on Mental Health* (2007) stated that 38% of soldiers, 31% of Marines, and 49% of service members in the National Guard reported mental health problems following their deployments. According to presenters at the program, more recent estimates suggest that 50% of Iraq/Afghanistan War veterans have a diagnosable psychiatric disorder. The rate of mental health issues is greater among military personnel who have had multiple deployments, a cohort that is rapidly increasing in size. Twenty-seven per cent of Iraq/Afghanistan War service persons who presented at Veterans Administration hospitals have been diagnosed with posttraumatic stress disorder. Substance abuse disorders have been diagnosed in roughly 150,000 of this group of military veterans. As is typical in civilian populations, this figure is thought to underestimate the extent of the substance abuse problem in returning service persons.

We learned that few large sample studies have been conducted to assess the prevalence of psychological problems among spouses, children, parents, and siblings of current military personnel. In research that has been conducted, spouses of deployed members of the military have been found to suffer from similar rates of psychiatric disorders as soldiers. Relative to nonmilitary spouses, military spouses experience greater incidence of depression, sleep disorders, and anxiety-related disorders (Eaton, Hoge, Messer et al., 2008). One study showed that children of deployed service people increased their outpatient mental health visits by 11%. Stress disorders and behavioral disorders were especially common (Gorman, 2008).

We also learned that, more than ever before, the Department of Defense (DOD) is relying on community clinicians to provide mental health services to military personnel and their families. DOD recognizes that the mental health model used with Vietnam veterans, of dividing individuals according to their psychiatric diagnoses and treating them in VA hospitals, did not work. Instead, a public health approach is now used for service people returning from Iraq and Afghanistan. This orientation is a community-based model in which the specific needs of service members and their families are addressed. The emphasis is on helping families and individuals restore their pre-deployment level of functioning. Dr. Kudler noted, "The military is a complicated psychosocial system. Think in terms of the individual, the family, the social community."

How can psychologists develop military cultural competence?

Ask clients at their intake session whether they have served in the military, or if anyone they are close to is a service member. Find out about local services to military personnel and their families. Consider attending continuing education programs that address military culture and military mental health issues. Valuable information is available online in a three part series at <http://www.aheconnect.com/citizensoldier/>.

Today's military engagements have singular features with mental health implications. The war in Afghanistan is our country's longest. As of November 27, 2006, the war in Iraq had lasted longer than World War II. Unlike in other wars, our military includes women in combat. For the first time, members of the armed services engaged in extended combat are volunteers. As the overseas wars continue, more North Carolinians are going to be directly affected. We psychologists have much to offer distressed service persons and their families. The civilian world is different from theirs, and we need to know about their world to be of optimal service to them.

*Faculty included Harold Kudler, MD; Jessica Meed, MPA; Gilbert W. Beeson, Jr., PhD; and Diane Coffill, Director of State Family Program for the N.C. National Guard.

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The following article appeared in the January/February 2011 edition of the North Carolina Psychological Association (NCPA) newsletter, and the Board has reprinted it with the permission of the author and NCPA. In Dr. Burlingame's article the responses below each vignette are the partial responses of the Board with regard to each question posed to the Board. The Board wishes to emphasize the following points about its response to Dr. Burlingame's inquiry:

The Board's decision in making its response to Dr. Burlingame's vignettes is based solely on the definition of the practice of psychology, as set forth in the Psychology Practice Act, in N.C. Gen. Stat. 90-270.2(8). As stated in the Dr. Burlingame's article, it is the Board's position that if one is engaged in the practice of psychology, then the Psychology Practice Act applies to the conduct, and the individual must comply with any applicable provisions of the Psychology Practice Act. The Board based its reasoning on the fact that, if a psychologist is engaged in the evaluation or interpretation of an individual's behavior, even in a record review, it is nonetheless the practice of psychology.

As a result, if an individual is engaged in the practice of psychology then, pursuant to N.C. Gen. Stat. § 90-270.15(a)(18), the complete case record must be maintained.

Under N.C. Gen. Stat. § 90-270.15(a)(17), a psychologist is required to maintain a clear and accurate case record which documents the following for each patient or client:

- a. Presenting problems, diagnosis, or purpose of the evaluation, counseling, treatment, or other services provided;
- b. Fees, dates of services, and itemized charges;
- c. Summary content of each session of evaluation, counseling, treatment, or other services, except that summary content need not include specific information that may cause significant harm to any person if the information were released;
- d. Test results or other findings, including basic test data; and
- e. Copies of all reports prepared.

In addition, pursuant to Standard 6.01, of the *Ethical Principles of Psychologists and Code of Conduct* (APA 2002), psychologists are required to maintain records and data relating to their professional work in order to facilitate the provision of services later by them or by other professionals.

Therefore, if a psychologist is engaged in the practice of psychology, then he/she shall maintain the complete case record, which includes all of the information set forth in N.C. Gen. Stat. § 90-270.15(a)(17). A psychologist will need to determine whether a document constitutes part of the case record. The Board wishes to point out that the Psychology Practice Act makes no distinction between primary and secondary materials, but rather requires that all documents that constitute the case record, be maintained in accordance with the requirements of N.C. Gen. Stat. § 90-270.15(a)(18).

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Retention of Records: The Licensing Board Speaks

By William V. Burlingame, Ph.D.

NCPA Member, Former Chair of N.C. Psychology Board & NCPA Ethics Committee & Member of APA Ethics Committee

When NCPA's Licensing Act Task Force drafted the overhaul of the North Carolina Psychology Practice Act some 15 years ago, it appeared to have remedied major ambiguities regarding records retention for psychologists in this state. At that time (and to the present), a multitude of conflicting mandates and recommendations existed which also varied considerably from jurisdiction to jurisdiction. In many states and for various professions, no binding records retention timelines or content rules have been developed.

For North Carolina psychologists, however, our Psychology Practice Act specifies that psychologists *retain securely and confidentially the complete case record for at least seven years from the date of the last provision of psychological services*. For minors, the records retention requirement specifies that *such records must be retained for three years beyond the 18th birthday or for at least seven years from the date of the last provision of psychological services, whichever is longer*. The statute (N.C. Gen. Stat. 90-270.15(a)(18)) contains additional provisions which identify circumstances under which records should be retained for longer periods — and also contains mandatory specifications regarding the content of the case record for each client or patient. All psychologists in North Carolina must be aware of and must comply with these prescriptions.

What Are the Prescriptions in Forensic and Consultative Situations?

Despite the seeming clarity of the statutes, confusion has emerged in recent years, particularly for psychologists practicing in forensic and consultative forums. Attorneys often provide forensic psychologists with volumes and file boxes of records comprised of transcripts of depositions and legal events as well as records of prior evaluations and treatment of a client. In some of these consultations, psychologists might not be evaluating the client face-to-face but may be offering impressions of the client to attorneys or critiques of the professional work of other psychologists, psychiatrists, or mental health professionals. While it is clear that the psychologist must maintain the records of his or her own face-to-face evaluation or treatment, psychologists inquire as to the retention requirements for the work of others and for the vast array of materials from secondary sources — all of which eventually present significant storage problems.

Further confounding of the issues occurs when attorneys who are attempting compliance with HIPAA privacy rules request that psychologists return the records when the case is settled (or ask the psychologist to certify that the records have been destroyed). Ethicists speaking from a national perspective, and unaware of the specificity of the North Carolina statute, have sometimes advised that it is not necessary to retain records from secondary sources since these are often in the public domain or are otherwise readily available. These ethicists emphasize that the issue is one of *transparency* rather than of meticulous retention of records from secondary sources.

Illustrative Vignettes and the Board's Responses

In order to secure definitive guidance, this psychologist posed a series of disguised vignettes from his own practice and from his consultation with other psychologists who had contacted him. These vignettes and the supporting context were presented to the North Carolina Psychology Board and were discussed at length in board meetings in May and July of 2010. The essence of the board's response is that the standards regarding records retention are governed in part by whether the psychologist's professional activity meets the

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definition of the practice of psychology as elaborated in the statute, “the observation, description, evaluation, interpretation, or modification of human behavior by the application of psychological principles, methods, and procedures....” This highly inclusive statutory definition, when coupled with the mandate to retain the *complete case record*, thus requires the retention of materials from secondary sources including all those used in rendering such *observation, description, evaluation, interpretation, or modification of human behavior....* These mandates apply whether the psychologist’s findings are provided orally or in written form to an attorney, the court, the client or patient, another health care professional, or to any other third party.

The Vignettes**Vignette 1:**

A psychologist was consulted by a capital defense attorney regarding possible defense strategies for a convicted murderer where a retrial had been ordered following the imposition of the death penalty. The attorney sought opinions relative to the competency and accuracy of the findings of other mental-health professionals who had testified for the defense in the original trial. The defendant’s father had also testified to having sexually molested the defendant for years, and the new defense attorney was troubled because he felt the jury had not adequately weighed the father’s testimony regarding this abuse as a mitigating factor. The psychologist never actually evaluated the defendant and never provided testimony or an affidavit but did consult extensively with the attorney. There are approximately three file drawers of transcripts and similar materials now in storage.

The licensing board responded as follows: “In order to provide expertise regarding sexual molestation by the father and in order to evaluate the competency of other expert opinions, you were evaluating the defendant through the review of records, and you were relying on psychological principles in your evaluation, or interpretation of human behavior....” Thus, those records must be retained. The board further noted that Ethical Standard 9.01 of APA’s *Ethical Principles of Psychologists and Code of Conduct* is also binding for North Carolina psychologists and additionally buttresses this interpretation.

Vignette 2:

A psychologist was consulted by a professional liability insurer when a community mental-health authority was sued by the parents of a young woman who had committed suicide. Despite many warnings and pleadings from the parents, who were worried about the status of their daughter who lived independently, the case manager did not make contact with the young woman. In violation of the agency’s standards regarding the mandated frequency of contacts with the patient, and despite the pleading and warnings of the parents, the case manager for the agency did not follow up. When she did, she had to call the police to break down the door to the daughter’s residence. They found the patient dead from a suicide. The family sued the mental-health center for negligence and failure to provide an acceptable standard of care. The psychologist agreed to evaluate the situation and provide an opinion as to the applicable standard of care. The psychologist reviewed boxes of clinical records, agency policies, and personnel records, and provided consultation but never testified. Attorneys for the insurer and the family settled and no trial occurred.

The board reasoned similarly as in Vignette 1, noting that the psychologist was “evaluating the [daughter’s] personality through a record review . . . and applying psychological principles....,” thus requiring retention of all records.

Vignette 3:

A senior psychologist was called by a psychologist who requested assistance regarding the applicable ethics and case law in North Carolina regarding possible duty to protect. The psychologist who requested the consultation had a potentially homicidal patient, and she was seeking information on the standard of care, applicable case law, issues of liability, and strategies for containing risk. The consulting psychologist spoke with her several times over the next few days (documenting the contacts and circumstances), advising her regarding the array of risks, her responsibilities, and relevant strategies and contingencies. Recognizing that there may be issues as to whether the requesting psychologist had become a consultee over the course of these telephone calls for which there was no charge and no opening of a chart or record, the consulting psychologist wonders whether this situation requires the retention of records on his part. Worth noting is that experienced psychologists, ethicists, and those who consult relative to risk management receive many calls of this sort.

The licensing board responded, indicating that if the consulting psychologist had only provided “a recitation of the current state of the law, without providing any sort of evaluation or interpretation of the patient’s behavior, then it would appear not to be the practice of psychology.” However, any consultation which provided “an evaluation or interpretation of the patient’s behavior through the application of psychological principles” is the practice of psychology and requires records retention. Although not addressed specifically, it appears as if the consulting psychologist has entered into a consultant – consultee relationship with the caller in the eyes of the board.

Vignette 4:

This vignette is a variation on Vignette 1: A psychologist was contacted by the attorneys for an insurer who represented a school district which had been sued by several parents whose young children had been extensively and traumatically sexually abused by a school employee over the course of at least a year. The attorneys needed clinical opinions regarding the emotional harm done and any potential claims for which they might be responsible relative to the ongoing care and psychological treatment of these young children. Opinions were provided by the psychologist, the opposing attorneys negotiated, and settlements were reached in each case. However, the children were never personally evaluated. There were many boxes of records of the evaluations and treatment already rendered to these children in addition to the transcripts of the testimony provided by the children in the trial of the employee and in the investigation of the abuse by law enforcement authorities. Should the records be preserved, and if so for seven years or possibly longer given the minority status of the children?

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The board reasoned similarly as it had in Vignettes 1 and 2, to the effect that this constituted the practice of psychology and that records must be retained. However, records need *only be retained for seven years* from the last date of service to the attorneys for the insurer, inasmuch as the children were not the clients or patients or the recipients of the practice of psychology.

Vignette 5:

A psychologist called and discussed a situation in which he thought he might be required by statute to report suspected child abuse or neglect. The consulting psychologist was asked whether the circumstances met statutory criteria for the mandated reporting of abuse or neglect to a department of social services.

The licensing board reasoned that the consultant's interpretation of statute does not appear to be the practice of psychology. However, if the consultation then merges with clinical advice regarding management of the situation or the children, parents, guardians, custodians, or caretakers, then it likely has become the practice of psychology. Since ethics complaints not uncommonly result from matters involving abuse and neglect reporting, the prudent psychologist would probably want to maintain complete documentation of contacts and advice provided both in consultation and in any such reporting relative to particular cases.

The Board Has Spoken Well

The psychologist community has been well served by this thoughtful, comprehensive, and nuanced response from the board and its staff in this complex matter. It is clear that extensive discussions and reflection occurred on the part of the board's staff and well as its volunteer board members over the course of the two meetings.

Italicized material is quoted from the North Carolina Psychology Practice Act, N.C.G.S. 90-270, which can be accessed most easily from the home page of the North Carolina Psychology Board. Other quoted material is from the letter of August 3, 2010 from board chair Jane E. Perrin, Ph.D., to William V. Burlingame, Ph.D. A copy of this letter will be provided on receipt of an e-mail request to wvb5@bellsouth.net. The Ethical Principles of Psychologists and Code of Conduct is available on the American Psychological Association's website, www.apa.org.

Record Keeping: What Is Required and Some Helpful Hints

Susan Batts, M.A.

As a staff psychologist with the North Carolina Psychology Board, one of my responsibilities includes the review of patient records when investigating cases. While many records meet the statutory requirements for record keeping, unfortunately, some of the records I have reviewed have been determined to be out of compliance with the requirements of the NC Psychology Practice Act.

This article is written to provide guidance to psychologists in documenting services to patients. It is my hope that this article will assist psychologists in improving their documentation of services to patients and complying with statutory requirements for recordkeeping. In my review of records, I have observed that the manner in which psychologists document their services varies greatly, particularly in the area of amount of detail provided, and in what they determine to be necessary to include in their documentation. The documentation of services, while primarily for the individual psychologist's own use in working with a patient, may also be released to others, such as the patient him/herself, the Court, a subsequent provider, a family member (in the case of a minor), other mental health professionals, or the Board.

As a result of the potential reliance by others on the psychologist's records, it is important that a psychologist's records meet the requirements of the North Carolina Psychology Practice Act and the *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2002), hereinafter referred to as the Ethics Code, as set forth below:

Pursuant to G.S. § 90-270.15(a)(17), a psychologist may be found in violation of the Psychology Practice Act, if he/she has failed to maintain a clear and accurate case record which documents the following for each patient or client:

- a. Presenting problems, diagnosis, or purpose of the evaluation, counseling, treatment, or other services provided;
- b. Fees, dates of services, and itemized charges;
- c. Summary content of each session of evaluation, counseling, treatment, or other services, except that summary content need not include specific information that may

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LEGAL PROCEEDINGS

During the period of time from February 1, 2011, through May 31, 2011, the Board reviewed and closed 20 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 6 cases involving a non-psychologist. Further, it issued remedial action in 2 cases and took the following action:

Ervin S. Batchelor, Ph.D. – CONSENT ORDER was approved on February 17, 2011. Dr. Batchelor admits that the described conduct constitutes violations of N.C. Gen. Stat. § 90-270.15 (a) (18), of the North Carolina Psychology Practice Act, and Standards 4.01, 6.01, & 6.02(a) of *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2002). Dr. Batchelor's license is REPRIMANDED. He must successfully complete tutorials and remit \$300.00 in costs.

Donald Douglas Davis, Jr., Psy.D. – CONSENT ORDER was approved on May 4, 2011. Dr. Davis admits that the described conduct constitutes violations of N.C. Gen. Stat. § 9-270.15(a) (10) of the North Carolina Psychology Practice Act, and Standards 3.05(a) and 10.06 of the *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2002). Dr. Davis' license is SUSPENDED for a minimum of six months. His release from the suspension is contingent upon his successful completion of a fitness for practice evaluation, following which he could begin practicing psychology under conditions of probation specified in the Consent Order. Further, he must successfully complete tutorials and remit \$300.00 in costs.

Janis Jaworski, Ed.D. – CONSENT ORDER was approved on May 4, 2011. The Board agrees to dismiss all charges against Dr. Jaworski which are set forth in the September 29, 2010 Statement of Charges. Dr. Jaworski is retiring from the practice of psychology effective June 30, 2011, and voluntarily relinquishes her license as a licensed psychologist, and the Board accepts her relinquishment. Dr. Jaworski agrees not to engage in the practice of psychology or apply for reinstatement of her license at any time in the future, and she is required to remit \$300.00 in costs.

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- cause significant harm to any person if the information were released;
- d. Test results or other findings, including basic test data; and
- e. Copies of all reports prepared.



Further, Standard 6.01, Documentation of Professional and Scientific Work and Maintenance of Records, of the Ethics Code provides as follows:

Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law.

As a result of the above requirements, psychologists are reminded to include the following basic information in their documentation of psychological services:

- Clearly state the presenting problem(s) and purpose of the service(s) provided.
- Provide the date of service on each entry or process note. (In my investigations I have observed records in which dates were missing for services provided, the dates listed were inconsistent with other information in the record, or one note was written for multiple sessions. These examples do not meet the statutory requirements for record keeping.)
- Document responses and results on test protocols as instructed. (I have reviewed records in which the examinee's responses were not properly documented by the psychologist.)
- Include in the patient record all written correspondence sent out or received, including electronic mail messages.
- Include in the patient record all legal documents or other documents received during the course of treatment or evaluation. (I have reviewed records in which the psychologist never obtained a copy of the court order wherein family therapy had been ordered, which included important details about the family therapy that was to be provided by the treating professional.)
- Document justification for changes in treatment or diagnosis. (I have reviewed records which included a change in diagnosis where there was no documented justification for the change.)

N.C. Gen. Stat. § 90-270.15(a)(17)(c), which requires that "summary content of each session ..." be provided proves challenging for many psychologists. Even when some information in a record is well-documented, such as background information, the documentation of content will be inadequate if there is a failure to document or insufficient documentation of other information, such as critical/turning points in treatment. Sometimes these events occur outside of a therapy session, such as through a phone call or through written correspondence, and can rise to the level of becoming a vital part of a patient's record. Committing the following omissions could be considered as failing to meet the requirements in statute or in the ethical standards:

- Not including any meaningful summary content or repeating the same content for multiple sessions. For example, "doing well; no changes," "school's about the same."
- Not adequately documenting events that would be considered as significant "turning points" or "critical points" in treatment. For example, failing to clearly document why the husband is no longer joining the wife for marital counseling and the psychologist has decided to see only the wife individually.
- Not adequately documenting the psychologist's assessment of whether or not a client is suicidal. For example, the psychologist's documentation including only a scant amount of information with little to no specific information about the client's thoughts, feelings, and/or intent, when this assessment was prompted by a verbal suicidal threat made by the client.
- Not including a clear description of the discussion that occurred between the client and the psychologist regarding the client's expressed attraction to his/her psychologist.
- Not including adequate details about what the psychologist reported to a department of social services in making a report of suspected child abuse/neglect.
- Not including documentation that explains the reason for termination of services.
- Not documenting a hostile phone call from an estranged parent of a child to whom the psychologist is providing services.

Some of the above observed omissions by psychologists have resulted in complaints with the Board. Because Standard 6.01 of the Ethics Code requires that a psychologist create a record that will "facilitate provision of services later by them or by other professionals," the information in the record needs to be clear and complete, and provide the reviewer an adequate understanding of the services provided to the client and why these services were provided.

Further, it is important that a record be written legibly or typed. This is not mandated by the Practice Act, but a legible record removes any guess work or possible misunderstanding on the part of the reviewer, and does not require the reviewer to contact the psychologist to ask about their documentation. On more than one occasion, psychologists have had to read me the patient record or type their notes because they were illegible. Third party payors, external reviewers, or the courts may not extend themselves to that degree.

In summary, documentation in a psychologist's record must meet the requirements of the N.C. Psychology Practice Act and the APA Ethics Code as discussed above, and documentation included in the record must also be sufficient enough that it can withstand the test of time, and not be reliant upon the availability of the psychologist of record. Therefore, ask yourself: "Do I routinely document my provision of psychological services in the above manner, and if not, what must I change so as to be in compliance?"

I am a licensed psychological associate who is interested in obtaining my doctoral degree through an online university. Will I be able to obtain licensure at the doctoral level with a degree from an online institution?

The Board does not have the authority to approve, or disapprove, graduate training programs prior to the submission of an application for licensure. Only after an individual formally applies for licensure is the Board able to evaluate each individual applicant's program. However, in previous instances when the Board has reviewed applications of graduates who completed educational programs which primarily provided instruction online, the Board has denied the applications. Based on past review, the majority of online educational programs have difficulty meeting the requirements listed for licensure in Board rule. The requirements for licensure are specified in the NC Psychology Practice Act and Board rules. For the doctoral level of licensure, Licensed Psychologist, see G.S. § 90-270.11(a) and 21 NCAC 54 .1803 (also see 21 NCAC 54 .2704 for health services provider requirements). Some of the reasons for denial, based upon Board rule, may include, but are not limited to the fact that a program must have "an identifiable body of students in residence at the institution . . .", "an identifiable full-time psychology faculty in residence at the institution . . . providing instruction at the home campus of the institution", and that the program must include one year's residency which is defined as 30 semester (45 quarter) hours taken on a full-time or part-time basis at the institution. If an online training program provides a supervised training experience, which is required for licensure, it often does not meet the criteria listed in Board rule as an acceptable supervised training experience. The Board has not determined that instruction provided on a computer in one's home or another location which is not at the institution is the equivalent of being "at the institution." In addition to requirements in rule regarding the faculty and students having to be in residence at the institution and requirements related to the provisions for residency, the applicant's degree program must meet all other provisions set forth in rule. Any individual who is considering enrolling in an online program should review the requirements for licensure prior to the program start date to determine if the program meets the requirements. For more information about this topic, please review the requirements for licensure listed above and/or visit the Frequently Asked Questions section on the Board's website.

I have been providing supervision to a Licensed Psychological Associate (LPA) who recently decided to close his private practice. During the past year, he did not engage in any activities that require supervision. Do I still have to complete a Supervision Report to terminate our contract or can he just complete Section 2 of the report to terminate supervision?

A supervisor who has a Supervision Contract on file with the Board to provide supervision to an LPA must always complete a Supervision Report in order to terminate the Supervision Contract, regardless of whether or not the supervisee engaged in any activities that required supervision during the reporting period. It is the supervisor's responsibility to verify what did or did not occur with regard to supervision during the reporting period, and therefore, Section 1 must be completed. Section 2 of a Supervision Report may only be completed if an individual had a Section 2 Supervision Contract on file with the Board. Many of the questions in Section 1 of the report may not be applicable if the supervisee has not engaged in activities requiring supervision during the reporting period; the supervisor should write "0" (zero) for any items in the Supervision Report that do not apply. If the total number of hours of supervision reported equals zero ("0"), ratings should be left blank, the supervisor may simply note "N/A" in the margin, and sign and date the report. It should be noted that only one section per report form may be completed. Therefore, a supervisor should never complete Section 1 to indicate that supervision was not required and then have the supervisee complete Section 2 to verify that the individual did not engage in activities requiring supervision.

BOARD NEWS

Effective, July 1, 2011, Dr. Kris Herfkens will serve as Board Chair and Dr. Jane Perrin, who has served as Board Chair for the past three years, will serve as Vice Chair of the Board. Dr. Herfkens was appointed to serve on the Board in 2008.

In the October, 2010 issue of psychNEWS the Board published proposed rule changes to Rule .2001 Supervisor and Rule. 2104 Continuing Education. As a result of the written comments received and the feedback from the December 1-2, 2010 rule making hearing, the Board is currently reviewing and working to make additional changes to these rules. Updates, when available, regarding the status of the proposed rule changes will be published online on the Board's website and in the Board's newsletter.

U P C O M I N G

BOARD MEETINGS

JULY 13-15, 2011

SEPTEMBER 21-23, 2011

NOVEMBER 30-DECEMBER 2, 2011

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