



## Aging and Competence for Psychologists

*a message from the vice-chair*

Kristine M. Herfkens, Ph.D., ABPP

As it happens, psychologists age just like everyone else. We are subject to an array of changes as we age, some of which potentially create changes in professional competency. Cognitive problems are among the most difficult changes for people to adapt to, and pose particular challenges to psychologists.

The challenges of aging are not unique to psychologists. We are all living longer, and age is the greatest risk factor for cognitive decline and dementia. Although there are lesser types of cognitive change, one in three people die with dementia. Between the ages of 75 and 84, 43% of people have dementia. More concerning, even with the explosion of knowledge about neurocognitive disorders, dementia and other forms of cognitive decline are under-diagnosed.

If psychology involved more heavy lifting, psychologists might retire before the onset of age-related cognitive changes. For better or worse, according to the 1999 APA Older Psychologists Survey (APA, 1999), psychologists tend to work longer than many other occupational categories because many psychologists do not want to leave work that is for them meaningful and engaging. More than a third of psychologists between the ages of 65 and 74 continue to work full-time, and another quarter work part-time. A third of psychologists over 75 work either part or full time. There are many positives to these longer careers. The field, and the public, benefit when highly skilled and experienced clinicians remain in the work force. In addition, psychologists in the APA survey reported increased empathy, awareness, and acceptance in their work with others as they age, and also more confidence in their abilities.

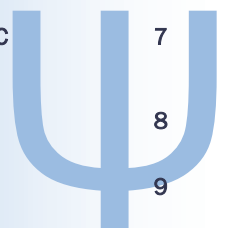
Unfortunately, confidence in one's abilities is not always a positive. Competency is dynamic, and can be fragile. What happens when cognitive change reduces the ability for accurate self-appraisal? And, is self-appraisal ever really the best manner in which to determine competence? Social psychologists have long known that humans are poor judges of their own competence. Yet, psychological services are most often provided in a private, solitary manner, without a window into performance until problems are obvious to others. Compounding the solitary nature of our service provision, our Ethics Code and practice standards continue to describe competence as a solely individual responsibility (Johnson, Barnett, Elman, Forrest, & Kaslow, 2012). According to the Ethical Principles, psychologists are supposed to know when we must limit or stop practice, or when we need outside assistance to continue practicing (Ethical Standard 2.06). For people with cognitive decline, that is a tricky proposition at best.

The idea of screening aging doctors as a condition for granting hospital staff privileges or for medical group employment or partnership, especially as physicians practice into their sixties and beyond, is gaining traction across the country. Often this occurs in the procedure-based specialties in which it easier for outside observers to determine if practice is problematic. In my professional experience, physicians referred for mandated cognitive evaluations never see this as a supportive move by caring colleagues, but instead are highly (understandably) threatened by the process.

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Erica Wise, Ph.D., wrote an excellent article for the North Carolina Psychologist in 2014 (Vol. 66, No. 2, Spring 2014) in which she discussed both the problems with the current Ethical Principles, and the challenges for psychologists to intervene with other psychologists. The current ethical mandates and regulatory environment seem to leave psychologists with three options: self-identify competency loss and take independent action, engage in difficult and sometimes unproductive conversations with peers when there appear to be problems, and report overt problems to the Psychology Board for potential disciplinary action. As Dr. Wise pointed out, "there presently exists no standard that can be readily applied to working collaboratively with colleagues to more proactively address potential problems with professional competence that don't involve a clear ethical violation." (North Carolina Psychologist, 66:2, p.25)

A 2013 article, "The Competence Constellation Model: A Communitarian Approach to Support Professional Competence," (Johnson, W. B., Elman, N.S., Barnett, J. E., Forrest, L., & Kaslow, N. J.(2013) *Professional Psychology: Research and Practice*, 44, 343-354.) provides a model for conceptualizing supportive, proactive professional relationships that help psychologists to help each other with self-care and maintenance of competence. The authors advocate a constellation of support, one that includes high quality, long-term peer relations, and an atmosphere of trust, intimacy, and mutually beneficial support and mentoring. A communitarian model requires this constellation of support to be relational, egalitarian, and collaborative, fostering honest communication between caring colleagues. Across these relationships, as lives change and competence shifts, psychologists support each other in reinforcing skills and more realistically assessing needs and problems.

In North Carolina, the legal profession has established a novel network of support for aging attorneys. The NC Bar Association has established a program called Transitioning Lawyers Commission (TLC). According to Woody Connette, the co-chair of the program, the NC TLC is a model, pioneering program. Mr. Connette indicated that TLC serves three groups: lawyers who need to retire but will not, lawyers who want to retire but need help with strategic planning, and caregivers dealing with dementia-related issues of loved ones. The two main purposes involve assisting these attorneys, and also protecting their clients who may suffer due to the lawyer's cognitive issues.

I spoke with Mareah Steketee, Ph.D., about her consultant role in TLC. According to Dr. Steketee, attorneys are trained to work as teams to both teach their colleagues how to manage their practices and transition into retirement with dignity, but also how to intervene when potential problems are brought to their attention. When necessary, attorneys make a "nonthreatening visit," not an intervention, to offer information and support, and to assist in locating relevant services. Unlike physicians, who are mandated to report colleagues with problems affecting their practice, these attorneys assist their peers, and are not required to report to the Bar unless all other attempts at support and assistance are unsuccessful.

As a neuropsychologist, I spend a good percentage of my time performing dementia evaluations. Everyone who works with a cognitively impaired population knows that collateral information is critical to assess functioning because people with cognitive impairment are often unaware of the range and extent of their difficulties. In a profession where much practice is unobservable by others, it is critical that we explore options to work together collaboratively in a manner that allows aging psychologists to function professionally as long as they desire while reducing the potential for harm to the public.

## The ABC's of Renewal

All licensees are required to renew their psychology licenses by 10/01/2018.

Renew online or via mail.

Renew online for faster renewal and get an instant receipt.

The online renewal system on the Board's website will be available in mid-August and renewal forms will be mailed out in August.

Be sure all contact information is current so that you receive all necessary information regarding the 2018 renewal. Visit the Change of Address section on the Board's website to update your contact information.

Continuing education is required in order to renew your license.

18 Hours must have been completed between 10/1/16-10/1/18.

Category A  
9 Hours Minimum  
3 hour requirement in ethical/legal issues.

Category B  
9 Hours Maximum

Click [here](#) to review the CE requirements.

## Clinical vs. Informed Consent: Similarities and Differences

Helen T. Brantley, Ph.D.

One of the most important professional considerations in psychological practice, Informed Consent, requires clarification in its application with regard to clinical versus forensic use. The term is defined and described in seven sections of the Ethical Principles of Psychologists and Code of Conduct (Standard 3.10, Standard 8.02, Standard 8.03, Standard 9.03, Standard 10.01, Standard 10.02, Standard 10.03, 2017). Hill (2013) provided Guidelines for providing informed consent for assessment and therapy, in particular. In addition, the Specialty Guidelines for Forensic Psychology (APA, 2012) contains a separate section on Informed Consent, Notification, and Assent (Guideline 6). Multiple articles have been written about informed consent in specific situations (e.g., Coffman, C., & Barnett, J.E., 2015; Fidnick, L. S., Koch, K.A., Greenberg, L.R., & Sullivan, M., 2012). Other resources for Informed Consent are the National Register ([www.nationalregister.org/pub](http://www.nationalregister.org/pub)) and The Trust ([www.trustinsurance.com/resources/download-documents](http://www.trustinsurance.com/resources/download-documents)) where sample Informed Consents are available.

Informed Consent(3.10) is required when conducting research, assessment, therapy, counseling, or consulting services whether these services are “in person or via electronic transmission or other forms of communication.” When someone is not capable of signing a formal consent due to being a minor or incompetent, then assent is needed. While it is necessary to obtain permission from a legal guardian (such as a parent) for a child or adolescent, the psychologist should give an appropriate explanation to the young person and gain their agreement. When interpretive services are required, the client/patient must agree to the use of an interpreter (ES 9.03) and explain the limits of confidentiality when such services are necessary. Different kinds of Informed Consent are required depending on the service provided. The procedures taken to gain Informed Consent or assent must be documented.

Common elements required in all types of Informed Consent (ES 3.10) are a description of services, fees, and limits of confidentiality.



### Services

For clinical Informed Consent, it is important to explain the purpose of the evaluation and to specify how long an evaluation will take. If the service is an assessment, the consent form may include what tests will be used and how collateral information may be obtained and for what purpose. If the evaluation is for assessment for therapeutic intervention, how the agreement for psychotherapy will be reached should be included. In addition, the consent may specify how long sessions will last, what charges will be made, and what is required for cancellation without charge for both evaluations and for therapy. Informed Consent for therapy requires how sessions are scheduled, length of sessions, and fees. Any other expectations of the patient, such as charges for missed sessions, late notification, or collateral contacts, also need to be stated.

Forensic Informed Consent may describe the meetings quite differently in that many forensic evaluations may be conducted in longer blocks of time and more than one person may be required to attend, e.g., a custody evaluation. A description of the areas of functioning that will be assessed need to be included in some detail and the description should relate directly to a court order. There should be some declaration of activities that are part of an evaluation and do not constitute any kind of intervention or treatment, unless the forensic activity is court ordered therapy. As with a clinical Informed Consent, specification of what charges will be incurred and what notice is required if a cancellation of meetings occurs, should be included.

### Fees

In clinical work, fees are generally charged for time spent in therapy or assessment and must be specified in the Informed Consent. If the clinician charges for consultation, office expenses (such as mailing), or other fees (such as travel), the cost to the patient should be explicitly conveyed in the consent form. The clinician may specify additional costs if the patient's case re-

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quires legal activities, such as depositions or court testimony.

The same conditions are true for forensic work, with additional provisions for charges and rates for report writing, preparation for court testimony, court testimony, depositions, travel, or other expenses. It is customary that depositions, court appearances, and travel time are charged at different rates, and these costs should be specified.

Responsibility for payment is another difference between forensic and clinical work. Generally, in clinical work, the patient and/or insurance will be billed for services. In the Informed Consent, it should be clearly indicated whether the clinician collects insurance or not. Billing and payment requirements are also clarified and may be listed under practice policies.

Fees for forensic work are rarely billed to insurance. Again, it should be specified in the Informed Consent who will be billed for forensic services and at what rate. If a deposit is required, then some designation of how the deposit will be used in billing should be included. Further billing and payment concerns are also specified.

### **Limits of Confidentiality**

Informed Consent for forensic services has significant differences from more general consent for clinical assessment and therapy. The primary difference is in the limits of confidentiality. If the evaluation or therapy is requested by the court or by an attorney, confidentiality is not guaranteed; and limits of confidentiality must be specified in the consent. For example, if the court (or judge), attorneys, Departments of Social Services, or other agency or person is to receive a report (verbal or written), the client must be informed of the nature of sharing of information. The person who is to receive the report should be specified in the Court Order.

If the case of an evaluation, if there is no Court Order, but it is a forensic evaluation, it must be made clear to the client who owns the report. In most cases, the report will not be given directly to the client which should be indicated in the Consent, as well as the method for the client to obtain a copy. Mandatory reporting obligations must be included in both forensic and clinical Informed Consent, i.e., both forms should include statements about the need for reporting child or elder abuse to appropriate authorities. Threats of suicide or harming oneself also precludes confidentiality in that notification to a family member or others or commitment to hospitalization may be necessary. Since consultation with other professionals may be sought in either a clinical or forensic case, it is important to specify how confidentiality will be maintained and how such consultation will be billed.

### **Contact Information**

Clinical Informed Consent should specify how and when a patient may contact you. In addition, the Informed Consent should also contain emergency contact information. For forensic Informed Consent, there should be methods of contact specified, but emergency contact information should be also indicated and how and if it should be used.

### **Agreement**

There usually follows a place for the patient to agree to the terms of the Informed Consent and to indicate they will follow the terms of the agreement during the course of the professional relationship. A date of the agreement is also designated. In a forensic situation, it is frequently added that the terms of the agreement have been discussed with the client's attorney and are agreed to by the attorney.

### **Summary**

The most important difference between clinical and forensic Informed Consents is the limits of confidentiality. Clinical confi-

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dentiality generally is between the patient and the psychologist. Forensic confidentiality is not guaranteed, and the parties with whom information will be shared should be specified. The second major divergence between clinical and forensic Informed Consents is how and to whom bills for services are submitted. Forensic services are rarely covered by insurance, whereas many clinical services are. Finally, forensic work may require a variety of fees for different services, and the fees should be specified. If clinical duties involve different fees for different services, these costs should be included in the Informed Consent.

#### References

American Psychological Association. (2016) Ethical Principles of Psychologists and Code of Conduct. Retrieved from: <https://www.apa.org/ethics/code/ethics-code-2017.pdf>

American Psychological Association. (2013) Specialty Guidelines for Forensic Psychology. *American Psychologist*, 68, 1, 7-19.

Coffman, C. & Barnett, J. E. (2015) Informed consent with children and adolescents. [Web article]. Retrieved from: <http://www.societyforpsychotherapy.org/informedconsentwith-children-and-adolescents>

Fidnick, L. S., Koch, K.A., Greenberg, L.R., & Sullivan, M. (2012) Association of Family and Conciliation Courts white paper guidelines for court-involved therapy: A best practice approach for mental health professionals. *Family Court Review*, 49, 3, 557.

Hill, R. (2013) Guidelines for providing informed consent. *PsychNEWS*, 20, 3, 1-2.

## Suggestions to Help Avoid Complaints Being Submitted to the Board

Marc B. Davis, M.A., Board Staff Psychologist and Investigator

While it is the goal of any psychologist to avoid having a complaint submitted to the Board about them, it is not necessarily as simple as “just be ethical and you won’t get a complaint”. Even the most ethical and professional psychologist cannot completely prevent someone from filing a complaint with the Board.

However, there are observable trends in complaints received by the Board. For example, it is much more likely that a complaint will be made by an individual receiving services from a psychologist as part of a high-conflict custody case. Those who work in this challenging area of practice are disproportionately represented in the pool of complaints received by the Board. While this may not be a surprise to those who do custody work due to the conflictual nature of the work and the tendency of at least one individual to be unhappy with the outcome of the case or the recommendations of the psychologist, this is an added challenge that should make anyone be on guard. The same could be said for psychologists who work in other areas where there tends to be more conflict or disagreement: forensic evaluations, DSS referrals, correctional settings, or even inpatient settings.

This does not necessarily mean that psychologists who work in these areas are more likely to be unethical; rather, it means that there may be more eyes on your work, meaning more pressure to be consistently cautious about all facets of your practice. With that in mind, there are things that any psychologist (including those who are more at risk) can do that can assist in reducing the likelihood of having a complaint filed against them.

### Communication

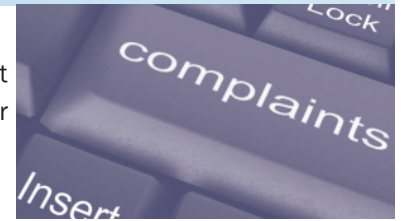
One of the most common factors that seem to crop up in many investigations by the Board as to why a client or other individual filed a complaint comes down to simple communication. Many clients who do not feel heard or respected by a psychologist often feel they have no other recourse than to file a complaint with the Board to feel heard or respected by someone. Often times, many complaints could have been avoided if the client had been provided a way to voice their grievances directly to the psychologist or to have the issues addressed and a resolution reached. While psychologists cannot be constantly available to their clients and often have to have firm boundaries, a return phone call to a client to answer a question can go a long way to resolving an issue before it turns into a complaint to the Board. Additionally, communication with other service providers or profes-

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sionals (primary care physician, psychiatrist, case manager, attorney, etc.), with the consent of the client or responsible party, can ensure the best care for clients and reduce mistakes or miscommunication.



### **Informed Consent**

Another common factor in many complaints is a client's feeling that they experienced a "bait and switch" regarding what they could expect out of the services provided by the psychologist. Having unrealistic expectations from therapy or a psychological evaluation or recommendations provided can set the stage for disappointment. Being clear with clients is important and ensuring that your informed consent documentation is thorough, using understandable language, and communicating reasonable outcomes and explaining what to be expected out of the services can help eliminate misunderstanding, particularly in cases where the services are unusual (such as related to court action or legal charges). Additionally, having the informed consent process more than just the client signing a form and providing the client an opportunity to ask questions or understand the services being provided can be helpful to avoid disappointment and a possible complaint with the Board.

### **Documentation**

Documentation is often a protected product of any psychologist's work, one which can be helpful to clients seeing other professionals, but potentially dangerous when misinterpreted. Be aware when completing the documentation for any services provided of what potential impact the documentation may have when or if it is released. Ensure the client knows about the limits to confidentiality and if you release documents to the client upon request, ensure that the documentation is reviewed with the client and they are given every opportunity to understand it. Additionally, well-written, factual, and thorough documentation can eliminate many miscommunications later. Court ordered evaluations may result in much more disagreement with the findings by laypersons, as well, so being clear and factual can assist in preventing issues later on. Additionally, accurately documenting any communications with clients or collaterals can help your memory and ensure that your account of what happened during the provision of services is recorded for future reference if necessary.

### **Termination**

The end of therapy services can be difficult for many clients, and, if therapy ends prematurely due to a termination by the psychologist or a lapse in services by the client, there can be unresolved feelings on behalf of the client. Reaching out to a client whose services have lapsed or who has ceased services to offer a final session can assist in addressing any residual feelings of dissatisfaction and can be therapeutic by gaining closure to facilitating referral to another provider or additional services.

While not every complaint can be avoided, there are many that can. And even those psychologists who do not work in high-conflict areas of practice are susceptible to making decisions that make complaints more likely. Hopefully, with a bit of planning, though, many psychologists can take a few simple steps to avoid a stressful situation and be more helpful to their clients, too.

### **Have an idea for the next newsletter?**



If there is a topic you would like to see addressed in a future edition of *psychNEWS*, please send an email to [rebecca@ncpsychologyboard.org](mailto:rebecca@ncpsychologyboard.org). Comments and suggestions about the newsletter are always welcome.

## Upcoming Deadline to Connect to North Carolina's Health Information Exchange

Sally Cameron, Executive Director North Carolina Psychological Association

In 2015, the General Assembly of North Carolina established a state-managed Health Information Exchange Authority (NC HIEA) to oversee and administer the NC Health Information Exchange Network. The NC HIEA is housed within the NC Department of Information Technology's (DIT) Government Data Analytics Center (GDAC).

The NC HIEA operates North Carolina's state-designated health information exchange, NC HealthConnex, a secure, standardized electronic system in which providers can share important patient health information. According to the NC HIEA, the use of this system promotes the access, exchange and analysis of health information. This law also requires that health care providers who receive State funds (e.g. Medicaid, State Health Plan, Health Choice) to connect to NC HealthConnex by certain dates in 2018 and 2019 in order to continue to receive payments for services provided.

The original date for psychologists to be connected was June of 2018. The North Carolina Psychological Association (NCPA) worked with other partners to get this deadline extended to June of 2019 for any psychologist receiving Medicaid, State Health Plan, or Health Choice reimbursement.

### Who must connect?

- Hospitals, physicians, physician assistants and nurse practitioners who provide Medicaid services and who have an electronic health record system must connect by June 1, 2018.
- All other providers of Medicaid and state-funded services must connect by June 1, 2019. This includes psychologists.
- Local Management Entities/Managed Care Organizations (LMEs/MCOs) are required to submit encounter and claims data by June 1, 2020.

Providers who do not receive state funding for the provision of health care services may also connect to the NC HIEA on a voluntary basis to support whole-person care.

NCPA is part of a behavioral health workgroup of the NC HIEA that is working on the feasibility of connection for behavioral health providers. NCPA also is urging vendors who provide behavioral health electronic medical records to become connected with the HIEA.

As part of its advocacy to provide information to the NC HIEA about the difficulties for behavioral health providers, in April of 2017, NCPA along with the other associations representing licensed behavioral professionals completed a survey of association members' responses to existing and planned use of the highway by providers. A total of 287 professionals (105 psychologists) responded – over 51% of whom have been in the field more than 21 years. The results are summarized here:

- Over 71% of the respondents reported they were in a solo or group practice.
- Over 83% indicated that they were the person that would be making the decision regarding purchase and use of an electronic health record (EHR) in their practice or organization. For those who weren't that person, 41% reported that their agency head would be making the decision.
- Only 6% of respondents were already connected to an HIE. 23% of them were connected to NC HealthConnex, and 12% were connected to the Federal eHealth Exchange.

The NC HIEA is in the process of preparing a feasibility study to provide further information on the ability of providers to connect. For more information go to <https://hiea.nc.gov/frequently-asked-questions>.

## ANNUAL REPORT AND SUPPLEMENTAL INFORMATION FROM 07/01/16-06/30/17

## NUMBER OF:

Individuals who applied to the Board for Examination	233
Individuals who were refused examination	2
Individuals who took the state examination	198
Individuals who took the national examination	142
Individuals who were issued a license	219
Psychological Associate	44
Licensed Psychologist	141
Licensed Psychologist (Provisional)	34
Application forms and state laws mailed (forms are available online )	0
Number of Psychologists Licensed in NC as of 6/30/17	4,772
Psychological Associate	1,186
Licensed Psychologist	2,876
Licensed Psychologist (Provisional)	55
Corporations and PLLCs registered	49
Official complaints received involving licensed and unlicensed activities	52
Complaints resolved	55
Number of visits to Board's website	4,772
Investigations, including complaints, pending as of 06/30/2017	37
Disciplinary actions taken against licensees, or other actions taken against non-licensees, including injunctive relief (8 disciplinary; 4 remedial; 0 injunction)	12
Licenses suspended or revoked	6
Licenses terminated for any reason other than failure to pay the required renewal fee	7
Licenses terminated for failure to pay the renewal fee	121

## DURING THE FISCAL 2016-2017 YEAR, THE BOARD:

1. reviewed applications and licensed qualified individuals
2. reviewed and resolved complaints regarding ethical and legal issues
3. sought fee increases to enable the Board to fulfill its statutory mandate to protect the public from incompetent, unethical, and unprofessional practice
4. continued development of an online state exam
5. continued development of an online license application system
6. continued upgrade of IT systems and equipment
7. initiated digitizing licensure files
8. sought establishment of inactive licensure status
9. Initiated criminal background checks for applicants
10. launched an online license renewal system and conducted the biennial renewal of licenses
11. launched an online professional corporation registration renewal system
12. launched acceptance of fee payment by credit card
13. published an edition of psychNews the Board's newsletter

## OBJECTIVES FOR THE BOARD IN THE 2017-18 FISCAL YEAR INCLUDE:

- ❖ address budgetary and long-range planning issues
- ❖ adopt, amend, and repeal the Board's rules as necessary
- ❖ continue IT systems and equipment upgrade
- ❖ continue digitizing licensure files
- ❖ implement online license application system
- ❖ Implement online state exam
- ❖ continue to seek fee increases to enable the Board to fulfill its statutory mandate to protect the public from incompetent, unethical, and unprofessional practice





## Legal Proceedings



During the period of time from May 1, 2017 through April 30, 2018, the Board reviewed and closed 23 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 five cases involving a non-psychologist. Further, it issued remedial action in three cases and took the following action: [\[click on the highlighted names below to see copy of the Board Action\]](#).

UPCOMING

## BOARD MEETINGS

August 2-3 2018

November 8-9, 2018



**Mauldin, Anne, L., Ph.D.** - CONSENT ORDER was approved and signed on November 9, 2017. Respondent admits that the described conduct constitutes violations of N.C. Gen. Stat. §§ 90-270.15(a)(10), (a)(15) & (a)(17) of the North Carolina Psychology Practice Act, and constitutes violations of Standards 3.10, 4.01, 4.05 & 6.01 of the Ethical Principles of Psychologists and Code of Conduct. Respondent shall successfully complete a minimum of six to eight hours of tutorials regarding proper documentation; informed consent; assessment and diagnosis; confidentiality requirements for psychologists; how Respondent's behavior resulted in this action taken by the Board; Respondent's plan of action to prevent the recurrence of the behavior; and general ethical conduct. Respondent also is assessed \$300.00 in costs.

**Moler, Christina L., Psy.D.** - CONSENT ORDER was approved and signed on November 9, 2017. Respondent admits that the described conduct constitutes violations of N.C. Gen. Stat. § 90-270.15(a)(10) of the North Carolina Psychology Practice Act, and 21 N.C.A.C. 54 .2002(b)(4) of the North Carolina Psychology Board rules. Respondent further admits that the described conduct constitutes violations Standards 3.04, 3.05, 3.06, 4.01, and 4.05(a) of the Ethical Principles of Psychologists and Code of Conduct. The license of Respondent is hereby REPRIMANDED. As of the date of the Consent Order, Respondent's license is suspended because she has not renewed it. In order for Respondent to reinstate her suspended license or to obtain a new license in the future, she shall successfully complete a minimum of eight to ten hours of tutorials regarding confidentiality requirements for psychologists and appropriate boundaries with patients and their significant others/family members, and general ethical issues for a psychologist. Respondent also is assessed \$300.00 in costs.

**Sloan, Jerry, Ph.D.** - CONSENT ORDER was approved and signed on February 9, 2018. Respondent admits that the described conduct constitutes violations of N.C. Gen. Stat. §§ 90-270.15(a)(10), (a)(14) & (a)(15) of the North Carolina Psychology Practice Act, and constitutes violations of Standards 3.10, 9.01(a), 9.02(a) & (b), 9.03(a), 9.06 and 9.08(a) of the Ethical Principles of Psychologists and Code of Conduct. Respondent's license is REPRIMANDED. Respondent shall complete a minimum of six to eight hours of tutorials regarding the proper use of testing instruments; requirements for updates to testing instruments; general testing guidance, including re-administering a test that has previously been administered; informed consent requirements; how Respondent's conduct resulted in this action taken by the Board; Respondent's plan of action to prevent the recurrence of the behavior which resulted in Board action; and general ethical conduct. Respondent also is assessed \$300.00 in costs.

### MEMBERS

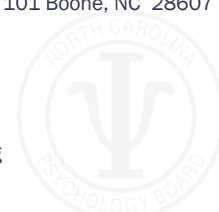
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