Nebraska Board of Psychology Newsletter

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Practice Regulations to Change in 2009

Given the statutory changes that were effective December 1, 2008, (due to the passage of LB 463), the Board is working on revisions to the regulations in order to comply with LB 463. The public hearing was held June 11th, you can view the proposed changes on the Department's web-site at:

http://www.sos.ne.gov/rules-and-regs/regtrack/index.cgi

HEALTH AND HUMAN SERVICES Title: 172 Chapter: 155

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Record Retention

By Lori Lunquist Wall, PhD

The State of Nebraska does not currently provide specific guidelines regarding psychology records' retention. However, psychologists have several good resources to seek guidance, and new language regarding record retention is being included in draft regulations for Nebraska. The following article summarizes the American Psychological Association's record keeping guidelines and integrates other relevant resources to inform practitioners. The Record Keeping Guidelines article published in the American Psychologist (2007) presents a comprehensive review regarding professional record keeping and is available at www.apa.org/practice/recordkeeping.pdf. Also, refer to the "Ethical Principles of Psychologists and Code of Conduct" (APA, 2002), the Health Insurance Portability and Accountability Act (HIPAA, 1996), and APApractice.org for additional information. The Record Keeping Guidelines article (APA, 2007) was written to provide broad guidance to mental health service providers and is summarized as follows:

Guideline 1- Responsibility for Records: Psychologists generally have responsibility for the maintenance and retention of their records.

This guideline clarifies the importance of legibility and organization of records as well as the management of competent staff who handle the record. Ultimately, the psychologist- not clerical staff- is responsible for the accuracy and maintenance of the record.

Guideline 2- Content of Records: A psychologist strives to maintain accurate, current, and pertinent records of professional services as appropriate to the circumstances and as may be required by the psychologist's jurisdiction. Records include information such as the nature, delivery, progress, and results of psychological services as well as related fees.

Content of records reflects that the psychologist must balance client care with legal and ethical requirements and risks. While Nebraska does not specify record content currently, some States such as Washington specify mental health records must contain the following types of information in each document: a) the presenting problem(s), purpose, or diagnosis; b) the fee arrangement; c) the date and service provided; d) a copy of all tests and evaluative reports prepared; e) notation and results of formal consults including information obtained from other persons or agencies through a release of information; f) progress notes reflecting ongoing treatment and current status; and g) if a client requests that no treatment records be kept and the psychologist agrees to the request and no state or federal law mandates a more thorough record be maintained, the client's request must be in writing and retained with some minimal information documented (e.g., service dates and fees). In all States, Medicaid and other third party payers may present specific requirements regarding documentation that you should consider when determining record content for your clients. Guideline 2 suggests that practitioners consider the following issues in regards to record content: the client's wishes; less substantial record content expectations in disaster relief situations; issues related to alteration or destruction of records; legal/regulatory issues (e.g., sealed juvenile records, HIV test results, chemical dependency information); institutional guidelines regarding records; and third party contracts.

Guideline 3- Confidentiality of Records: Psychologists takes reasonable steps to establish and maintain the confidentiality of information arising from service delivery.

Confidentiality of records is mandated by law, regulation, and ethical standards (see Ethics Code Standards 4.01 and 6.02), and psychologists are urged to be aware of the legal and regulatory requirements governing the release of information (e.g., mandated child abuse reporting). This guideline references the increasingly present issue regarding privacy, or lack thereof, regarding a child's record following a marital dissolution. Refer to Dr. Rentmeester's article in this newsletter for more information regarding this topic.

Guideline 4- Disclosure of Record Keeping Procedures: When appropriate, psychologists inform clients of the nature and extent of record keeping procedures (including a statement on the limitations of confidentiality of records; Ethics Code, Standard 4.02).

Psychologists obtain and document informed consent at the beginning of a professional relationship and clarify the record keeping and disclosure policies. The psychologist should make their clients aware that when they, according to a properly signed consent to release information, release information to a third party (e.g., another treating professional), control of the record is then beyond the control of the psychologist who sent the information.

Guideline 5- Maintenance of Records: The psychologist strives to organize and maintain records to ensure their accuracy and to facilitate their use by the psychologist and others with legitimate access to them.

Guideline 5 is self-explanatory, with special consideration needed for the circumstance of an unexpected death of the practitioner or for closing a psychology practice. Refer to the APA Good Practice document (APA, 2008) to review the Checklist for Closing Your Practice as well as to Guideline 13 in this document.

Guideline 6- Security: The psychologist takes appropriate steps to protect records from unauthorized access, damage, and destruction.

Security guidelines emphasize the need for increased vigilance for protection of records given advances in technology including electronic record-keeping. Consideration for off-site record keeping for back-up and other issues are summarized in the Record Keeping Guidelines article.

Guideline 7- Retention of Records: The psychologist strives to be aware of applicable laws and regulations and to retain records for the period required by legal, regulatory, institutional, and ethical requirements.

Barring guidance from more stringent regulations within a State, Guideline 7 reflects a recommendation to retain full records until 7 years after the last date of service delivery for adults or until 3 years after a minor reaches the age of majority, whichever is later. Some States such as Texas require more lengthy retention (e.g., 10 years after termination of services and after a minor is the age of majority). The new language which is included in draft regulations for Nebraska reflect that a clients' records must be held for 7 years following termination of services, except in the case of a minor wherein records are held for 7 years after their 19th birthday. Practitioners may wish to keep records longer than 7-10 years given the potential for litigation or other future considerations.

Guideline 8- Preserving the Context of Records: The psychologist strives to be attentive to the situational context in which records are created and how that context may influence the content of those records.

Primary consideration goes to contextual circumstances when documenting perceptions regarding a client (e.g., trauma may precede a cognitive evaluation that would not accurately predict a child's future functioning). Significant effort to present data in a way that would not prejudice or harm the client is emphasized.

Guideline 9- Electronic Records: Electronic records, like paper records, should be created and maintained in a way that is designed to protect their security, integrity, confidentiality, and appropriate access, as well as their compliance with applicable legal and ethical requirements.

The HIPAA Privacy Rules and Security Standards provide guidance to scrutinize office practices (e.g., personal health information protection, authorization of release of information). Considering the risks taken, for example, by emailing clients is paramount. Additionally, special consideration is given to ensuring secure transmission, storage, and destruction of electronic records.

Guideline 10- Record Keeping in Organizational Settings: Psychologists working in organizational settings (e.g., hospitals, schools, community agencies, prisons) strive to follow the record keeping policies and procedures of the organization as well as the APA Ethics Code.

Guideline 10 reviews three specific issues that present in organizational settings: conflicts between organizational and other requirements, ownership of the records, and access to the records. Psychologists are urged to clarify issues regarding the physical record "ownership" initially in a relationship with an organization (e.g., in consultative relationships, record could possibly go with the psychologist upon departure). Psychologists are encouraged to be sensitive to team access to records and note only information congruent with organizational requirements and necessary to accurately portray the services provided. If allowed and appropriate, the psychologist may consider keeping more sensitive information in a confidential file.

Guideline 11- Multiple Client Records: The psychologist carefully considers documentation procedures when conducting couple, family, or group therapy in order to respect the privacy and confidentiality of all parties.

Specifying within the record who are the identified clients and who has the authority to release records, particularly as part of the initial informed consent, is particularly important when working with multiple clients (see: Ethics Code Standards 10.02 and 10.03). Subsequent requests for records release will necessitate only portions relevant to the specific party covered by the release be provided.

Guideline 12- Financial Records: The psychologist strives to ensure accuracy of financial records.

Psychologists may consider having the following information discussed during the first session and documented in the record: fee arrangement identifying the amount to be charged for the services, terms of any agreement for the payment, clarity regarding who is responsible for the payment, how missed appointments will be handled, acknowledgment of any third party payer authorization requirements, any agreement regarding co-payments and adjustments to be made, payment schedule, interest/late fee policies, suspension of confidentiality when collection procedures are employed, and the methods by which financial disputes may be resolved.

Guideline 13: Disposition of Records: The psychologist plans for transfer of records to ensure continuity of treatment and appropriate access to records when the psychologist is no longer in direct control. In planning for record disposal, the psychologist endeavors to employ methods that preserve confidentiality.

Psychologists are urged to clarify a plan for unexpected departures such as disability or death as well as for an anticipated retirement, focusing on the control and management of record disposition via a trained individual or agency. They are also encouraged to consider accompanying records be shredded and to make particularly careful concessions for electronic data (e.g., seeking technical expertise to fully delete or erase records on a computer hard drive).

These guidelines provide an overall conceptual model and strategies for resolving considerations in record retention. Ongoing consideration for the APA Ethics Code, HIPAA, and emerging State regulations is indicated. Regarding HIPAA, psychologists should be aware of certain record keeping considerations under HIPAA's Security Rule and Privacy Rule (e.g., The HIPAA Security Rule primer via http://www.apapractice.org/apo/hipaa/hipaa_security_rule.html#). The HIPAA guidelines indicate some key areas in which HIPAA considerations impact record keeping. None the less, detailed information of the HIPAA compliance requirements is beyond the scope of this article, and practitioners should continue to actively monitor new implications for competent record management and retention.

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Ethics

By Christy Rentmeester, PhD

Interesting, important, and complex ethical questions commonly arise in the daily practices of psychologists. Consider the following case:

> Jack and Jill have been married for several years and devotedly love their child, Sam. Sam has been expressing behavioral problems, however, and Jack and Jill agree to visit a highly recommended psychologist, Dr. Psych, to have Sam's problems and needs thoroughly evaluated. Dr. Psych initially suggests that Sam can probably be helped most if Jack and Jill agree to participate in Sam's therapy sessions. Jack and Jill's relationship problems become apparent as a source of significant stress for Sam, and before long, Jack and Jill divorce. Conflict about visitation and custody accompanies Jack's and Jill's strong disagreement about how to appropriately guide and parent Sam. Jack stops attending the sessions and expresses that he no longer intends to participate in therapy for Sam. Jill sees benefits of continued therapy for Sam, however, and wants to continue therapy "as a family," until she begins to suspect that Jack may be neglecting Sam during the time they spend together. Dr. Psych continues to believe that, clinically, it is in Sam's best interests for Jack and Jill to participate in therapy sessions. Additionally, Dr. Psych believes it's important to address the impact of Jill's neglect concerns as well as on how the family may continue to benefit from therapy participation. What should Dr. Psych do?

The *Ethical Principles of Psychologists and Code of Conduct* (published by the APA most recently in 2002) addresses several of the ethical issues Dr. Psych faces. General principles cited in the *Code* are consistent with those standardly represented in ethical guidelines for most health professions: *beneficence* and *nonmaleficence*, for example. These and other principles are typically useful insofar as they confer duties, responsibilities, and obligations upon professionals. Beneficence expresses a duty to do good, for example, and nonmaleficence expresses a duty to avoid doing harm.

Sometimes these duties conflict, however, and professionals need more guidance about how to respond. In the case, for example, one course of action might have both good and bad outcomes, and definitions of what constitutes good and what constitutes harm can vary according to different participants' perspectives. A few prominent issues and questions this case illuminates are canvassed below.

Informed Consent (3.10 and 10.01)

How ought psychologists address informed consent in these kinds of cases? Whenever possible, psychologists generally try to get informed consent from patients and family members at the beginning of therapy. However, changes to treatment plans or treatment goals, and changes to who is willing to participate in treatment suggest that informed consent, in actual practice, is less an event hallmarked by placing signatures on a page that it is an ongoing process that must negotiate and respond to changes over time. In this case, for example, one way Dr. Psych can respond to Sam and his parents is by integrating the following steps into the informed consent process:

- Facilitate regular clarification of the goals of therapy.
- Summarize progress that has been made so far and map possible therapy plans for subsequent progress.
- Facilitate clarification of possible positive and negative consequences of continuing therapy without Jack.

In this case, there does not appear to be any question about whether Jack and Jill are Sam's custodial parents. But, the case is complicated by Jack's apparent withdrawal of consent to treat Sam. Even when, in legal terms, only one custodial parent's consent is required to continue treating Sam, there can be important ethical and clinical consequences for Sam when Jack and Jill disagree about whether therapy should continue, which Dr. Psych should be prepared to discuss and address.

Confidentiality and its Limits (4.02 and 4.05)

How ought psychologists determine how to proceed with therapy when they report suspicions of abuse or neglect? Legal requirements state that psychologists are required to report in the presence of mere suspicion (Nebraska Statute 28-711), and this should be clarified to families early in the informed consent process. The legal requirement expresses support for psychologists to err on the side of protecting children, who are—because of their status as minors—typically the most vulnerable clients in these kinds of cases, but it can still leave psychologists puzzling about how to proceed with therapy.

In the presence of confusion about the motivations of divorcing spouses and in the absence of certainty about long-term outcomes for children, the consequences of sharing protected health information with or reporting suspected abuse to authorities are not always clear. Psychologists, however, are obliged to consider the consequences, risks, possible harms, and possible benefits of reporting on children and their families. Dr. Psych might draw upon the following approaches to consider how to respond to Jill's accusation that Jack neglects Sam:

- Remind Jill and Jack that psychologists are required to report suspected abuse or neglect and that adjudicating whether a suspicion is well-founded is not within the scope of psychologists' discretion or duties, but the responsibility of law enforcement and courts.
- Create opportunities to invite comparisons, analogies, and hypotheticals to get a better idea about how therapy participants think and reason about the concept of neglect. Specifically, get more information from all therapy participants, perhaps separately, about how they define neglect and develop a sense of whether Jill, Jack, and Sam have similar assessments of the severity of neglect. For example, suppose Sam is served lunch at 2 PM instead of 12 PM. Does this constitute neglect from Jack's perspective and from Jill's perspective? Does this feel neglectful from Sam's perspective? Invite further discussion about ways in which this situation is similar to or different from letting Sam make macaroni and cheese without supervision;
- Solicit Jack's and Jill's views, perhaps separately, about what constitutes Sam's best interests and what kinds of actions they do regularly to promote his best interests.
- If Jack's absence in Sam's therapy sessions or if Dr. Psych's reporting of suspected irreparably damages or undermines the therapeutic efficacy of Dr. Psych's relationship with Sam, Dr. Psych should initiate discussion about transitioning the child and family to the care of a different psychologist.

Roles and Goals (3.05 and 10.02)

How ought psychologists negotiate different relationships with different participants in Sam's therapy? The *Code* (10.02) recommends that psychologists clarify two things: (1) Who is the patient? and (2) What is the psychologist's relationship with each participant in therapy for the patient? Elaborating why these two questions are important is helpful. In this case, Dr. Psych's patient is the child, and Dr. Psych's role with respect to Sam is as his advocate. Here are a couple suggestions for how Dr. Psych might draw effectively upon Jack and Jill as parents participating in Sam's care:

- Clarify the precise nature and scope of Jack's and Jill's roles in motivating therapeutic goals for Sam.
- Emphasize the importance of Dr. Psych's professional decisions to direct the course of therapy in ways that might, at times, feel awkward or inconsistent with Jack's and Jill's standard parenting practices. That is, *outside of therapy*, parents direct decision-making and assume responsibility for their child's well-being. *In therapy*, however, psychologists direct decision-making about how to proceed and draw upon parents as allies in helping the child.

Cases like this one in which parents' marriages appear to be eroding often prompt psychologists to wonder how to avoid getting embroiled in future "custody battles." Psychologists can feel that subpoenas of records, for example, force them to betray patients' trust and violate agreements to keep health information confidential. While there does not appear to be a way psychologists can protect themselves completely from the threat of having therapy records subpoenaed, psychologists can use the informed consent process to clearly explain the therapeutic importance of trust and their commitment to avoiding "taking sides" in parental disputes, including those adjudicated in courts. The following points can help psychologists educate parents about the clinical purposes of trust and confidentiality in the informed consent process. In discussion or on a form, for example, parents signify their understanding of the following points:

- Their child participates in therapeutic mental health services with the psychologist.
- Their child's trust in the psychologist is essential for maintaining a therapeutic relationship between the child and psychologist.

- Discussions between the child and psychologist are generally confidential with privacy limits discussed clearly at the beginning of therapy (e.g., mandated to report suspicions of abuse against any child).
- Unless parental rights have been terminated or legally restricted, each parent of the child has access to information and therapeutic recommendations regarding the child. It is not within the scope of the psychologist's professional responsibilities or authority to adjudicate disputes between parents about access to information and therapeutic recommendations.
- Unless parental rights have been terminated or legally restricted, each parent of the child may make appointments with the psychologist to review the child's status, ask questions, or discuss concerns.
- Session records and therapy notes are confidential. A psychologist's duty to keep records and notes confidential requires that a psychologist's records and notes will not be shared with parents' representatives (e.g., attorneys) with rare exceptions (e.g., judge declines a psychologist's formal objection to a subpoena).
- In the case of a custody dispute or court-directed placement of a child, for the purposes of preserving trust and the integrity of therapeutic relationship between the child and psychologist, parents should not request the child's psychologist's testimony but seek an independent custody evaluation by someone specifically trained in forensic psychology.

Brief analysis of these issues in this case suggests that the *Ethical Principles of Pyschologists and Code of Conduct* is not all that useful as an "answer book" for tough ethical questions. One way to draw upon the *Code* effectively, however, is to look to it as a catalogue of concepts that psychologists can use to carefully and thoughtfully consider, by themselves and in conference with one another, what is at stake in ethically complex situations and how to respond.

HIPAA and Parents' Right to Access

By Sarah E. Sujith, J.D.

Nebraska law recognizes parents' right to access their children's medical records, but how is this correlated with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? The answer is that HIPAA allows an individual's "personal representative" access to protected health information in most situations, and a parent is considered the personal representative of his or her minor child for the purposes of the HIPAA Privacy Rule. Thus, disclosure of records to a parent is allowable under HIPAA. There are, however, three situations when a parent would not be considered the minor child's personal representative.

First, when the minor consents to the care him- or herself and the parent's consent is not required under State or other applicable law. There is one situation in Nebraska law wherein a minor child may consent to his or her own treatment. This is the testing and treatment for sexually transmitted diseases under Nebraska Revised Statute §71-504. Therefore, a parent would not be able to obtain medical records if his or her child independently sought testing or treatment for this reason.

Second, parents are not considered their children's personal representatives when care is obtained at the direction of a court or a person appointed by the court. For example, when a juvenile court orders certain evaluations for juveniles, such as a Comprehensive Child and Adolescent Assessment (CCAA) the resulting records are not accessible by parents. Additionally, if a minor child has been placed in the care and custody of the Department of Health and Human Services or the Office of Juvenile Services, a parent does not have the authority to obtain their child's treatment records.

Finally, when a parent enters into an agreement that the minor child and the health care provider have a confidential relationship, he or she would not be entitled to access the child's records in relation to this provider. There is some question, however, as to what effect such an agreement by one parent would have on the other parent. This uncertainty stems from a State law indicating that "each parent shall … have full and equal access to the … medical records of his or her child." Neb. Rev. Stat. §42-381. This might be read to imply that when one parent limits his or her access to the child's information, the other parent's access is also limited in order to conform to this "equal access" provision. It might also be argued that both parents are entitled "full and equal access," but that parent who is a party to the agreement has, in effect, waived his or her right in this respect. The answer to this question has not been clearly decided under Nebraska law.

Even when these exceptions apply, there may be situations when parents may be allowed access to the medical records of their minor children when State or other applicable law requires or permits such access. One example of this in Nebraska law, is that a pregnant woman under the age of 18 may consent to an abortion, but Notice of the procedure is required to be sent to one parent of the pregnant minor unless a court waives the requirement, the woman's life or health is endangered, the person entitled to notification authorizes the procedure in writing, or the pregnant woman declares she is a victim of sexual abuse.

If a State or other applicable law is silent on a parent's right of access, a provider should exercise professional judgment to the extent allowed by law in granting or denying parental access to a minor child's information. The HIPAA Privacy Rule also provides that a provider may choose to not treat a parent as a personal representative with rights of access when the provider reasonably believes, in his or her professional judgment, that the child has been or may be subjected to domestic violence, abuse or neglect, or that doing so could endanger the child.

Portions of this article were formulated using information from the United States Department of Health and Human Services website at: http://www.hhs.gov/ocr/privacy/hipaa/faq/personal/227.html

Unmatched Intern Applicants: The Problem and the Implications for Licensing

By John J. Curran, Ph.D.

On February 25, 2008, the Association of Psychology Postdoctoral and Internship Centers (APPIC) once again released the predoctoral match results for the coming internship year. As in the past it was a time of great joy and relief as well as a time of sadness and disappointment. For this year's selection, APPIC reported that 2,749 applicants were successfully matched to internship positions. APPIC explained that 48% of these applicants were matched to their first choice, while 81% were matched to one of their top three choices. On the sad and disappointing side, APPIC reported that 743 of this year's applicants were not matched to a position, which represents 21% of the applicant pool. Softening these numbers was the fact that 309 internship positions went unfilled through the match procedure; it is expected that some of the unmatched applicants will fill these positions. Nonetheless the hard reality is that approximately 400 applicants this year will not have arranged an internship through APPIC's match procedure and will need to look elsewhere for their training or reapply next year.

This problem of unmatched applicants is not new to the psychology profession. Pederson (1997) wrote "Over the past several years, it has become increasingly clear that there are larger numbers of students seeking professional psychology internships than there are available internship positions." Pederson explained that, while the number of internship positions was growing, the number of applicants was increasing at a much faster rate. He did not believe that this trend would change any time soon. In examining APPIC data listed below beginning in 2001, his statements continue to be accurate.

Year	Applicants	Positions	Difference
2001	2947	2763	184
2002	2842	2752	90
2003	2963	2718	245
2004	3039	2732	307
2005	3117	2757	360
2006	3210	2779	431
2007	3430	2884	546
2008	3492	3058	434

As seen in the table below, the number of unmatched applicants also continues to grow, while the number of unfilled positions appears to remain relatively steady.

Year	Number of Unmatched Applicants	Number of Unfilled Positions
2001	520	336
2002	432	342
2003	533	288
2004	611	304
2005	669	309
2006	731	300
2007	842	296
2008	743	309

The impact of this imbalance on the intern applicant is quite significant and has been described in the professional literature. Draper and Lopez (1997) identified the tremendous investment that applicants make in securing an internship position. Given the competitive nature of internships, doctoral students are increasing their pre-internship experiences, are applying to more sites over larger geographic regions, and are investing more time and money in internship applications and interviews. Intern applicants spend December and January traveling many miles for internship interviews, taking away precious time from their graduate studies. Students who are not placed struggle with demoralization and disappointment in the profession. Entering graduate school, students may have assumed that the profession would provide the necessary training opportunities to proceed systematically to a degree and eventual licensing. If unmatched, the intern applicant is then challenged with having to make decisions which potentially could have far reaching effects on their future.

In an article on the Inside Higher Education website posted soon after this year's match, Redden (2008) discussed the growing disparity and the fact that more and more intern applicants will look to non-APA accredited internships for their training. In doing so, these students place themselves at risk for future licensing and employment difficulties.

Given that there will be little change in the current situation over the coming years, there will be a growing pool of graduate students choosing to participate in predoctoral internships which are not accredited by the American Psychological Association (APA). This growing number increases the likelihood that a potential employer or supervising psychologist will need to be aware of the Nebraska licensing requirements for individuals coming from non-APA-accredited internship programs. Here in Nebraska, the licensing requirement is that the applicant successfully completes an APA-accredited predoctoral internship or that their arranged internship meets the standards of accreditation adopted by the American Psychological Association. The fact that an internship is listed in the APPIC Directory is irrelevant to the question of APA-accreditation; APPIC is not an accrediting body.

The Psychology Licensing Board has developed an application for these individuals which outlines those requirements and necessitates that the applicant provide documentation related to each of these standards. It is the responsibility of the applicant to provide evidence of equivalency. Some, but not all of these requirements, are that the arranged internship was at least 12 months in duration, consisted of at least 1500 or more hours completed in not more than 24 months, was directed by a licensed psychologist, was sequentially and progressively organized with increasing levels of responsibility and skills, and required at least four hours of supervision per week of which two of the four hours must have been individual, face-to-face supervision. For further information about the specific requirements for licensing of an individual coming from a non-APA-accredited internship, please contact Kris Chiles at the Nebraska Psychology Licensing Board.

In summary, the problem of unmatched intern applicants for predoctoral internship appears to be continuing and growing. This will lead to an increase in the number of doctoral level psychologists seeking licensing who have not attended APA-accredited internships. It would behoove potential employers and supervising psychologists to become familiar with the process of licensing these individuals. This familiarity could lead to fewer hiring mistakes and drawn-out struggles for license applicants.

In concluding this article, a special thank you goes to Dr. Jean Laing, Director of Internship Training at the Norfolk Regional Center. She was invaluable in assisting with the gathering of resources for this article.

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ASPPB Practice Analysis Study–Large-scale validation survey launched

ASPPB has been in the business of credentialing psychologists since 1961. As part of its mission to provide excellence in regulation, and in adherence with best practices in credentialing, a critical component of ASPPB's development of valid and reliable licensure examinations and certification programs is the conduct of periodic analyses of the practice of psychology. The last such study was completed in 2003, and ASPPB is currently conducting its third major practice analysis in partnership with Professional Examination Service, the organization that administers the EPPP. Results of this study will be used to update the EPPP, to develop complementary assessments, and to guide the education and training of future psychologists.

You may have recently received, or may receive in the next few days, an invitation to participate in the final phase of the study – a large-scale online survey of 5,000 psychologists across the US and Canada, who will be evaluating the knowledge and competencies used by psychologists in practice today.

Nebraska is a member jurisdiction of ASPPB, and it is critical that the study and ultimately the credentialing process include perspectives of psychologists from your jurisdiction. We urge you to participate if you are included in the sample of psychologists to whom the invitation has been sent. Your responses will help ensure that ASPPB achieves the most comprehensive and contemporary description of psychology practice possible. If you have any questions about the study, contact ASPPB at 334-832-4580.

We appreciate your contribution to this endeavor.

Emil Rodolfa, Ph.D., President, ASPPB
Stephen DeMers, Ed.D., Executive Officer, ASPPB

License Statistics (as of 5/6/2009)

Psychologists:	428	Provisionally Licensed Psychologists:	42
Special Licensed Psychologists:	10	Temporary Licensed:	3
30-Day Permit:	3		
Psychology Associates:	2	Psychological Assistants:	93

Mandatory Reporting

Every credentialed person who has first-hand knowledge of unlicensed, illegal or unethical activities is required to report (includes self-reporting) within 30 days of the occurrence. **Failure to report** may result in discipline. You may view additional information relating to mandatory reporting at the following web sites:

- Reporting Forms - http://www.dhhs.ne.gov/reg/INVEST-P.HTM#Forms
- Mandatory Reporting Regulations 172 NAC 5 - http://www.dhhs.ne.gov/crl/reportregs.pdf

The following chart is a quick reference to mandatory reporting:

WHAT TO REPORT	WHO IS TO REPORT
1. Practice without License.	All Professionals
2. Gross Incompetence. 3. Pattern of Negligent Conduct. 4. Unprofessional Conduct. 5. Practice while Impaired by Alcohol/Drugs or Physical, Mental, or Emotional Disability. 6. Violations of Other Regulatory Provisions of the Profession.	All Professionals Report Others of the SAME Profession*
7. Gross Incompetence. 8. Practice while Impaired by Alcohol/Drugs or Physical, Mental, or Emotional Disability.	All Professionals Report Others of a DIFFERENT Profession*
9. Loss of or Voluntary Limitation of Privileges 10. Resignation from Staff 11. Loss of Employment, 12. Licensure Denial (9–12: ***Due to Alleged Incompetence, Negligence, Unethical or Unprofessional Conduct, or Physical, Mental, or Chemical Impairment.) 13. Loss of Membership in Professional Organization 14. Adverse Action pertaining to Professional Liability Coverage. 15. Licensure Discipline/Settlement/Voluntary Surrender/Limitation in any State or Jurisdiction. 16. Conviction of Felony or Misdemeanor in this or any other State or Jurisdiction.	All Professionals—Self-Reporting
17. Payment made due to Adverse Judgment, Settlement, or Award. 18. Adverse Action affecting Privileges or Membership.***See above	Health Facilities, Peer Review Organizations, and Professional Associations
19. Violation of Regulatory Provisions Governing a given Profession.** 20. Payments made due to Adverse Judgment, Settlement, or Award. 21. Adverse Action affecting Coverage.	Insurers
22. Convictions of Felony or Misdemeanor involving Use, Sale, Distribution, Administration, or Dispensing Controlled Substances, Alcohol or Chemical Impairment, or Substance Abuse. 23. Judgments from Claims of Professional Liability.	Clerk of County or District Court

Exceptions to Mandatory Reporting include:
* 1) If you are a spouse of the practitioner, 2) If you are providing treatment which means information is protected by a practitioner-patient relationship (unless a danger to the public), 3) When a chemically impaired professional enters the Licensee Assistance Program, 4) When serving as a committee member or witness for a peer review activity.
** Unless knowledge is based on confidential medical records.

Conviction Reporting

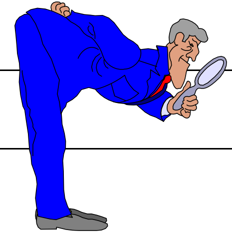
We commonly find that applicants fail to submit convictions that may have occurred while the person was a minor. While this may have been several years ago or longer, by law you are still required to disclose this information on your initial application for licensure.

Initial License Applicants: If you have ever had a misdemeanor or felony conviction, or have been disciplined by another state board, you are required to report this information on your application for licensure. Failure to report or disclose convictions is grounds for denial or discipline. If you are not sure if a ticket or arrest resulted in a misdemeanor or felony conviction, we suggest you contact the court where the action was taken to assure you are reporting all convictions.

In addition to reporting the conviction or disciplinary action, you are also required to submit the following:
1. A list of any misdemeanor or felony convictions;
2. A copy of the court record, which includes charges and disposition;
3. Explanation from the applicant of the events leading to the conviction (what, when, where, why) and a summary of actions the applicant has taken to address the behaviors/actions related to the convictions;
4. All addiction/mental health evaluations and proof of treatment, if the conviction involved a drug and/or alcohol related offense and if treatment was obtained and/or required;
5. A letter from the probation officer addressing probationary conditions and current status, if the applicant is currently on probation; and
6. If your license in health care in another state has been revoked, suspended, limited or disciplined in any way, an official copy of the disciplinary action, including charges and disposition.

Licensee: Once you obtain your license, if you have any criminal charges or license disciplinary actions pending that result in a misdemeanor or felony conviction or license discipline, you are required to report such actions to this Department **within 30 days** of the conviction or license discipline. Along with the report, you are also required to submit items 1-6 listed above. Failure to do so is grounds for discipline.

Investigative Case Resolutions - Board Recommendations



1 Close the Case (no action)
2 Request Further Investigation – need more info

3 IF THE SUBJECT OF THE COMPLAINT IS NOT LICENSED:

A. Letter of Cease and Desist (if found to be practicing without a license/certificate)

4 IF THE SUBJECT OF THE COMPLAINT IS LICENSED:

A. Non-Disciplinary Actions

Recommended Actions:

Assurance of Compliance	The assurance shall include a statement of the statute, rule, or regulation in question, a description of the conduct that would violate such statute, rule, or regulation, the assurance of the credentialed person that he or she will not engage in such conduct, and acknowledgment by the credentialed person that violation of the assurance constitutes unprofessional conduct. Such assurance shall be signed by the credentialed person and shall become a part of the public record of the credentialed person. The credentialed person shall not be required to admit to any violation of the law and the assurance shall not be construed as such an admission.

B. Disciplinary Action – Must File a Petition

Recommended Actions:

(a) Censure	Reprimand
(b) Probation	For a specified period of time (to be recommended by the Board) the licensee will be required to meet certain terms and conditions. Failure to meet those conditions will result in a petition to revoke probation and the license. Examples of probationary conditions are: Body Fluid Screens, Assigned Supervisor, AA Attendance, Treatment , LAP Evaluation, Continuing Education, Jurisprudence Exam
(c) Limitation	Licensee's authority to practice is limited in some fashion. Examples include – requiring the licensee to work under direct supervision, prohibit certain types of clientele, etc. (may petition reinstatement at any time)
(d) Civil Penalty	Impose a civil penalty not to exceed twenty thousand dollars. The amount of the penalty shall be based on the severity of the violation. Money collected from a civil penalty shall be transmitted to the State Treasurer for deposit in the Permanent School Fund (the money is not deposited into the board's fund).
(e) Suspension	Licensee loses his/her license for a specified period of time. The director may order that the credential shall be automatically reinstated upon expiration of such period, reinstated if the terms and conditions as set by the director are satisfied, or reinstated subject to probation or limitations or conditions upon the practice of the credentialed person. (may petition reinstatement at any time)
(f) Revocation	Licensee loses license for at least 2 years (may petition reinstatement at any time after a period of 2 years has elapsed 71-161.04)
(g) Voluntary Surrender	Licensee voluntary surrenders his/her authority to practice. There is no ending date for voluntary surrender. The licensee may petition the board for reinstatement at any time.

Disciplinary and Non-Disciplinary Action Statistics as of 1/1/2006 through 1/1/2009

Non-Disciplinary Assurance of Compliance: 2
Voluntary Surrender: 1
Probation: 1

Who Are the Board Members?

The Nebraska Board of Psychologists is comprised of 7 members, 5 psychologists and 2 public members. Members serve five-year terms, and may serve up to two consecutive terms. The Board members for 2008-2009 are listed below.

Board Member	Board Position	Term Begins	Term Ends
John Joseph Curran, PhD - Norfolk	Professional Member	12/01/2005	11/30/2010
David Carver, PhD - Omaha **Chair**	Professional Member	12/01/2006	11/30/2011
Ann I. Heermann - Lincoln **Secretary**	Public Member	01/24/2005	11/30/2009
Christy Rentmeester, PhD - Omaha	Public Member	05/21/2007	11/30/2009
Lori L. Wall, PhD - Lincoln	Professional Member	12/01/2004	11/30/2009
Jerry Van Winkle, PsyD - Kearney	Professional Member	12/01/2008	11/30/2013
Mark Weilage, PhD - Lincoln **Vice-Chair**	Professional Member	12/01/2007	11/30/2012

David Carver, Ph.D.: David Carver, Ph. D. is the Director of Counseling and Student Development at the University of Nebraska Medical Center where he has worked since 1987. Dr. Carver has faculty appointments in family medicine and psychiatry. He has been a licensed psychologist since 1984 and also maintains a small private practice in Omaha. In addition to serving on the Board of Psychologists, he is a member of the state Justice Behavioral Health Committee. His professional interest areas include cognitive behavioral therapy, solution focused brief counseling, consultation, academic performance enhancement, conflict resolution, substance abuse/ dependency, and psychological assessment.

Ann Heermann: Ms. Heermann is currently serving her fourth year as a public member of the Psychology Board. She reflects that serving on the Board of Psychology has been a great learning experience for her, and that she admires the dedication of the Board to the practice of psychology in the State of Nebraska. She sees her purpose on the board as offering an "outsider's" opinion about the issues people face and tries to offer a simple viewpoint on complicated matters. She is a 26-year veteran of the Lincoln Police Department and currently works as a street sergeant. Her role in law enforcement overlaps well with the goal of the board: to always protect the public. Her interests include fitness, golf, Nebraska volleyball, and the Boys and Girls Club of Lincoln/Lancaster County.

John "Jay" Curran, Ph.D.: Dr. Curran joined the Board of Psychologists in December 2005 and attended his first meeting on January 20, 2006. He spent his early years in Saint Louis, Missouri before graduating from colleges in Kansas and Missouri. He completed his internship at the Norfolk Regional Center in 1983 and obtained his doctorate from The University of Iowa in 1984. He has been a psychologist at the Norfolk Regional Center since 1985. He was Director of Intern Training there for some years up until 1995. In addition, he has been in private practice with Associated Psychologists and Counselors, LLC since 1991. In his spare time, he enjoys reading and learning about the Civil War and rooting for the Saint Louis Cardinals.

Christy Rentmeester, Ph.D.: Dr. Christy Rentmeester is a Public Member of the Board of Psychology. She is a member of the faculty at the Center for Health Policy & Ethics in the Creighton University School of Medicine who teaches and serves on the Case Consultation Subcommittee of the Creighton University Hospital's Ethics Committee. Trained as a philosopher, her academic interests focus on the intersections of ethics and humanities in health professions education and upon applications of moral and social & political theory to justice problems in healthcare, particularly those dealing with service provision to patients with mental illnesses. She is a member of the American Society for Bioethics and Humanities and the American Public Health Association.

Lori Lundquist Wall, Ph.D.: Dr. Lori Lundquist Wall grew up in South Dakota, completed her doctoral internship at the University of Minnesota Medical School, and ultimately earned her doctorate in Clinical Psychology at the University of NE-Lincoln. She is particularly interested in working with medical practitioners to provide collaborative care for the children, families, and adults she sees via her private practice and has enjoyed working with UN-L psychologists to provide teaching and supervision to doctoral students. She served several years on the Ethics Committee for The Nebraska Psychological Association, and she has been on the Board of Psychologists since 2004. Personal interests include spending time with her family, running, kayaking, and reading.

Jerry Van Winkle, Psy.D.: Jerry Van Winkle, PsyD, joined the Nebraska Board of Psychology in January, 2009. He is a Nebraska native, but left the Cornhusker State to completed his doctoral training in clinical psychology at Baylor University in Texas, followed by an internship in St, Louis, Missouri. Since returning to Nebraska, Dr. Van Winkle has worked in both outpatient and inpatient settings. He currently lives in Kearney with his wife and two daughters where he is in private practice. He also works part time at the Hastings Regional Center's Adolescent Substance Abuse program. When he is not working, he enjoys spending time with his family, traveling, reading and outdoor activities.

Mark Weilage, PhD: Dr. Weilage is the newest member of the board of Psychologists. He started in January of 2008. Dr. Weilage has been licensed for approximately 10 years. He has worked in private practice. For the last 8 years he has worked for the Nebraska Department of Correctional Services. For the last two of those years Dr. Weilage has directed Mental Health services for the Department of Corrections as the Assistant Behavioral Health Administrator for Mental Health.

Board Meeting Dates

Meetings of the Nebraska Board of Psychologists convene at 11:00 a.m. on the third Friday of every other month; however, the Board usually immediately goes into closed session to review investigative reports. Members of the public may not be present during closed session. Following closed session, the Board will return to open session.

Agendas for the meetings are posted on our Web site at http://www.hhs.state.ne.us/crl/brdmtgs.htm#Psychology and the remaining 2009 meeting dates are noted below:

Board Meeting Dates
July 17
September 16
November 20

All meetings are held at the State Office Building,
301 Centennial Mall South, Lincoln, Nebraska

Each member of the board brings something positive to contribute in terms of diversity of perspective and opinion. Professional members of the board bring their education, experience and understanding of what constitutes appropriate preparation and continuing professional conduct for licensure. Public members, also known as consumer members, contribute their experience as service recipients as well as the public's expectation for health professionals. Public members provide another perspective to the technical and professional expertise of the other members.

The board is charged with:

- providing for the health, safety, and welfare of the citizens;
- insuring that licensees or certificate holders meet minimum standards of proficiency and competency; and
- regulating the profession in the interest of consumer protection.

Board members are familiar with Nebraska's Uniform Credentialing Act, the statutes/regulations governing psychology, and statutes related to open meetings/public records. These laws and regulations form the basis for all actions and responsibilities as a board member.

If you are interested in becoming a Board member, visit our web site at: http://www.dhhs.ne.gov/crl/crlindex.htm

Web Site

The Nebraska Department of Health and Human Services Web site offers the "License Information System", a database of information on all professionals whose licenses are regulated by the DHHS Division of Public Health. Consumers, professionals, and any interested persons can find licensing and application information and forms. Information on licensees also is available, including licensee name, address, license number, date of issuance and expiration, license status and any disciplinary action that has been taken against the license. Licensees can also change their address information on-line. The information in this database is updated nightly to reflect changes.

DHHS also offers a "Professions and Occupations Index" Web site. This site has information about the Licensing Boards, Board meetings and listing of Board members for each of the regulated professions and occupations. A click on a particular profession listed leads to another Web page, which has information on applications, the application process, licensing requirements, license renewal procedures and other information about that regulated profession. The Internet links to each of the Web sites mentioned above are:

- License Information System: http://www.dhhs.ne.gov/lis/lisindex.htm
- Professions and Occupations Index: http://www.dhhs.ne.gov/crl/profindex1.htm

Duplicate licenses: You may obtain a duplicate copy of your license for $10 (see web site); or you may also download an official verification of your license (free) at: http://www.dhhs.ne.gov/lis/lisindex.htm

Department Staff Contacts

Licensure Unit
Nebraska State Office Building
301 Centennial Mall South (14th and M Street) P.O. Box 94986
Lincoln, NE 68509-4986

Office Hours: Monday - Friday
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Phone: (402) 471-2115
Fax: (402) 471-3577

Licensure and Renewal Information
Cindy Kelley, Health Licensing Specialist
(402) 471-4905
cindy.l.kelley@nebraska.gov

Non-Routine Licensure Issues
Kris Chiles, Program Manager
(402) 471-2117
kris.chiles@nebraska.gov

Complaint Filing
Investigations Division
(402) 471-0175
DHHS.InvestigationsPOL@nebraska.gov

Probation Compliance Monitoring
(402) 471-2117
DHHS.Licensure2117@nebraska.gov

It is the responsibility of the licensee to notify the Department of any name and/or address changes prior to the renewal period. **Address changes** may be made in writing or over the telephone. **Name changes** require submission of a photocopy of the documentation of the legal name change.

We hope you enjoyed the Board's newsletter.

We welcome comments relating to future articles that you would like the Board to address.

The Nebraska Department of Health and Human Services is committed to affirmative action/equal employment opportunity and does not discriminate in delivering benefits or services.