Virginia Department of
Health Professions
Board of Psychology

Agenda
Regulatory Committee Meeting
October 28, 2019
Board Room 4
1:00 p.m.

Call to Order – Jim Werth, Ph.d, Committee Chair

- Welcome and Introductions
- Emergency Egress Procedures
- Mission of the Board

Approval of Minutes

- Regulatory Committee Meeting – October 29, 2018* Page 4

Public Comment

The Committee will not receive comment on any pending regulation process for which a public comment period has closed or any pending or closed complaint or disciplinary matter.

Unfinished Business

- EPPP-Part II Page 7
- APA Master's Level Accreditation Page 20
- Professional Wills

New Business

- Guidance Document on Use of Social Media Page 42

Next Meeting – January 27, 2020

Meeting Adjournment

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*Requires a Committee Vote

This information is in DRAFT form and is subject to change. The official agenda and packet will be approved by the Board at the Regulatory Committee meeting. One printed copy of the agenda packet will be available for the public to view at the Board Meeting pursuant to Virginia Code Section 2.2-3707(F).

DRAFT

PERIMETER CENTER CONFERENCE CENTER

EMERGENCY EVACUATION OF BOARD AND TRAINING ROOMS
(Script to be read at the beginning of each meeting.)

PLEASE LISTEN TO THE FOLLOWING INSTRUCTIONS ABOUT EXITING THESE PREMISES IN THE EVENT OF AN EMERGENCY.

In the event of a fire or other emergency requiring the evacuation of the building, alarms will sound.

When the alarms sound, leave the room immediately. Follow any instructions given by Security staff

Board Room 4

Exit the room using one of the doors at the back of the room.

(Point) Upon exiting the room, turn RIGHT. Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

Virginia Department of

Health Professions

Board of Psychology

MISSION STATEMENT

Our mission is to ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to health care practitioners and the public.

Virginia Board of Psychology
Regulatory Committee Meeting
October 29, 2018
Draft Minutes

Time and Place:	The Regulatory Committee of the Virginia Board of Psychology ("Committee") convened for a meeting on Monday, October 29, 2018 at the Department of Health Professions (DHP), Perimeter Center, 9960 Mayland Drive, Henrico, Virginia Board Room 4.
Presiding:	James Werth, Jr., Ph.D., ABPP, LCP, Chairperson
Committee Members Present:	John D. Ball, Ph.D., ABPP, LCP Herbert Lee Stewart, Ph.D., LCP Susan Brown Wallace, Ph.D., LCP, LSP With four (4) committee members present, a quorum was established.
Committee Members Absent:	Jennifer Little, Citizen Member
Staff Present:	Jaime Hoyle, Executive Director Jennifer Lang, Deputy Executive Director Elaine Yeatts, Senior Policy Analyst
Call to Order:	Dr. Werth called the meeting to order at 1:02 p.m. and read the board's mission statement and emergency evacuation instructions. Board members, staff, and members of the public introduced themselves.
Ordering of the Agenda:	The Committee accepted the agenda as presented.
Approval of Minutes:	Dr. Ball made a motion to approve the minutes. The motion was seconded by Dr. Wallace and the motion passed unanimously.
Public Comment:	Public comment was made by Bruce Keeney with the Virginia Academy of Clinical

Psychologists, who made suggestions regarding the Draft Guidance Document on Assessment Titles and Signatures.

Unfinished Business:

Guidance Document on Assessment Titles and Signatures

The Committee reviewed the draft document and made changes to include clarification that this document applies to school psychologists, and school psychologists-limited, licensed by the Board of Psychology. Dr. Ball made a motion to recommend the amended document to the full board. The motion was seconded by Dr. Wallace and passed unanimously.

Guidance Document on Telepsychology

The Committee reviewed the draft guidance document and discussed proposed changes, including changing the name of the document to "Electronic Communication and Telepsychology." Dr. Ball made a motion to recommend the amended document to the full board. The motion was seconded by Dr. Wallace and passed unanimously.

Authority to Issue Temporary License

The Committee discussed the benefits and concerns of issuing resident level licenses, and decided that the issue needs more research and further discussion before a decision can be made.

New Business:

Professional Wills

The Committee will begin to review the requirement for professional wills in other jurisdictions and determine if the matter should be addressed by this board.

Masters Level Practice of Psychology

The Committee discussed the APA's consideration of accrediting Master's level psychology programs. No action is required by the Committee at this time.

ASPPB and EPPP

ASPPB has discussed making the different levels of the EPPP voluntary rather than required. No action is required by the Committee at this time.

Next Meeting:	The next committee meeting will be held on January 22, 2019.
Adjournment:	The meeting adjourned at 4:01 p.m.

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James Werth, Jr. Ph.D., ABPP, LCP, Committee Chairperson Date
Virginia Board of Psychology

____ __________________________

Jaime Hoyle, JD, Executive Director Date
Virginia Board of Psychology

ASPPB
Association of State and Provincial Psychology Boards

EPPP (Part 2-Skills)

Thank you for visiting the EPPP (Part 2-Skills) Information Page. A component of the EPPP, this is a computer based examination which assesses the skills needed for entry level licensure. On this web page you will find substantial information about the development (including its competency based foundation) and current status of the EPPP (Part 2-Skills). The exam is scheduled to launch in January 2020.

EPPP (Part 2-Skills) INFORMATION

Why Become An Early Adopter

Exam Overview

Why?

Format of the Exam

Validity

SAMPLE ITEMS

Comprehensive Overview

COMPETENCY INFORMATION

Job Task Analysis Report (2016)

ASPPB Competencies Expected (2017)

Brief History of the Competency Movement in Psychology

EPPP (Part 2-Skills) Candidate Handbook (Coming Soon)

My Profile
» Profile Home
» Manage Profile
» Groups
» Messages
» Membership Info
» Refer a Friend

FAQs & Latest News more

8/12/2019
Registration Open for ASPPB's 59th Annual Meeting

4/23/2019
PSYPACT becomes Operational

3/18/2019
Call for ASPPB Volunteers

ASPPB Calendar more

10/15/2019 » 10/16/2019
BOD Meeting - Minneapolis, MN

10/16/2019 » 10/20/2019
Annual Meeting - Minneapolis, MN

10/24/2019 » 10/27/2019
ExC 2 Meeting - TBD

11/8/2019 » 11/10/2019
ExC 1 - Austin, TX

4/23/2020 » 4/26/2020
ASPPB 35th Midyear Meeting - Montreal

ASPPB
Association of State and Provincial Psychology Boards

THE EPPP

One Exam, Two Parts: EPPP (Part 1-Knowledge) and EPPP (Part 2-Skills)

Early adoption phase of the EPPP (Part 2-Skills)

Q: **What is the 'early adoption' phase?**
A: *Starting on January 1, 2020, licensing boards will have the opportunity to become an Early Adopter of The EPPP (Part 1-Knowledge) and EPPP (Part 2-Skills).*

Q: **Can I take the EPPP (Part 2-Skills) if I haven't taken the EPPP (Part 1-Knowledge)**
A: *No. The EPPP (Part 1-Knowledge) will become the prerequisite for the EPPP (Part 2-Skills).*

Q: **I've already passed the EPPP (Part 1-Knowledge), do I have to take the EPPP (Part 2-Skills)?**
A: *ASPPB is recommending that candidates who pass the EPPP before December 31st, 2019, be exempt from taking the EPPP (Part 2-Skills).*

Q: **I haven't passed the EPPP (Part 1-Knowledge) yet, will I have to take the EPPP (Part 2-Skills)?**
A: *After January 1, 2020, if you are applying for licensure in an early adoption jurisdiction, then, yes, you will be required to take both parts of the exam.*

Q: **Who will approve me to sit for the EPPP (Part 2-Skills)?**
A: *Your state or provincial licensing board will make all decisions about eligibility.*

Q: **Do I need to score a 500 on each exam?**
A: *ASPPB's recommended passing score for both portions of the exam is a 500.*

Q: **How do I know if my state or province is an early adopter?**
A: *Check with your licensing board, and check our website for updates.*

The early adoption period is: January 1, 2020 until December 31, 2021

Candidates from early adopter jurisdictions will be eligible for a reduced exam fee for the EPPP (Part 2-Skills) portion: (the EPPP (Part 1-Knowledge) fee will remain $600):

$100
for Beta Candidates
**not including test center or jurisdictional fees*

$300
After the Beta Exam closes, until 12/31/2021
**not including test center or jurisdictional fees*

$450
After 1/1/2022
**not including test center or jurisdictional fees*

THE EPPP

One Exam, Two Parts:
EPPP (Part 1-Knowledge) and EPPP (Part 2-Skills)

The EPPP will be a two-part exam that more thoroughly assesses the totality of competency of candidates for licensure. This will include:

EPPP (Part 1-Knowledge)

The EPPP (Part 1-Knowledge) is the foundational knowledge exam that is presently in place in all jurisdictions.

This is a critical assessment as it provides licensure boards with information on their candidates general knowledge of psychology. This includes important psychological theories in areas such as cognition, affect, development and general knowledge of intervention and assessment, research, factors impacting psychological functioning as well as many other aspects of the foundational knowledge that psychologists are taught in graduate school.

This will become the prerequisite for the skills-based portion of the EPPP.

EPPP (Part 1-Knowledge): Domains and Weights

1. Biological Bases of Behavior (10%)
2. Cognitive-Affective Bases of Behavior (13%)
3. Social and Cultural Bases of Behavior (11%)
4. Growth and Lifespan Development (12%)
5. Assessment and Diagnosis (16%)
6. Treatment, Intervention, Prevention and Supervision (15%)
7. Research Methods and Statistics (7%)
8: Ethical/Legal/Professional Issues (16%)

EPPP (Part 2-Skills)

Starting January 2020, the EPPP (Part 2-Skills) will be used to evaluate the skills of a candidate applying for licensure in Psychology.

This skills-based assessment includes questions about applied, real world situations that psychologists face in practice. This provides valuable information to licensing board as it assesses the candidate's ability to show what they would DO in an applied setting. This has never been assessed through a universal standard across different jurisdictions.

The EPPP (Part 2-Skills) will assess the following areas:

EPPP (Part 2-Skills): Domains and Weights

1. Scientific Orientation (6%)
2. Assessment and Intervention (33%)
3. Relational Competence (16%)
4. Professionalism (11%)
5. Ethical Practice (17%)
6. Collaboration, Consultation, Supervision (17%)

Visit www.asppb.net for information on our other programs:

CPQ
Certificate of Professional Qualification in Psychology

IPC
Interjurisdictional Practice Certificate

PLUS
Psychology Licensing Universal System

PSYPACT
www.psypact.org

EPPP
Score Transfers

PEP
Psychopharmacology Exam for Psychologists

Why is the EPPP (Part 2-Skills) needed?

Psychology and most regulated professions have embraced the move to competency and the assessment of competence. Until now, the universal standard across all jurisdictions has been the EPPP (Part 1-Knowledge). This has served its purpose very well for over 50 years. However, adding the EPPP (Part 2-Skills) will provide a more thorough assessment of competence.

Skills assessment has been left to each individual jurisdiction to determine based on their own rules. This is most often done by requiring a number of supervised hours, oral examinations, and letters of recommendations. All of these methods have known reliability concerns.

Licensing Boards are charged with ensuring that candidates approved for licensure are competent to practice. Many jurisdictions would like better information about the skill set of their candidates. The EPPP (Part 1-Knowledge) allows candidates to demostrate a universal standard of foundational knowledge. The EPPP (Part 2-Skills) will provide a valid, reliable and legally defensible measure for regulators to assess their candidates' demonstration of a universal standard of skills.

Jurisdictions interested in adopting the EPPP (Part 2-Skills) are encouraged to contact Dr. Matt Turner at mturner@asppb.org

ASPPB
Association of State and Provincial Psychology Boards

THE EPPP

One Exam, Two Parts:
EPPP (Part 1-Knowledge) and EPPP (Part 2-Skills)

Format of the EPPP (Part 2-Skills)

The EPPP (Part 2-Skills) provides information on candidate understanding of how to proceed in applied situations. This is done by presenting case situations, or real world information, in a variety of item formats including:

Multiple Choice: Candidate must choose the best choice of 3 responses.

Multiple Choice/ Multiple Response: Candidate will be allowed to choose more than one response from a series of possible answers. For example, select 2 of 5 options.

Scenarios: Presents information from an applied situation. Scenarios have up to 3 "Exhibits" which present additional information. This can be an animation, a description of an interview, a test protocol, or other data that adds information. Each Exhibit can have up to 5 questions that pertain to that part of the scenario.

Point and Click: A graphical image is presented (ie. A test protocol, a business card, an advertisement, a letter, etc.) and the candidate may select one or more areas on the image to indicate a response to the question.

Drag and Drop: Matching multiple appropriate stimuli on the left side of the screen to an appropriate response on the right side of the screen.

The EPPP (Part 2-Skills):

Questions: 170

Exam Time: 4 hr 15 min

Exam Breakdown:

Multiple Choice or Multiple Choice Multiple Response:	45%
Scenario Based Questions:	45%
Other Item Types:	10%

Validity of the EPPP (Part 2-Skills)

Because the EPPP (Part 2-Skills) is a new assessment, ASPPB has received many questions regarding the validity of the exam. The process of development of both the EPPP (Part 1-Knowledge) and the EPPP (Part 2-Skills) follows a rigid content validation methodology that complies with the Guidelines for the Standards in Educational Testing suggested by American Psychological Association (APA), American Educational Research Association (AERA), and the National Council on Measurement in Education (NCME).

Overview of the Process

Job Task Analysis (JTA) - A comprehensive study that involves Subject Matter Experts (SMEs) who are licensed psychologists that establish the knowledge and skills that are required for practice in psychology. The resulting requirements are sent via survey to thousands of licensed psychologists throughout the United States and Canada. The survey respondents indicate which areas are important for entry level practice. The results establish the test specifications (blue print) for the exam. Essentially, the expertise of licensed psychologists establishes what should be assessed by the exam.

Item Writing - SMEs write exam items according to the test specifications established from the JTA. All writers for the EPPP (Part 2-Skills) are licensed in the United States or Canada.

Item Review - Each item is reviewed by an Item Development Committee (IDC) SME in that Domain who is an established expert in that specific area. Items are reviewed in an iterative process between the reviewer and the item writer until the item is acceptable to both or discarded.

Exam Form Review - Each item is again reviewed prior to being placed on an exam by the Examination Committee. This committee is comprised of 10 SMEs who are psychologists that have particular expertise in each of the domains on the exam and represent various areas of psychology practice and training. Items that have been approved by the IDC are again reviewed for accuracy, relevancy to practice, clarity, and freedom from bias, among other factors.

Psychometric Review - Once approved by the Examination Committee, each item is pretested (or beta tested) prior to being an active item that is scored item on an exam. Items that do not perform well during pretesting, according to psychometric standards, are not included on a candidate's overall scores.

Standard Setting - The pass point of the exam is established though a rigorous review process called a standard setting. This involves a committee of SMEs who are licensed psychologists, most of whom are typically early career psychologists. These SMEs review the exam form item by item and provide rating data on difficulty. The data is analyzed to determine the appropriate pass point which represents the minimal knowledge or skills required for entry level practice.

These multiple levels of review by Psychologists and the ongoing analysis of psychometric data ensures that the examination is accurate, relevant, valid and legally defensible.

A Brief History of the Competency Movement in Psychology

The Association of State
and Provincial Psychology Boards

March 2016

A Brief History of the Competency Movement in Psychology

This paper provides a brief overview of the development and integration of competency in United States and Canadian psychology.

Early in the development of professional psychology in the United States, there was limited discussion about what constituted a competent psychologist. At the end of World War II in 1945, the U.S. Department of Veterans Affairs sought information from the American Psychological Association (APA) about educational programs that train psychologists to practice (Commission on Accreditation (CoA), 2006). Within a year, 22 programs were identified and de facto accreditation began in North America. In 1949, the Boulder conference for clinical psychology resulted in the Boulder Model of training to produce psychologists who were both scientists and practitioners (Raimy, 1950). This was the predominant model in psychology until 1973, when the Vail Model of clinical training was developed, focusing on the "practitioner-scholar" model of training (Korman, 1976). The Bolder and Vail models of training provide the primary philosophical frameworks today for the education of competent psychologists.

Likewise, in Canada, applied psychology training developed in the years after World War II, although clinical training occurred primarily at the Master's degree level. The Couchiching Conference in 1965 endorsed a scientist practitioner model of clinical training at the doctoral level and the whole field of psychology grew exponentially in that decade (Conway, 1984). However there continued to be regional and programmatic differences in both training models and degree types throughout Canada. It wasn't until 1984 that accreditation criteria were adopted by CPA, thus providing more standardization to the training curriculums.

At the end of World War II, psychology was not a regulated profession. In 1945 Connecticut was the first jurisdiction in the United States (Heiser, 1945) and Ontario in 1960 was the first province in Canada to develop laws to regulate the practice of psychology. Other states and provinces followed, some quickly and others more slowly, with the last state, Missouri, adopting licensure laws in 1977 and the last province, PEI in 1991. Although the mandate for all psychology boards and colleges is to license competent psychologists, currently the primary criteria employed in most jurisdictions in the United States and Canada to establish readiness to practice independently, is meeting education and hours of supervised professional experience requirements, as well as displaying foundational knowledge assessed by the EPPP, as opposed to the demonstration of specific skills in the practice of psychology.

The first major national initiative in the United States regarding the discussion of a competency model in psychology occurred in a 1986 National Council of Schools and Programs of Professional Psychology (NCSPP) (Bourg et al., 1987; Bourg, Bent, McHolland, & Stricker, 1989). Limited, but important changes in terms of the conceptualization of practice

competency (functional skills) occurred in the 1990s and early 2000s. In 1996, the APA Committee on Accreditation revised the Guidelines and Principles for Accreditation of Programs in Professional Psychology to emphasize training to competence, rather than the accumulation of supervised hours. In 1997, the Council of Counseling Psychology Training Programs and APA Division 17 created a new competency-based model for academic programs, and the 2001 Education Leadership Conference focused on developing an improved definition of the competencies psychologists should possess for independent practice.

The *Competencies 2002: Future Directions in Education and Credentialing in Professional Psychology* conference provided a major step forward for psychology to identify the core competencies for the practice of psychology and the means of training students to function competently. One conference workgroup developed the "culture of competence" framework (Roberts et al., 2005), and a second developed a useful competency model (Rodolfa et al., 2005) called the Competency Cube.

In 2001 (amended in 2004), the psychology regulators from the Canadian provinces and territories signed an agreement of mutual recognition to facilitate the mobility of qualified psychologists between Canadian jurisdictions and the establishment of core competencies required for licensure as a psychologist. The agreement provided qualified members of the profession with access to employment opportunities nationwide. The Canadian Mutual Recognition Agreement specifies a nationally agreed upon set of competencies for psychologists. These core competencies were established through an analysis of competencies developed by the APA and CPA accreditation criteria, and a review of competencies and other requirements set forth by the provinces (Edwards, 2000). The current Canadian Psychological Association (CPA) Accreditation Standards (5th revision, 2011) have been mapped onto these competencies.

The Competency Benchmarks Workgroup (Fouad et al., 2009) expanded the Rodolfa et al. Cube model and defined 15-core competencies fundamental to the practice of psychology. The Benchmarks Competency Workgroup itself recognized that its model was overly complicated for practical use by trainers (Fouad, 2009) and developed a revised six-competency cluster model (Hatcher et al., 2013).

In 2012 in response to the evolving landscape of education and training in psychology, and to requirements from the US Department of Education, the CoA decided to thoroughly review and revise their requirements for accreditation of Doctoral, internship and post-Doctoral programs (CoA, 2012). As a result the CoA began to develop the *Standards of Accreditation for Health Service Psychology (SoA).* These Standards go into effect in January, 2017. Part of the new SoA and the accompanying Implementing Regulations include the concepts of "discipline specific knowledge" and "profession-wide competencies." Discipline specific knowledge refers

to the core knowledge base expected for all psychologists and profession-wide competencies refers to the areas of competence required for health service psychology.

Concomitantly, in 2010 the Association of State and Provincial Psychology Boards (ASPPB) formed a task force to begin an investigation into the possibility of developing a skills-based assessment mechanism to accompany the knowledge based exam that was already required for licensure in all jurisdictions in Canada and the United States. In 2014 ASPPB developed the ASPPB Competencies Expected at the Point of Licensure based on a practice analysis (ASPPB, 2010) and data from licensing and training communities. In early 2016, ASPPB began the process of a job task analysis to review and validate these competencies. The development of these competencies will provide the foundation for a skills based examination to be used in combination with the Examination for Professional Practice in Psychology. This skills-based exam will allow psychology boards (in the US) and colleges (in Canada) to better assess the competencies for independent practice as a psychologist.

Some of this overview was summarized from Rodolfa et al (2014). For a more complete abstract of the history of the competency movement in Psychology, please refer to Rodolfa et al (2014). For more information about the history of competencies movement, please refer to the reference list accompanying this document.

Reference List

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Rodolfa, E., Baker, J., DeMers, S., Hilson, A., Meck, D., Schaffer, J., Woody, S., Turner, M., Webb, C. (2014) Professional psychology competency initiatives: implications for training, regulation, and practice. *South African Journal of Psychology*, 1-15. DOI: 10.1177/0081246314522371

Articles Related to EPPP-Part 2

- http://thepsychologytimes.com/2018/05/14/asppb-presents-their-reasoning-for-eppp2-at-psychology-board/
- https://www.modernpsychologist.com/the-american-psychologist-licensure-crisis-explained-3/
- https://www.modernpsychologist.com/a-psychologists-ethical-examination-of-the-eppp/
- https://www.psychology.ca.gov/about_us/meetings/materials/20180629_eppp2_5.pdf
- http://www.gradpsychblog.org/tag/eppp2/#.XaUHum5FzA0

Report of the BEA Task Force to Develop a Blueprint for APA Accreditation of Master's Programs in Health Service Psychology

January 2019

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Executive Summary

Recognizing that current issues and developments had risen to the level that APA should consider options related to master's level training and/or practice, in 2018 APA Council requested the Board of Educational Affairs (BEA) to appoint a Task Force that would be charged with developing a blueprint for APA to pursue for accreditation of master's programs in health service psychology (HSP; which currently includes the practice areas of clinical, counseling and school psychology). That Task Force was specifically asked to:

- Develop a statement that broadly delineates the scope of accreditation for training at the master's level as contrasted with the current scope at the doctoral level
- Prioritize possible pathways for APA to establish accreditation of master's programs in psychology, and
- Identify the necessary expertise to comprise the accreditation decision making body.

The Task Force was convened in the summer of 2018. Subsequent to a series of calls and a meeting that included other relevant stakeholders (including senior staff from the National Association of School Psychologists [NASP], the Masters in Psychology and Counseling Accreditation Council [MPCAC], APA Office of Program Consultation and Accreditation [OPCA], and the Association of State and Provincial Psychology Boards [ASPPB]), the Task Force now recommends:

1. That there be an expansion of the APA's current accreditation of doctoral programs in HSP, the APA Commission on Accreditation, to include accreditation of HSP master's programs within the United States and its territories,
2. That this expansion of the APA Commission on Accreditation (CoA) to include master's programs in HSP be undertaken as part of the continuum of education and training in HSP recommended by the Health Service Psychology Education Cooperative in 2013,
3. That the purpose of accreditation remains fundamentally unchanged: "to promote consistent quality and excellence in education and training in health service psychology" and to provide "tangible benefits for prospective students; the local, national, and international publics that are consumers of psychological services; and the discipline of psychology itself" (APA, CoA, 2015, p.3),
4. That accreditation in HSP programs at the master's level be conceptualized as focusing on core aspects of HSP (represented by the knowledge and competencies common to HSP—rather than accreditation specific to the practice areas of clinical, counseling or school psychology at the master's level, and
5. That HSP, regardless of accreditation at the master's or doctoral level remain defined as "the integration of psychological science and practice in order to facilitate human development and functioning" (APA CoA, 2015, p.1).

To implement such accreditation, the Task Force further recommends that the APA CoA also consider the following in order to implement accreditation at the master's level:

6. That master's programs providing education and training in the practice of health service psychology, regardless of program title, be considered for accreditation,
7. That pathways to recognize programs already accredited/approved by the Masters in Psychology and Counseling Accreditation Council (MPCAC) and the National Association of School Psychologists (NASP) be explored, and
8. That efficient processes for accredited master's programs, that are either imbedded within or affiliated with doctoral HSP programs and undergoing periodic review for re-accreditation be examined.

Finally, to ensure the fair and informed accreditation review of master's HSP programs, and to address the increased workload and expertise demands of reviewing master's HSP programs, the Task Force recommends an expansion in the membership of the Commission on Accreditation (CoA) to include:

- Two faculty members from terminal HSP master's degree programs,
- One faculty member from a program for whom master's training in HSP is prerequisite and/or foundationally integrated *en route* to the doctorate" (Jackson & Scheel, 2013, p. 10),
- Three seats nominated from appropriate master's training councils, such as the Council of Master's Counseling Training Programs (CMCTP), Trainers of School Psychologists (TSP), and the Council of Applied Master's Programs in Psychology (CAMPP)
- Two additional members to those appointed by BPA *Representing Practitioners of the Profession*—to include master's level practitioners in HSP in the areas of clinical psychology, counseling psychology, or school psychology, and representing independent/ institutional practice.
- One student nominated by the American Psychological Association of Graduate Students (APAGS) from a terminal master's program or an integrated master's program, and
- A sufficient number of public members to assure quality from a public perspective and to meet the requirements of external accrediting agency recognition.

The report concludes with additional recommendations and considerations moving forward. These recommendations are intended to facilitate implementation of the proposed blueprint and address issues identified in the development of this report. These issues include clarification and differentiation of the competencies of successful graduates of accredited master's programs in HSP, identification of scope of practice and title, collaboration with existing accrediting organizations, and implications for APA membership of graduates from these programs.

Introduction

Background

In 2003, while writing on the future of accreditation, Beidel, Phillips and Zlotlow argued that, "The most contentious issue in accreditation is accreditation of programs that train students at the master's level" (Beidel, Phillips & Zlotlow; in Altmaier, 2003, p. 119). Indeed, although the APA has discussed the role of master's training in psychology through numerous initiatives dating as far back as 70 years (Woods, 1971), there has been a decided lack of consensus on this matter. Prior to its last reauthorization, APA's 1987 Model Act for Licensure of Psychologists recognized non-doctoral practice via section J Exemptions # 3, for appropriately credentialed school psychologists, however, other non-doctoral psychology practitioners were not recognized. In the absence of such consensus, the profession has continued to affirm the doctoral degree as the entry degree for independent practice—the position instantiated in the APA's most recent iteration of its model licensing act (APA, 2011). Relevant to this point, the Health Service Psychology Education Collaborative's most recent blueprint proposed a "seamless transition across levels (undergraduate through postdoctoral)" for education and training in HSP, while at the same time making no reference to training at the master's level — despite there being master's program representation within the collaborative (Health Service Psychology Education Collaborative, 2013).

In March 2018, the APA Council of Representatives took a historic step and approved (with 92% of those voting in favor) a motion to pursue "accreditation of master's level programs in psychology in areas where APA already accredits." In doing so, Council established that the general scope of APA's accreditation efforts be expanded from the accreditation of doctoral, internship, and postdoctoral programs in HSP to include master's level programs.

Council directed staff and governance, in particular the Board of Educational Affairs, to take steps to develop an accreditation system for master's level programs in HSP which includes clinical, counseling, and school psychology.

The decision to pursue accreditation of master's programs in HSP, which includes programs in clinical psychology, counseling psychology, school psychology, stemmed from a discussion at the August 2017 Council meeting. Council participated in small and large group discussions related to master's level training and practice in psychology. Drs. Jim Diaz-Granados and Katherine Nordal provided a presentation to Council on the history and current considerations related to master's education and practice, and the report of a 2016 summit convened by the APA Minority Fellowship Program on master's training in psychological practice. At the end of the discussion by Council in August 2017, the following statement was approved:

> "Current issues and developments have risen to the level that APA should consider options related to master's level training and/or practice and that staff and governance should identify and explore options for APA to consider."

In late 2017, a survey and series of webinars were conducted to gather information from key stakeholders about considerations for APA to pursue different options related to master's level training in practice. Prior to the March 2018 Council meeting, webinars were offered to members of council about the possible options to inform the discussion that occurred during the face-to-face meeting.

After the March 2018 Council meeting, the Board of Educational Affairs (BEA) developed and disseminated a call for nominations (Appendix A) for a Task Force that would be charged with

developing a blueprint for APA to pursue accreditation of master's programs in health service psychology. Specifically, the charge of the Task Force included:

- •Developing a statement that broadly delineates the scope of accreditation for training at the master's level as contrasted with the current scope at the doctoral level.
- •Prioritizing possible pathways for APA to establish accreditation of master's programs in psychology. For example, what are the advantages and disadvantages of creating an entirely new accreditation system vs. expanding the scope of APA's current accrediting body. Included would be a review of how the accreditation body would (or would not) overlap with existing accreditation systems for individuals trained at the master's level in health service areas of psychology.
- •Identifying the necessary expertise to comprise the accreditation decision making body.

The call for nominations was widely disseminated on April 20, 2018, with a deadline date of May 11, 2018. Approximately 66 nominations were received that represented a broad range of expertise and diversity across many dimensions. In June, BEA approved an 8-person Task Force, including a chair, Dr. James Lichtenberg. BEA also appointed Dr. Celeste Malone as the BEA liaison to the group. The Task Force roster is included in Appendix B.

Work of the Task Force

The Task Force held monthly conference calls starting in July and met in-person November 30 – December 2, 2018. Initial discussions of the Task Force focused on understanding the current landscape of accreditation at the master's level with the intention that APA's efforts to undertake accreditation be collaborative to the extent possible.

To do so, the Task Force invited other relevant stakeholders to provide input to their discussions. Eric Rossen, PhD, NCSP and Director, Professional Development and Standards at the National Association of School Psychologists (NASP), participated in a Task Force conference call and provided Task Force members information about the NASP approval process and perhaps most importantly advised Task Force members about considerations of the potential impacts of APA accreditation of master's programs in school psychology. There has also been ongoing dialog with Patricia O'Connor, PhD, the Executive Director of the Masters in Psychology and Counseling Accreditation Council (MPCAC) via Task Force conference calls, email exchanges, and telephone calls with the Task Force chair and Education Directorate staff. An invitation to attend the face to face meeting of the Task Force was extended and accepted. Unfortunately, the executive director was ultimately unable to participate in person due to health reasons. Dr. O'Connor did participate in part of the face to face meeting via video conference. In addition, the Task Force sought input from the director of the APA Office of Program Consultation and Accreditation, Jacqueline Remondet Wall, PhD and Jacqueline Horn, PhD, representing the Association of State and Provincial Psychology Boards. Both Drs. Wall and Horn were present at the face to face meeting of the Task Force. Dr. Lynn Bufka served as a liaison to the Task Force from the APA Practice Directorate and attended the meeting.

The Task Force undertook its work by dividing into three small groups, each focused on one aspect of the charge. Each subgroup developed options related to their piece of the charge, formulated considerations both positive and negative associated with each option, and ultimately made a recommendation as to the best course of action. Subgroup work was presented to the larger group for discussion and feedback on conference calls and at the face to face meeting where final decisions were made.

Recommendations and rational for such are now presented. Please refer to the glossary of terms in Appendix C for definitions of common terms used below.

Task Force Recommendations and Rationale

Proposed Scope of Accreditation

Task: Developing a statement that broadly delineates the scope of accreditation for training at the master's level as contrasted with the current scope at the doctoral level

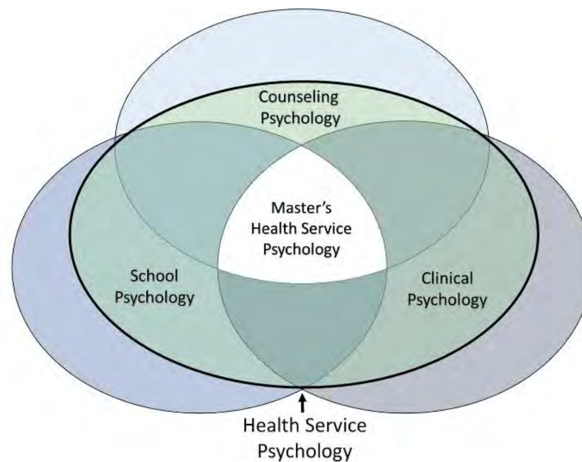
The Task Force began the process by reviewing the following documents: Standards of Accreditation (SoA), the current accreditation standards for Health Service Psychology (HSP) and the Blueprint for Education and Training in Professional Psychology in Health Care Services (Health Service Psychology Education Cooperative, 2013). Following consideration of these documents, the Task Force focused on master's programs in HSP (i.e., Clinical, Counseling and Psychology practice areas). The Task Force also reviewed the First Street Accord (https://www.apa.org/ed/accreditation/signed-accord-cpa.pdf) and the Quality Assurance in International Education and Training (https://www.apa.org/about/policy/quality-assurance-resolution.pdf), and concluded that the scope of accreditation only applies to HSP master's programs within the United States and its territories.

The Task Force recognizes that there are different routes through which master's degrees are achieved. Some master's programs stand as distinct and separate programs ending with the master's degree (i.e., "terminal" programs), while others are part of an HSP doctoral program (i.e., "integrated" programs). In regard to type of program or route through which a degree is earned, *accredited* master's programs in HSP must meet a set of standards leading to a specific set of professional competencies and outcomes. Consistent with doctoral-level accreditation, master's programs in HSP may also choose to have additional program-specific education and training, above and beyond the standards for accreditation at the master's level. The Task Force conceptualizes accreditation in HSP at the master's level as a core HSP—rather than accreditation specific to the practice areas of clinical, counseling or school psychology.

The Task Force recommends pursuing accreditation of programs in HSP at the master's level as part of the continuum of education and training in HSP, following the recommendations of this group.

Master's Level HSP

The Task Force conceptualizes health service psychology at the master's level to be represented by the knowledge and competencies common to clinical, counseling, and school psychology as noted in the figure below. This would include minimum levels of achievement (MLA) as defined by the core HSP competencies.



APA's scope for *Doctoral* programs

As a reference point for the expansion of accreditation to include the accreditation of master's programs in HSP, the scope of accreditation as stated in the current Standards of Accreditation for doctoral programs in HSP is provided: *Standards of Accreditation for Programs in Health Service Psychology I. Scope of Accreditation*:

> The accreditation process is intended to promote consistent quality and excellence in education and training in HSP. Education and training provides tangible benefits for prospective students; the local, national, and international publics that are consumers of psychological services; and the discipline of psychology itself.
>
> For the purposes of accreditation by the APA Commission on Accreditation (CoA), HSP is defined as the integration of psychological science and practice to facilitate human development and functioning. HSP includes the generation and provision of knowledge and practices that encompass a wide range of professional activities relevant to health promotion, prevention, consultation, advocacy, assessment, and treatment for psychological and other health-related disorders.
>
> Programs that are accredited to provide training in HSP prepare individuals to work in diverse settings with diverse populations. Individuals who engage in HSP have been appropriately trained to be eligible for licensure as doctoral-level psychologists.
>
> The Commission reviews programs for accreditation at doctoral, internship, and postdoctoral levels.
>
> The CoA reviews doctoral programs in psychology that provide broad and general training in scientific psychology and in the foundations of practice in HSP. Practice areas within HSP include clinical psychology, counseling psychology, school psychology, and other developed practice areas. The CoA also reviews programs that combine two or three of the above-listed practice areas. (APA CoA, 2015, p. 1).

Scope of accreditation as discussed by two other relevant HSP accrediting bodies:

The table below provides a brief synopsis of the scope of accreditation of the two accrediting/approval bodies that accredit/approve psychology-based HSP master's programs: the Masters in Psychology and Counseling Accrediting Council (MPCAC) and the National Association of School Psychologists (NASP).

Both are accrediting organizations that would have at least some degree of overlap with proposed scope of accreditation proposed in this report.

Component	MPCAC	NASP
Scope	Regionally accredited academic institutions in the United States that offer master's degrees in counseling and psychology and are based on the science-based practice of counseling and psychological services.	Doctoral and specialist level programs in school psychology in an institution that is regionally accredited by an accreditor recognized by the U.S. Department of Education.

Context for Scope of Accreditation for HSP Master's Programs:

While expanding its scope of accreditation to include master's programs, the Task Force proposes that the purposes of accreditation remain fundamentally unchanged: "to promote consistent quality and excellence in education and training in health service psychology" and to provide "tangible benefits for prospective students, students; the local, national, and international publics that are consumers of psychological services; and the discipline of psychology itself" (APA CoA, 2015, p.1). Programs in the US that are accredited to provide training in HSP, irrespective of whether this is at the doctoral or master's level, will prepare individuals to deliver science-based psychological practices with diverse populations in multicultural settings.

The Task Force understands the scope of accreditation to be applied to the university or institutional context whereas the scope of *practice* is relevant to individual state requirements. It recognizes, however, an important relationship between the scope of accreditation and practice. In this regard, the Task Force expects that the scope of *practice* of master's level practitioners, while encompassing a range of professional activities relevant to health promotion, prevention, consultation, advocacy, assessment, and treatment for psychological and other health-related disorders, will be shaped by the *education* and *training* experiences provided in university or institutional programs. By definition, and as noted in the figure above, master's education and training will be foundational in HSP, whereas doctoral training will be more extensive building on that common foundation within the specific practice areas of clinical, counseling, and school psychology.

The Task Force recognizes that master's programs in HSP may exist within academic departments in different ways and with different program labels (e.g., clinical, counseling and school psychology programs). Master's programs in HSP may exist in university or institutional departments as stand-alone programs, or they can be integrated within doctoral programs in HSP. Regardless of their independence from or association with doctoral programs, master's programs in HSP must be based on a formalized curriculum or curricular sequence for that terminal degree, not simply as a transitional degree that is obtained after accrual of a set number of course credits or as a consolation for having not quite completed the degree requirements for a doctorate. In other words, the scope of accreditation for master's programs in HSP applies only to programs meeting a set of standards leading to a specific set of professional competencies and outcomes.

Recommendation: Proposed Scope of Accreditation for Master-level Programs in HSP

Based on the above, the Task Force recommends the accreditation of master's programs in psychology that provide education and training in the practice of health service psychology (HSP). It further recommends that this accreditation be of general HSP programs, rather than those in the specific practice areas of clinical, counseling or school psychology. For purposes of master's level accreditation, HSP remains defined as "the integration of psychological science and practice in order to facilitate human development and functioning." Programs that are accredited to provide training in HSP, irrespective of whether this is at the doctoral or master's level, will prepare individuals to deliver science-based psychological practices with diverse populations in multicultural settings. These programs may stand alone or may be integrated within existing doctoral programs in HSP in institutions and universities that are consistent with current APA policies.

Possible Pathways to Establish an Accreditation System

Task: Prioritizing possible pathways for APA to establish accreditation of master's programs in psychology. For example, what are the advantages and disadvantages of creating an entirely new accreditation system vs. expanding the scope of APA's current accrediting body? Included would be a review of how the accreditation body would (or would not) overlap with existing accreditation systems for individuals trained at the master's level in health service areas of psychology.

Establishing an accreditation system within the APA for master's programs in health service areas of psychology could be done either by expanding the scope of the current Commission on Accreditation (CoA) to include review of master's programs or a completely independent, new system within the APA. Each option has advantages and disadvantages that are detailed below.

Option #1 – Expanding the Scope of the Commission on Accreditation

- **Advantages**
    - Because the APA CoA is already recognized by the United States Department of Education (US ED) and the Council of Higher Education Accreditation (CHEA), expanding the scope of CoA to include accreditation of master's programs would likely allow for a quicker pathway to external recognition.
    - Including master's programs in CoA's scope is consistent with a perspective of a continuum of HSP training, as well as with the expertise of staff and commissioners.
    - Moreover, the APA's *Standards of Accreditation for Health Service Psychology* (2015) states that "education in health service psychology resides on a continuum: progressing from broad and general preparation for practice at the entry level at the doctoral and internship levels to advanced preparation at the postdoctoral level in a focus area and/or recognized specialties" (p. 4).
- **Disadvantages**
    - Given the profession's history of requiring the doctoral degree for entry to practice, the development of accreditation standards and areas of expertise for those who are serving as evaluators will be crucial for the success of master's program accreditation.
    - The workload for commissioners and staff has increased significantly in recent years such that it is not practical to simply add accreditation of master's programs to the current system. Additional resources including staff, space, and technology would be needed.

Option #2 – Creating a New Accreditation System

- **Advantages**
    - It may be easier to develop a new accreditation system as opposed to modifying the existing CoA to accredit master's programs. This new accreditation system can replicate the structure of the existing CoA (i.e., representation from groups involved in master's education and clinical practice), while also having the flexibility to add representation from other groups as appropriate.
    - The discussion around the resources needed for accreditation may be more meaningful or accurate with a separate accrediting system. APA may more clearly see what additional resources are needed to engage in master's level accreditation and how resources should be allocated.
    - Additionally, a separate accreditation system may provide opportunities for APA to accredit master's programs outside of health service psychology (e.g., behavior analysis, industrial-organizational) in the future.
- **Disadvantages**
    - Given requirements set by external recognition bodies for time in operation before an application can be made, there would be a delay in seeking external review as a specialized accreditor from the U.S. Department of Education [US ED] and Commission on Higher Education Accreditation (CHEA). This timing issue is a major consideration especially as the Council for Accreditation of Counseling and Related Educational Programs (CACREP) expands its reach to licensing and credentialing boards that have implications for individuals from master's level counseling psychology programs. Counseling psychology programs would likely by most impacted by the length of time it will take for a master's accreditation system to be operational.
    - Creating a new accreditation system will require additional resources, such as staff, space, and technology that may be redundant with existing accreditation system.

Relationship between APA and Other Accreditor/Approval Systems in Health Service Psychology

Currently, there are many accrediting or approval systems in behavioral and mental health (e.g. Council of Social Work Education (CSWE), Commission of Accreditation for Marriage and Family Therapy Education (CoAMFTE), Association for Behavior Analysis International Accreditation Board (ABAIAB), Association of Occupational Therapy Accreditation (AOTA), Masters in Psychology and Counseling Accreditation Council (MPCAC), the National Association of School Psychologists (NASP), and the Council for Accreditation of Counseling and Related Educational Programs (CACREP). Of note, only MPCAC and NASP have overlap with training in psychology. However, neither of these accreditation bodies address the core overlap in all areas of HSP.

MPCAC	NASP
- Accredits clinical psychology, counseling, and counseling psychology programs - Requires a self-study from the applicant program and a site visit - Utilizes a competency-based model in accreditation standards - Program requirements: two years, full-time, or the equivalent with a minimum of 48 semester hours; minimum of 600 hours of supervised experience	- Offers an approval process for specialist (60+ graduate credits) and doctoral school psychology programs housed in CAEP accredited units and an accreditation process for programs outside of schools of education and/or in non-CAEP accredited units - Requires a self-study and site visit - Utilizes a competency-based model in accreditation standards - Program requirements: minimum of three years of full-time study and 60 credit hours; minimum

	of 1200-hour internship along with practicum training

Both MPCAC and NASP utilize a competency-based model in their accreditation standards; this is consistent with APA's accreditation standards for HSP, which are grounded in the competencies developed by the Health Service Psychology Education Collaborative (HSPEC; 2013). These competencies were based in part on the benchmarks competencies (Fouad, et al., 2009). Consistent with its focus on accrediting programs that educate students in the science-based practice of counseling and psychological services, the MPCAC accreditation standards are also aligned with the benchmarks competencies. While the NASP standards do not reference the HSP competencies, the curricular content required for NASP approval/accreditation overlaps significantly with the curricular content required for APA accredited HSP programs (Prus & Strein, 2011).

The APA should work collaboratively with MPCAC and NASP, acknowledging the important role that these organizations have played in accrediting/approving master's and specialist (e.g. EdS, CAS, CAGS) level training. As APA develops a method for accrediting master's programs, the Task Force encourages master's programs in HSP, including those already accredited by MPCAC or NASP, to pursue APA accreditation as well.

Recommendation: Pathway to Develop an Accreditation System

Based on a review of the advantages and disadvantages of the two options, the Task Force recommends Option #1, that APA expand the scope of the existing Commission on Accreditation to accredit master's programs that provide training in the practice of HSP, regardless of program title (i.e., programs which may not include "psychology" in their titles). Additionally, the Task Force recommends that APA CoA explore pathways to recognize programs already accredited/approved by MPCAC or NASP. Finally, that the APA CoA explore efficient processes for accredited master's programs, that are either imbedded within or affiliated with doctoral programs and undergoing periodic review for re-accreditation.

Expertise Necessary

Task: Identifying the necessary expertise to comprise the accreditation decision making body.

The Task Force considered two major options as it related to the expertise needed to fulfill the accreditation process. First, the Task Force examined whether master's level accreditation should be done with an expansion of the Commission on Accreditation (CoA) or with a new, completely separate commission. The Task Force chose the expansion of CoA in order to integrate this new accreditation process within the current APA structure. Having an expansion of the CoA allows for overlapping areas of resources and expertise to be used efficiently in an aligned manner. Second, given this proposed expansion of the CoA, the Task Force examined the structure within an expanded CoA. The Task Force attempted to accommodate inclusion of master's accreditation within the refinement of existing structures and operations. This approach fully integrates master's accreditation as part of the standard process within APA accreditation. After considerable discussion, the Task Force believes that such integration is the only way to support fully master's accreditation within the APA.

In these deliberations, the Task Force considered the implications of different models for the expertise necessary for master's accreditation. Further, the Task Force reviewed both the current structure of the CoA and that of organizations that currently accredit/approve master's programs. In mental health The

Task Force considered representational models, competency-based models, and hybrid models. The Task Force recommend a hybrid model that involves inclusion of various groups, but which also allows for obtaining expertise for the unique constituencies related to master's accreditation. This allows for the CoA to obtain a broader range of expertise to better mobilize psychology's contributions to the healthcare workforce and to better meet the public's need for mental health services.

Given these assumptions, the CoA should expand its scope and numbers. CoA currently has 32 members. In the *Snowbird Summit Final Report* document, the Structure and Appointment of the Commission on Accreditation and the Domains of Representation on the CoA is outlined beginning on page 3 (APA BEA, 2005, p. 3). Various groups (e.g., Council of Graduate Departments of Psychology, Association of Psychology Postdoctoral and Internship Centers) already are represented on CoA. As the current effort to accredit master's programs is a new initiative, an effort would be made to obtain participation from individuals outside of the current CoA structure.

In considering this expanded accreditation structure, the Task Force reflected upon what knowledge, skills, and abilities would be needed in an expanded CoA structure, such as, general knowledge of the discipline and core knowledge of HSP. It is also important to understand the connection between the standards of accreditation and the requirements for practice in HSP at the master's level. Consistent with the *APA Policies of Accreditation Governance*, "representatives on the Commission should reflect individual and cultural diversity and the breadth of psychology as a discipline," and consistent with CoA requirements, public representation and graduate student representation (APA CoA, 2006). In addition, the group considered roles associated with master's level training, settings employing master's level graduates, and representation for individuals who come from non-traditional channels. Finally, the group considered the role of other professional bodies in nominating individuals to be involved with CoA.

Recommendation: Expertise Needed

Under the proposed structure, as with the current CoA, all appointments other than the student appointment, would be made for three-year terms, renewable one time. The number of appointments initially would be limited and could expand if and when demand increases. Appointments would come from the following domains:

A. Two faculty members from terminal master's degree programs. All are from HSP programs, such as clinical psychology, counseling psychology, and school psychology programs.
B. One faculty member from a program "for whom master's training is prerequisite and/or foundationally integrated en route to the doctorate" (Jackson & Scheel, 2013, p. 10; referred to here as an integrated master's program).
C. Three seats nominated from appropriate master's training councils, such as the Council of Master's Counseling Training Programs (CMCTP), Trainers of School Psychologists (TSP), and the Council for Applied Master's Programs in Psychology (CAMPP).
D. Add two additional members to those appointed by BPA *Representing Practitioners of the Profession.* These will be master's level practitioners in HSP in the areas of clinical psychology, counseling psychology, or school psychology. They can represent independent practice or institutional practice.
E. One student nominated by APAGS from a terminal master's program or an integrated master's program (one-year term with a reappointment for one-year).
F. A sufficient number of public members to assure quality from a public perspective and to meet the requirements of external accrediting agency recognition

The Task Force conceptualizes that the expertise needed to fulfill the Commission appointments A-E, must be stakeholders from master's HSP constituencies. This includes students, faculty who serve as core faculty in master's HSP programs, and practitioners at the master's level.

Additional Recommendations and Considerations

In conducting its work, the Task Force identified several items that related to their charge and that would ultimately impact the implementation of an accreditation system for master's programs in psychology that warrant timely consideration by the APA. These are articulated below:

1. It will be important going forward to clarify and distinguish between the competencies that are expected of those successfully completing an accredited master's program in HSP in contrast to the competencies of those completing an accredited doctoral program as well as, to clearly articulate the profession's support for a scope of practice of these graduates as they enter professional practice. The Task Force recommends a group be convened and charged with the task of differentiating and articulating a scope of practice. The group should include individuals from both the practice and education communities (including the Commission on Accreditation/CoA and representatives from master's constituency groups). The Task Force further recommends the inclusion of, (a) student perspectives and (b) representation from this Task Force in the group.

2. Although stated earlier in this report, the Task Force believes it important to reiterate and stress the purpose of accreditation. Irrespective of whether one is discussing the accreditation of master's or doctoral training programs, doctoral internships, or postdoctoral residencies, "accreditation is intended to protect the interests of students; benefit the public, and improve the quality of teaching, learning, research, and practice in health service psychology" (APA, Commission on Accreditation, Standards of Accreditation, p. 4). Although academic program accreditation has been recognized as an important factor in the determination of individuals' eligibility to attain licensure to practice, the fact of accreditation is significant in itself and a worthy and important effort of our professional association.

3. It has been and remains the case that with respect to accreditation in HSP that the education and training in graduate programs must demonstrate, (a) an integration of empirical evidence into one's practice, (b) should be sequential, cumulative, and graded in complexity, and prepare students for practice or further organized training, and (c) engage in actions that indicate respect for and understanding of cultural and individual differences and diversity. The Task Force does not waiver in its recommendation that these same principles to which accredited doctoral programs are held accountable must apply as well to accredited master's programs. With particular regard to (b), the Task Force recommends that not only should master's programs in HSP be the sequential, cumulative and graded in complexity, but that these programs be understood and valued as a part of the sequential, cumulative, increasingly complex nature of graduate training and professional practice in HSP. In this regard, master's training in HSP should not be viewed as HSP training "lite," but rather as the significant—indeed foundational--portion of training in HSP that it is.

4. The Task Force recognizes that society benefits from providers that are trained at multiple levels. At the same time, the Task Force understands that masters-level providers in particular are more likely than doctoral level providers to live and practice in rural areas and provide

access to mental health services for those that are underserved as well as in urban areas in settings that are under-resourced. For these reasons, the Task Force recommends that the APA CoA consider attention to issues of social justice advocacy as a part of an accredited master's program's education and training sequence and expected competencies.

5. The Task Force recognizes that in each of the 50 states and territories, there are masters-level practitioners who are licensed for independent practice, and it believes that in tandem with a master's program accreditation effort, the APA must acknowledge and support the current status of these practitioners, rather than work to minimize or diminish their already achieved practice standing.

6. Although outside of the scope of the Task Force and of accreditation generally but consistent with the above, the Task Force presumes that graduates will have a professional practice identity, and it believes it's critical that a suitable practice title—one consistent with the program graduates' psychology-based training—be afforded and recommended to state regulators for purposes of licensing. The Task Force suggests that a survey of other health professions and how they handle the titling of their mid-level professionals, might be useful.

7. With respect to #5 and #6 above, the Task Force suggests that the APA collaborate with MPCAC (Master's in Psychology and Counseling Accreditation Council) on state-level advocacy on matters related to the licensing and scope of practice of master's level HSP practitioners and to the recognition of APA accreditation of master's programs.

8. The Task Force recognizes a long history of non-inclusion of masters-level practitioners and their graduate training programs in APA policy. As a master's program accreditation system moves forward, the Task Force recommends that APA undertake a comprehensive review of its current, standing policies to ensure alignment with and support of accredited masters-level training and of masters-level practitioners from accredited programs. Efforts should also include communications to current members about why the APA is developing an accreditation system for master's programs at this time.

9. The Task Force recognizes that APA's accreditation of master's HSP programs and its support of masters-level HSP practitioners, may have implications for membership of the association, including the role of those holding master's degrees. It believes that such implications need to be addressed, sooner than later.

10. The Task Force recognizes what may be a significant increase in the CoA's workload with the addition of the accreditation of master's programs (an estimate of 487 academic institutions offer a master's degree in HSP based on a recent APA workforce analysis; APA, 2017) and would note that in addition to the expansion of representation on the CoA (recommended earlier in this report), additional program review consultants (PRCs) may be necessary to assist with the work of the CoA. In addition, the OPCA will be impacted and additional association resources (e.g., staffing, space, financial, technology) will be needed.

11. The Task Force recognizes the significant role that CoA will play as these efforts move forward. Several particular issues relevant to master's program accreditation regarding the development of standards of accreditation are:

a. The Task Force encourages consideration of whether a restructuring of the CoA (per its earlier recommendation) and having this restructured group undertake this task might be a fruitful way to proceed.
b. The Task Force recognizes the value of current master's level accreditors/approval systems (e.g., NASP, MPCAC), and encourages the exploration and development of alternative pathways to accreditation for those programs that are already accredited/approved—at least during initial years of APA's system. The Task Force does not recommend that such programs be "grandfathered in" as APA accredited programs, but rather that such programs be provided with a way to move expeditiously toward accreditation given their current accredited/approved status.
c. The Task Force also encourages the exploration of accreditation policies and procedures for streamlining the accreditation processes for academic units or departments with both a master's and doctoral program (e.g., single site visit for the two levels of programs).
d. Recognizing the significant role that technology (distance education) plays in the current offering of master's programs in the health service areas and considering how technology may be successfully deployed in masters-level HSP programs.
e. Ensuring that accreditation standards for master's programs ensure minimally acceptable levels of program quality and academic rigor but do not extend programs beyond two years of fulltime graduate study.
f. Including provisions for the transfer of credit into accredited doctoral programs for students who complete an accredited master's program within either a terminal master's or integrated master's program.

12. The Task Force recommends that there be efforts to help ensure that the classification of these programs (their CIP codes), reflect that these master's programs are "psychology programs" rather than as (e.g.) "education programs" --that their classification is 42.xxxx rather than 13.xxxx.

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Appendix A: Call for Nominations

Call for Task Force Members
The Board of Educational Affairs (BEA) Task Force to Develop a Blueprint for APA Accreditation of Master's Programs in Health Service Psychology

Task Force Charge:

The Task Force shall be charged to outline a plan by which APA could pursue development of an accreditation system for master's programs in health service areas (clinical, counseling, school) of psychology. Specifically, the charge of the Task Force would include:

- Developing a statement that broadly delineates the scope of accreditation for training at the master's level as contrasted with the current scope at the doctoral level
- Prioritizing possible pathways for APA to establish accreditation of master's programs in psychology. For example, what are the advantages and disadvantages of creating an entirely new accreditation system vs. expanding the scope of APA's current accrediting body. Included would be a review of how the accreditation body would (or would not) overlap with existing accreditation systems for individuals trained at the master's level in health service areas of psychology.
- Identifying the necessary expertise to comprise the accreditation decision making body.

Once the Task Force membership is approved, work is planned to begin immediately, in anticipation of a progress report due to the APA Council of Representatives in August 2018. The Task Force will conduct its initial work via conference call (at minimum monthly), and electronic mail. A face to face meeting of the Task Force may be scheduled to occur at APA headquarters in Washington DC in 2018. Task Force member expenses related to this meeting will be covered by the APA.

Background:

APA has discussed the role of master's training in psychology through numerous initiatives dating as far back as 70 years with no consensus. However, in August 2017 the APA Council of Representative voted that:

> "Current issues and developments have risen to the level that APA should consider options related to master's level training and/or practice and that staff and governance should identify and explore options for APA to consider."

In March 2018, the Council was provided this information and voted to approve pursuing accreditation of master's level programs in areas where APA already accredits (clinical, counseling, school). Council directed staff and governance, in particular the Board of Educational Affairs, to take steps to develop an accreditation system.

Proposed membership:

BEA will appoint 8 members (including a Chair), to the Task Force from those that apply. The Task Force shall represent individuals with the following areas of expertise:

- Graduate education, at the master's and/or doctoral level, in clinical, counseling, or school psychology

- Accreditation of doctoral programs in health service psychology
- Accreditation of master's programs in clinical or counseling psychology
- Approval of master's programs in school psychology
- Leadership role(s) specific to the professional practice of psychology
- Academic leadership (department chair or higher) associated with a department, college, or school offering master's and doctoral degrees in psychology
- Current student in a doctoral program that obtained a terminal master's degree in psychology prior to admission into a doctoral program
- Department of Veteran's Affairs experience in training and employment of individuals with psychology degrees

Individuals with multiple areas of experience and expertise will receive precedence and are strongly encouraged to apply.

Those interested in serving on the Task Force should submit:

- A CV or resume documenting experience and knowledge related to the charge of this Task Force
- A one-page (maximum) letter specifically articulating how qualifications relate to the areas of expertise outlined above and any aspects of diversity that you represent and choose to make known.
- Matrix for the BEA Task Force to Develop a Blueprint for APA Accreditation of Master's programs in Health Service Psychology

Questions and nomination materials should be sent by **May 11, 2018** to:

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Appendix B: Task Force Roster

Board of Educational Affairs Task Force to Develop a Blueprint for APA Accreditation of Master's Programs in Health Service Psychology

Task Force Members

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Appendix C: Glossary of Terms and Acronyms

Health service provider – "Psychologists are certified as health service providers if they are duly trained and experienced in the delivery of preventive, assessment, diagnostic, therapeutic intervention and management services relative to the psychological and physical health of consumers based on: 1) having completed scientific and professional training resulting in a ***doctoral degree in psychology; 2) having completed an internship and supervised experience in health care settings; and 3) having been licensed as psychologists at the independent practice level***." (APA, 2010)

Health service psychology (HSP) - "the integration of psychological science and practice in order to facilitate human development and functioning" (APA CoA, 2015).

I**ntegrated master's program** - are part of a HSP doctoral program

Terminal master's program - stand as distinct and separate programs ending in with the master's degree

Acronyms

APAGS - American Psychological Association of Graduate Students

CACREP - Council for Accreditation of Counseling and Related Educational Programs

CAMPP – Council of Applied Master's Programs in Psychology

CHEA – Council for Higher Education Accreditation

CMCTP - Council of Master's in Counseling Training Programs

MPCAC – Masters in Psychology and Counseling Accreditation Council

NASP – National Association of School Psychologists

OPCA _ Office of Program Consultation and Accreditation

SoA – Standards of Accreditation

US ED - United States Department of Education

PROPOSED GUIDELINES FOR THE OPTIMAL USE OF SOCIAL MEDIA

IN PROFESSIONAL PSYCHOLOGICAL PRACTICE

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1 **Introduction**

2 Social media have become well established methods of communication for both
3 personal and professional purposes. Many healthcare organizations and academic institutions
4 now rely on social media to support their organizational goals, and some have implemented
5 policies that govern employee, consultant, and trainee use of these media when engaged in
6 professional activities. Many of these policies offer general guidelines for using social media
7 when carrying out professional responsibilities but may not address specific situations
8 commonly encountered by psychologists. In addition, few organizations have developed
9 guidelines for employee use of social media outside the workplace (although there are
10 important exceptions, including The New York Times and The Wall Street Journal; Stewart,
11 2017). Psychologists who work in private practice or other organizations also may have no
12 policies or guidelines of any kind regarding the use of social media. Given the many benefits as
13 well as the potential challenges and risks presented, guidance regarding the optimal use of
14 social media by psychologists is needed.

15 The benefits of online communications and social media can hardly be overstated. Many
16 Americans use social media and internet search engines to obtain information regarding
17 physical and behavioral health concerns. In 2017, an estimated 88% of the North American
18 population had used the internet (Internet World Stats, 2018), and the Pew Internet and
19 American Life Project estimated that "8 in 10 internet users go online for health information,
20 making it the third most popular activity online among those in Pew Internet Surveys" (Pew
21 Research Center, 2014). PriceWaterhouseCoopers (PWC) Health Research Institute (2012)

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found that 90% of 18- to 24-year-olds indicated they would engage in health-related activities promoted through social media. They also found that nearly 50% of the respondents expect their health care providers to respond within a few hours to appointment requests made through social media and that customers spent 24 times as much time on healthcare consumer community websites than on healthcare company websites.

New health care delivery models are increasingly relying on online health information tools to provide state-of-the-art information about mental and physical health promotion, prevention and wellness, and treatment. Online information about psychological practice also may enhance public awareness of the benefits of behavioral health interventions. In 2015, the US Food and Drug Administration (FDA) began reviewing the growing number of mobile health applications (also known as “mHealth”) as digital health companies attempted to meet the growing demand for more sophisticated medical and public health applications that rely on mobile digital devices. The FDA has now approved hundreds of such products (FDA, 2018). New systems for analyzing extremely large datasets to reveal patterns and trends, often referred to as “big data” analytics, are also being used to better understand the epidemiology and outcome of diseases, including behavioral health influences on common illnesses such as diabetes and cancer.

Leading government agencies as well as health service providers have used social media to collect data and report on health issues and trends. For example, the US Centers for Disease Control uses social media to provide access to credible, science-based health information using a wide variety of social media tools to reinforce and personalize messages, reach new

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43 audiences, and build a communication infrastructure based on open information exchange.
44 "Connect with SAMHSA" (the Substance Abuse and Mental Health Services Administration)
45 enables policymakers and the public broad access via social media tools such as Facebook,
46 Twitter, the SAMHSA blog, and YouTube to learn more about SAMHSA's behavioral health,
47 substance abuse and mental illness resources, campaigns, and advocacy programs. The
48 American Psychological Association (APA) uses social media to share research findings,
49 psychology news, and other information with its members, policymakers, and the general
50 public.

51 Psychologists have been increasingly active in their use of social media, a trend that
52 reflects the increased use of these media by the public in general. In 2016, 69% of American
53 adults were identified as active users of social media (Pew Research Center, 2017). As more
54 people have adopted social media, the user base has also grown more representative of the
55 general population, with younger adults continuing to use these media at high levels and usage
56 by older adults increasing dramatically. Psychologists in training, including graduate students
57 and those newly post-graduate, are particularly active users of social media (Lehavot, Barnett,
58 & Powers, 2010). It is therefore important that psychologists become familiar with these new
59 internet-based tools and understand how they can be used to communicate, educate, and
60 optimize psychological practice and advance public health and well-being. This familiarity is
61 particularly important in integrated primary care settings where these tools are increasingly
62 being employed.

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63 The development of social media has greatly increased opportunities for
64 communication among individuals, groups, and the public in general. The potential of these
65 new opportunities is so great that many organizations employing psychologists encourage them
66 to interact with the public using Facebook pages, Twitter accounts, and other social media
67 tools. Psychologists working in private practice often use social media in similar ways. However,
68 there are a variety of risks and challenges associated with leveraging the power of social media.
69 For example, the personal use of social media for communicating with friends, relatives, and
70 social groups needs to be carefully distinguished from their professional use because the
71 responsibilities and risks incurred as a result of one's professional role as a psychologist are very
72 different from those assumed by private citizens interacting on a social basis. It is also
73 important to consider how clients, other professionals, public officials, and citizens in general
74 view psychologists' use of social media. Despite the efforts psychologists might employ to
75 distinguish between personal and professional uses of social media, internet users may not
76 recognize those same distinctions nor interpret them in the manner intended.

77 It is also critical to recognize that the use of social media involves public communication
78 that is normally quite distinct in nature and purpose from communication with patients and
79 clients receiving health care and other professional psychology services. The provision of health
80 services is conducted through private, professional relationships that are legally and
81 professionally regulated by a range of requirements involving confidentiality and the security of
82 protected health information (see, e.g. HIPPA; APA Standards for Educational and Psychological
83 Testing, APA, 2014; APA Guidelines for the Practice of Telepsychology, APA, 2013). Failing to

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84 differentiate professional communication within the context of health service delivery from
85 public communication through social media can have significant consequences for both health
86 care providers and their clients.

87 Psychologists seeking professional guidance on these issues turn to resources such as
88 the APA "Ethical Principles and Psychologist's Code of Conduct" (hereafter referred to as the
89 Ethics Code; APA, 2010), licensing laws, professional guidelines, and workplace policies. With
90 the advent of social media, however, psychologists must address familiar ethical and
91 professional issues (e.g., confidentiality, self-representation, advertising, making public
92 statements supported by research, dual relationships) in an entirely new and constantly
93 changing media environment. Workplace policies tend to address professional aspects of social
94 media use related to managing risk for the workplace. Few policies or guidelines are available,
95 however, to help psychologists use social media to build their professional practice or increase
96 their visibility; promote and optimize health service provision, research, education, and
97 advocacy; while also managing the multiple roles and responsibilities that psychologists have
98 with their clients, their profession, and the public at large. The guidelines described below are
99 designed to educate psychologists and provide a framework for the optimal use of social media
100 in professional psychological practice.

101 **Definitions**

102 The World Wide Web has evolved dramatically over recent decades and defining "social
103 media" precisely has been challenging. Prior to the development of Web 2.0 in the late 1990s
104 and early 2000s, many static websites were created to convey content similarly to the way

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105 traditional print media conveys content in a unidirectional manner from author to reader
106 (Cormode & Krishnamurthy, 2008). With the emergence of Web 2.0, however, technologies
107 became available that allowed users to contribute to website content by commenting on
108 published articles or otherwise participating in online discussions. These newer technologies,
109 Facebook and Twitter being among the best known, are generally now referred to as "social
110 media" (Obar & Wildman, 2015).

111 Some definitions of social media are broader and include technologies that allow users
112 to create and share content (e.g., by publishing webpages) as well as applications that allow
113 users to actively participate in social networking through Facebook or Twitter (e.g., Oxford
114 Dictionaries, 2018, define "social media" as "Websites and applications that enable users to
115 create and share content or to participate in social networking"). Other definitions only
116 emphasize social networking (e.g., Merriam-Webster, 2018, defined "social media" as "forms of
117 electronic communication (such as websites for social networking and microblogging) through
118 which users create online communities to share information, ideas, personal messages, and
119 other content [such as videos]"). At the time of this writing, some of the most popular types of
120 social media platforms include social networking sites such as Facebook, microblogging sites
121 such as Twitter, content sharing platforms such as YouTube, blog publishing media (e.g.,
122 Blogger), open-source content management system (CMS) (e.g., Wordpress), and livestreaming
123 and livecasting programs (e.g., Facebook Live, Livestream, Periscope, YouTube live streaming).

124 Electronic mailing lists or "listservs" have become a common means for professionals to
125 communicate and network with colleagues. Listservs are usually not accessible to the public

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and are often intended to remain confidential among the listserv members, and consequently some experts do not consider them to be forms of social media. Regardless of the definitional issue, psychologists are aware that confidential listserv use should not be assumed, listservs are not Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule compliant, and the membership on listservs may be quite large and difficult to ascertain. Though listservs do not provide ready public access in the same manner as many social media platforms, they also do not provide the security and confidentiality required when providing health services. Alternative platforms known as private online communities do provide HIPAA-compliant communication for confidential discussions of clinical cases and other professional issues among a clearly identified group of colleagues (e.g., Doximity, Sermo). Though listservs may not fall clearly within common definitions of social media, psychologists are mindful that the limits of listserv security and confidentiality result in them sharing some similarities with public social media tools. Therefore, several of the guidelines discussed below also apply to psychologists' use of listservs.

Professional psychology practice encompasses a wide range of settings and services. This document was written to provide guidance primarily to psychologists engaged in health service, forensic, industrial-organizational, and consulting psychology. However, many of the guidelines will be applicable for psychologists engaged in education, research, policy, and other activities as well.

The guidelines discussed below are focused on psychologists' use of online social networking tools though the use of related internet technologies is addressed when it seems

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147 pertinent and useful. Online communication technologies obviously continue to evolve, and
148 sometimes very quickly, which also highlights the need to keep current and be thoughtful when
149 considering the opportunities and risks they present.

150 **Purpose of Guidelines and Guidelines Terminology**

151 These guidelines are designed to educate psychologists and provide a framework for
152 making decisions regarding optimal social media use in professional psychological practice.
153 They were developed as a companion document to the APA Guidelines for the Practice of
154 Telepsychology (APA, 2013) which serve to educate and guide psychologists on aspects of
155 health service provision using telecommunications technology, often referred to as
156 *telepsychology*. Health services offered through telepsychology occur in a very different context
157 than social media which are, by definition, accessible to the public. Therefore, efforts have
158 been made throughout this document to distinguish the optimal use of social media by
159 psychologists from the practice of telepsychology.

160 *Guidelines* are statements that suggest or recommend specific professional behavior,
161 endeavors, or conduct for psychologists. They differ from standards which are mandatory and
162 may be accompanied by an enforcement mechanism. Guidelines, on the other hand, are
163 aspirational in intent. They are intended to facilitate the continued systematic development of
164 the profession and to help facilitate a high level of practice by psychologists. Guidelines are not
165 intended to be mandatory or exhaustive and may not be applicable to every professional
166 situation. They also are not definitive and are not intended to take precedence over the
167 judgment of psychologists (APA, 2015).

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168 The guidelines described below are intended to provide a general framework for
169 psychologists to make full and appropriate use of social media in their professional practice.
170 Such use is, of course, always informed by the APA Ethics Code and legal and regulatory
171 requirements. Ethical standards for psychologists' use of social media and all their work-related
172 conduct require a personal commitment and lifelong effort to act ethically; to encourage ethical
173 behavior by students, supervisees, employees, and colleagues; and to consult with others
174 concerning ethical problems (APA, 2010). Within these guidelines, more directive language is
175 used when a particular guideline is based specifically on mandatory provisions of the Ethics
176 Code or law. However, guidelines are not intended to be enforceable rules, but to help
177 psychologists identify ways that the enforceable rules, such as the Ethics Code and legal and
178 regulatory requirements, might be applied appropriately.

179 **Interaction with State and Federal Laws**

180 A variety of specific state and federal laws and regulations govern the practice of
181 professional psychology with respect to social media. To the extent possible, this document
182 attempts to provide guidelines that are consistent with those laws and regulations. In the event
183 of a conflict between these guidelines and any state or federal law or regulation, the law or
184 regulation in question supersedes these guidelines. It is anticipated that psychologists will use
185 their education, skills, and training to identify the relevant issues and attempt to resolve
186 conflicts in a way that conforms to both law and ethical practice. Psychologists are aware that
187 they should consult a qualified attorney when particularly difficult questions or concerns arise
188 regarding usage of social media and professional practice.

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189 **Expiration**

190 These guidelines are scheduled to expire 10 years from [insert the date of adoption by
191 APA Council of Representatives]. After this date, users are encouraged to contact the APA
192 Practice Directorate to determine whether this document remains in effect.

193

194 **The Guidelines**

195 **Section 1. Importance and Relevance of Social Media**

196 **Guideline 1.1. Psychologists are aware that social media can be highly useful for improving**
197 **public access to information about behavioral health, psychological services, and the**
198 **integration of behavioral health within primary, secondary, and tertiary health care.**

199 **Rationale.** Online social media platforms represent a very important asset for
200 psychologists. These communication tools provide opportunities for educating the public about
201 behavioral health and psychological services as well as broader interrelated health issues. They
202 can also be very useful for reaching individuals from underserved populations, disabled
203 individuals without access to transportation, and those living in remote areas. Though many
204 individuals do not have online access (an estimated 12% of North Americans did not use the
205 internet in 2017; Internet World Stats, 2018), very large proportions of those with internet
206 access use it to obtain information about behavioral and physical health. In fact, Pew Research
207 Center (2014) found that obtaining health information via the internet was the third most
208 popular online activity, utilized by approximately 8 in 10 internet users. Social media provides a

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209 valuable opportunity for psychologists to directly communicate with the wider public about
210 health issues and psychological services.

211 **Application.** Psychologists are mindful of the great potential that social media and
212 other online platforms have for promoting the health and well-being of the general public. A
213 variety of online social media tools can be used to reach individuals across geographic and
214 socioeconomic lines and from many different diagnostic and health status groups. These tools
215 provide opportunities for psychologists to efficiently share reliable, research-based information
216 that can help individuals prevent behavioral, physical, and other problems from occurring or
217 from increasing in severity, access the health services they need, and promote health and well-
218 being in general.

219 To effectively realize the potential of social media for these purposes, however,
220 psychologists also need to be mindful of the many ethical, legal, and professional issues that
221 arise when communicating with the public using these tools. Social media present the
222 opportunity to easily engage in a variety of therapeutic and extra-therapeutic interactions with
223 clients and others that can be problematic. Psychologists working and living in rural and other
224 close communities are familiar with how easily professional boundaries can become blurred
225 and strive to maintain awareness of potential boundary and role conflicts that can arise in
226 personal and professional interactions. These same boundary and role conflicts can arise within
227 the context of social media interactions. The guidelines discussed below highlight psychologists'
228 obligations to protect the privacy and confidentiality of clients, ensure the accuracy of their

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229 communications, avoid communication with past or current clients that can compromise
230 professional boundaries, and be aware of additional issues that are critical to the ethical and
231 professional use of social media, such as a clear delineation between personal and professional
232 usage. Psychologists also need to be aware that participating in social media opens a public
233 record of their communications that is searchable by current and potential future clients,
234 students, research participants, legal and regulatory professionals, employers, and others
235 (Kolmes, 2012).

236 **Guideline 1.2. Psychologists are mindful of social media's growing importance as a tool for**
237 **communicating and engaging with interested groups of clients, students, peers, and other**
238 **stakeholders around particular health issues, thereby adding value to health services,**
239 **research, and education.**

240 **Rationale.** Social media is a nearly instantaneous form of communication that has great
241 potential for public engagement in myriad aspects of health and healthcare. Psychologists are
242 mindful of social media's growing importance in the public health arena, including applications
243 that facilitate communication, collaboration, and sharing of information among groups of
244 interested parties (Deloitte Center for Health Solutions, 2016). For example, it is estimated that
245 one-third of Americans who go online to research their current health conditions also use social
246 networks to find fellow consumers and discuss their conditions with them (Elkin, 2008; Korda &
247 Itani, 2013). In addition, 36% of social network users consider other consumers' experience and
248 knowledge before making health care decisions (Keckley & Hoffman, 2010).

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249 Psychologists are also mindful of the potential for social media to add value in the
250 provision of health services. For example, social media enables psychologists to connect with
251 medical patients or family members of medical patients who are coping with particular medical
252 conditions (Fox, Pew Internet and American Life Project, 2004; Ferguson (2007). A prominent
253 example of this is Crohnology.com which is one of the most closely watched experiments in the
254 use of social media to facilitate treatment and promote health among clients with a particular
255 condition. This social network provides clients with Crohn's, colitis, and other inflammatory
256 bowel conditions with a means to track symptoms, share information on nutrition, diet and
257 remedies, and provide support and encouragement to each other. These opportunities
258 involving real-time interaction, support, and access to information serve to increase clients'
259 efficacy in self-care and disease management, and have the potential to improve the delivery
260 and even the economics of health care. The participation of psychologists on these types of
261 sites when they are patients or consumers themselves, either when they possess professional
262 expertise in the subject matter or not, also raises questions involving multiple roles and
263 relationships. The sections below address several issues to consider when pursuing these types
264 of participation.

265 Social networks also hold considerable potential for health care research and policy
266 because they can be used to reach stakeholders, aggregate information, and leverage
267 collaboration (Keckley & Hoffman, 2010). For example, social media can be an important tool
268 for advancing the understanding of the epidemiology and etiology of a variety of behavioral and
269 physical health conditions by facilitating the collection of very large datasets from individuals

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270 coping with particular conditions that can then be investigated through big data analytics.
271 Hence, psychologists are, in fact, stakeholders in the use of social media for research on
272 questions that are best addressed through big data analytics and related procedures.

273 **Application.** Psychologists who utilize social media are encouraged to maintain and
274 update their working knowledge of social media for communicating with various audiences
275 regarding health and psychological well-being. This may include seeking professional
276 development opportunities or collaborating with a community of learners. Effective models are
277 also being developed that exemplify how social media can responsibly reach and engage
278 consumers. For example, the Mayo Center for Social Media (MCCSM) is a first-of-its-kind social
279 media center that aims to advance health globally by accelerating the application of social
280 media tools across the Mayo Clinic system through broader and deeper engagement by
281 hospitals, medical professionals, and clients. Mayo has also established a Social Media Health
282 Network (SMHN) that provides tools, resources, and guidance for organizations as well as
283 individuals who want to use social media for health education and health care. Johns Hopkins
284 Hospital likewise has a wide range of social media resources for communicating with various
285 client and other groups about issues of common interest (Malcomson, 2016).

286 It is also recommended that psychologists encourage the organizations they work for
287 and/or support to develop and implement policies addressing the use of social media for
288 sharing and discussing information and work products within relevant communities. Within
289 professional psychology education, for example, social media are being used to support student
290 education and mentorship (e.g., the Association of Psychology Postdoctoral and Internship

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291 Centers (APPIC) Intern-Network listserv facilitates the discussion of professional psychology
292 internship issues among internship applicants and current interns as well as training directors
293 and other psychology professionals). It is also common for the divisions of APA and other
294 psychological organizations to use blogs and listservs for communication among their members.
295 Such networks provide opportunities for psychologists to address a wider range of concerns
296 and needs and within a much shorter time frame that was traditionally the case. Psychologists,
297 students, and others using these networks need to keep in mind, however, the public or
298 potentially public nature of most of these networks (see the next section below). Psychologists
299 should also be aware of the various legal concerns pertaining to the use of listservs with respect
300 to professional practice, including anti-competitive activity, privacy, and ethics. Psychologists
301 working in educational, clinical, research or any other type of setting are also mindful of the
302 need to educate and train students and staff under their supervision in the appropriate use of
303 social media (see Section 3 below).
304

305 **Professional Ethics**

306 **2. Ethical and Professional Issues**

307 **Guideline 2.1. Psychologists are mindful of the public nature of social media and that their**
308 **privacy and confidentiality often are not protected nor expected on social media.**

309 **Rationale.** In their commitment to increasing scientific and professional knowledge,
310 psychologists strive to help the public develop informed judgment and choices concerning

311 human behavior (APA Ethical Code: Preamble). This can occur through a variety of means,
312 including social media. Though the use of social media may facilitate this goal, it may also pose
313 an increased risk to practitioner privacy and confidentiality, revealing personal information
314 that, in the past, has remained private. Online information about the psychologist allows
315 greatly increased exposure to past, current, and prospective clients; other professionals,
316 including supervisors, peers, and supervisees; as well as the public in general. Therefore,
317 psychologists using social media are encouraged to become educated on how to protect their
318 own privacy, the privacy of their family and friends, the privacy of their clients, as well as the
319 privacy of the family and friends of clients. To address these concerns, psychologists are
320 encouraged to learn how to develop social media use policies, how to monitor the accuracy of
321 information about them on social media, and when and how to inform their clients about their
322 social media practices and policies.

323 **Application.** Psychologists who use social media remain cognizant of the boundaries of
324 their competence (Ethics Code 2.01) and take reasonable steps to ensure their competence in
325 using new techniques and technologies (Ethics Code 201[c]). Before using social media,
326 psychologists are encouraged to become informed about the nature and technology of social
327 networking sites including the processes by which information is shared and stored, as well as
328 the circumstances under which it may be sold or otherwise displayed, distributed, or published
329 by unknown parties. Similarly, inasmuch as some platforms (e.g., Facebook, LinkedIn) scan user
330 contact files and display identity information to others as possible “friends” or connections,
331 psychologists carefully consider the implications of granting access to these platforms when

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332 queried, periodically review the permissions they previously granted, and/or are careful to
333 maintain separate contact files for personal versus professional pages.

334 In all circumstances, psychologists recognize that privacy and protection of
335 confidentiality are not to be expected when using social media. Psychologists understand that
336 all information posted on social media platforms is posted with the implicit understanding that
337 it might be seen by clients, people involved in the lives of clients, colleagues, employers,
338 students, or any member of the public.

339 Participating in social media can offer the semblance of anonymity and foster increased
340 disclosure as a result (Ma, Handcock, & Naamnan, 2016; Qian & Scott, 2007). Therefore,
341 psychologists are encouraged to take extra caution to avoid using speech that is potentially
342 libelous or denigrates the reputation of psychology. They are encouraged to refrain from
343 posting direct or indirect references regarding clients, disparaging comments about colleagues
344 or client groups, or opinions that denigrate the reputation of psychological practice, research,
345 or education.

346 Psychologists also strive to become educated on the unintended but uncontrollable
347 consequences of social media use for personal purposes. For example, some social media tools
348 such as Snapchat hold information only briefly, but screenshots can be made of posts on these
349 ephemeral applications and distributed publicly. The same is true of Facebook pages that are
350 intended to be limited to a private group of individuals (e.g., “Friends” or “Friends of Friends”).
351 Indeed, the Library of Congress has preserved every single tweet ever posted on Twitter from
352 its inception up through the end of 2017; even if an account is deleted the archive may remain

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353 in perpetuity. The Library is continuing to save many tweets beyond 2017 but only those
354 related to significant events and particular themes (Chokshi, 2017). Therefore, psychologists
355 recognize that any post on any social media tool, even when it is intended to be an ephemeral
356 or private posting, may potentially appear in the public domain.

357

358 **Guideline 2.2. Psychologists are mindful of ethical and legal obligations to maintain client**
359 **privacy and confidentiality at all times.**

360 **Rationale.** Participating in social media increases the risk of unintentionally exposing the
361 psychologist-client relationship. Psychologists using social media must be mindful of these risks
362 and legal obligations, considering and addressing them before as well as during their
363 participation in social media. Though social media use can benefit psychology and the public, it
364 creates new challenges to the psychologist-client relationship. Technological advances have
365 altered and will continue to alter professional psychological practice. Nonetheless,
366 psychologists must continue to maintain the privacy and confidentiality of their relationships
367 with clients.

368 **Application.** Psychologists remain mindful of ethical principles governing
369 communications, interactions, confidentiality, privacy, and respect for others when using social
370 media for personal or professional purposes. Similarly, psychologists diligently maintain
371 standards of client privacy and confidentiality that apply to all settings, comply with legal
372 requirements, and make every reasonable effort to safeguard the privacy of clients.

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373 Psychologists are aware of the potential need to consult a qualified attorney should questions
374 arise regarding legal privacy concerns and social media usage.

375 Psychologists carefully consider the risks and rewards that their online activity might
376 pose for their clients. For example, careful and thorough effort is to be applied to camouflage
377 discussions of client case studies, whether they occur in social media or traditional print media
378 (APA Ethical Code 4.07). The same suggestion applies to psychologists who decide that it would
379 be beneficial to consult regarding a client case on a listserv of professional colleagues. Listservs
380 are not HIPAA compliant. Consequently, psychologists need to exercise great care in protecting
381 client privacy if they decide to request consultative input via a listserv. In these cases,
382 psychologists do not disclose personally identifiable information of any kind concerning their
383 clients, students, research participants, organizational clients, or other recipients of their
384 services unless they take reasonable steps to disguise the client, the client has consented in
385 writing, and there is a legal authorization to do so (APA Ethical Code 4.07).

386 Psychologists also normally request clinical consultations from professionals who are
387 known to possess competence and expertise with regard to their client's circumstances, and
388 psychologists are aware that it may be very difficult to judge the competence of those who
389 respond to a consultation request on a listserv. An alternative format for conducting clinical
390 consultations online is through the use of private online communities that are specifically
391 designed for this purpose, are HIPAA compliant, and where membership is carefully monitored
392 (e.g., Doximity, Sermo).

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393 Use of social media can also invite multiple relationships and psychologists are
394 encouraged to be prepared to respond appropriately (e.g., Facebook may suggest clients or
395 therapists as "friends" simply because geolocation places them in the same clinic). Should
396 breaches of confidentiality or inappropriate multiple relationships occur, psychologists are
397 encouraged to be prepared to take appropriate steps to correct the problems.

398 Responding to negative comments posted on health care provider or course instructor
399 review sites can be complicated. Psychologists are advised to refrain from attempting to
400 influence such reviews by asking clients not to rate their services online (APA Practice
401 Organization, 2015), nor should psychologists encourage clients to post positive reviews (see
402 Ethics Code 5.05). Before considering any sort of online response to a negative review,
403 psychologists need to recall that their relationships with clients, students, and research subjects
404 are ordinarily protected by confidentiality and any reply should not imply any direct knowledge
405 of or history with any individual with whom one has had a professional relationship protected
406 by confidentiality (APA Practice Organization, 2015). If a psychologist suspects that a colleague
407 or competitor posed as a former client and posted a negative review, however, the psychologist
408 may have recourse by contacting the review website, by filing an ethics complaint, or through
409 other avenues as they would in other situations when their practice is intentionally harmed.
410

411 **Guideline 2.3. Psychologists consider the risks and implications of using social media and**
412 **online searches to obtain information about their clients, students, consultees, and others**
413 **with whom they work on a professional basis.**

414 **Rationale.** The emergence of social media and internet search capabilities affords
415 psychologists the opportunity to easily obtain online information about their clients, students,
416 and consultees without their knowledge. Despite the public nature of information available on
417 the internet and the potential usefulness of that information, conducting online searches raises
418 ethical issues associated with privacy, informed consent, and self-determination (DiLillo & Gale,
419 2011). The APA Ethics Code General Principle E states "psychologists respect the dignity and
420 worth of all people, and the rights of individuals to privacy, confidentiality, and self-
421 determination." While it is expected that clients disclose important information to
422 psychologists during evaluation and treatment, it is also understood that the client determines
423 the type, timing, and means by which personal information is to be disclosed (DeLillo & Gale,
424 2011). If psychologists seek personal information about clients without first obtaining informed
425 consent for such a search, it could be considered an intrusion on privacy and a violation of their
426 clients' right to self-determination (Barnett, 2008; Clinton, Silverman & Brendel, 2010; DeLillo &
427 Gale, 2011; Lehavot et al., 2010; Tunick et al., 2011). These issues are particularly relevant in
428 the context of clinical treatment, whereas additional considerations may weigh heavily in
429 various forensic, correctional, school, consulting, industrial-organizational, and other contexts—
430 the actual client in these contexts may be an organization or institution, a factor that has major
431 implications for the confidentiality and privacy of all the parties involved (Fuqua, Newman,
432 Simpson, & Choi, 2012).

433 A key element in evaluating whether an online search violates a client's privacy and self-
434 determination is the question of informed consent. The APA Ethics Code 3.10(a) requires

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435 psychologists to obtain informed consent from clients (or surrogate decision makers as in the
436 case of children) about the services to be provided. Although commonly known to involve other
437 aspects of treatment (e.g., confidentiality, fees, payment), consent also encompasses informing
438 clients about the nature and process of the psychotherapeutic relationship, including
439 approaches and techniques that might be used (Fisher & Oransky, 2008). This could be viewed
440 as including searches for online information involving the client.

441 Psychologists are also mindful of the unknown reliability of much information on the
442 internet. In addition, psychologists understand that prior information about an individual can
443 bias a psychological evaluation and influence a professional relationship. Possessing
444 information about new or prospective clients obtained online without their prior informed
445 consent places psychologists in the position of deciding how to use unauthorized and
446 potentially unreliable information in a therapeutic manner. Introducing such material in
447 treatment sessions might have the effect of enhancing trust in the therapeutic relationship, but
448 of course it could also harm the relationship as well, while keeping that information to one's
449 self may also affect one's reactions to the client and approach to the professional relationship.

450 **Application.** To conform to APA Ethics Code General Principle E and respect clients' right
451 to self-determination, psychologists typically refrain from conducting internet searches on or
452 about therapy clients unless it is needed to provide the service and the clients provide informed
453 consent to the searches. Should a psychologist believe internet searches about their client may
454 be of therapeutic value, obtaining prior informed consent is considered, including making clear
455 when, why, and how an internet search will be conducted. Psychologists consider developing

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456 and revising, as needed, a policy about this aspect of their practice, including clear principles
457 guiding the decision and the circumstances under which the psychologist conducts internet
458 searches about their client. Such a policy can be reviewed and signed by clients as part of the
459 informed consent process before conducting such a search.

460 Though APA Ethics Code General Principle E suggests that a client's rights to privacy and
461 self-determination might prevent therapists from conducting internet searches on clients
462 without their consent, surveys have found that many mental health providers routinely turn to
463 the internet as a source of information about clients (Clinton, Silverman, & Brendel, 2010;
464 DiLillo & Gale, 2011). Kolmes and Taube (2014) surveyed 227 psychotherapists and found that
465 28% "accidentally" came across client information online (of those, 70% through Facebook),
466 and 48% reported searching for online information about their clients in non-crisis situations
467 and without their clients' knowledge. Social networking and internet searching have become
468 commonplace for many people, and many student therapists entering the profession, for
469 example, may see little harm in conducting these types of searches. According to this view,
470 information on the internet is publicly available and represents an appropriate and, at times,
471 therapeutically useful source of information about clients (e.g., to check for prior criminal
472 offenses committed by a client, to gain a better understanding of how the client presents her-
473 or himself socially). One circumstance that may justify an online search without the client's
474 consent involves crisis situations when a client presents a danger to him- or herself or others,
475 and information on a client's current whereabouts or the whereabouts of a potential target of
476 the client may be important to preventing harm (Kolmes & Taube, 2014). Nonetheless, to

477 respect the principle of clients' rights to privacy and self-determination, psychologists are
478 encouraged to consider the ramifications of intentionally seeking out online information about
479 clients and refrain from conducting internet searches about clients without their informed
480 consent unless circumstances warrant such a search.
481

482 **Guideline 2.4. Psychologists consider the need to avoid contact with their current or past**
483 **clients on social media if it would blur boundaries of the professional relationship.**

484 **Rationale.** Within recent history, social media have become a routine aspect of life,
485 dominating aspects of popular culture, and transforming how people, including psychologists,
486 communicate with family, friends, their communities, and the broader society. Unlike
487 traditional forms of communication, social media may broadcast psychologists' personal and
488 professional information to a much broader audience and thereby may be exchanged with
489 individuals with whom psychologists have a therapeutic, supervisory, evaluative, or other type
490 of relationship. This broader dissemination of information may increase psychologists' risk of
491 blurred professional and personal boundaries (Kaslow, Patterson, & Gottlieg, 2011; Zur et al.,
492 2009).

493 Multiple relationships occur when a psychologist is in a professional role and at the
494 same time is in another role with the same person or another person closely associated with
495 the first person, or promises to engage in a personal role with the person or their close
496 associate in the future (APA Ethics Code 3.05). Psychologists refrain from entering multiple
497 relationships when the relationship could reasonably be expected to impair their objectivity,

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498 competence, or effectiveness in performing their functions as a psychologist, or otherwise risks
499 exploitation or harm to the person with whom the professional relationship exists. Multiple
500 relationships may include individuals with whom the psychologist has had or may have a
501 professional relationship, including those over whom they have supervisory, evaluative, or
502 other authority, including clients, students, supervisees, research participants, and employees
503 (Ethics Code 3.08). This guidance applies to all professional relationships, including those
504 initiated or maintained through social media.

505 **Application.** Psychologists are mindful that the risk of engaging in multiple relationships
506 can be increased through social media and hence consider how they will manage this risk.
507 Psychologists who use social media are encouraged to develop self-monitoring strategies such
508 as consulting with colleagues and supervisors (Gabbard, Kassaw & Perez-Garcia, 2011). To
509 manage and control the ease with which clients or prospective clients may access personal
510 information, psychologists who pursue an online presence consider maintaining a professional
511 website and social media accounts separate from their personal web presence, and/or use a
512 pseudonym for their personal account (American Medical Association, 2012; Myers, Endres,
513 Ruddy, & Zelikovsky, 2012). Psychologists are also encouraged to include only professional
514 information on their professional social media profiles (Bratt, 2010), and only personal
515 information on their personal social media profiles.

516 Whether or not it is appropriate to interact with individuals on professional social media
517 sites depends on the purpose and nature of those sites. For example, if psychologists maintain
518 a Facebook page focused on their psychotherapy practice and "friend" individuals through that

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site (and particularly if psychologists encourage their clients to do so), it might be assumed that many of the individuals on the site are or were therapy clients. This could give the impression that these psychologists are encouraging clients to reveal the confidential information that they were in treatment. Therefore, psychologists maintaining a social media site focused on their professional practice consider whether it would be appropriate to not “friend” clients or past clients under any circumstances (see Kolmes, 2010). In other cases, psychologists create social networking sites focused around particular mental health and other issues (e.g., to advocate for and support parents of children with particular behavioral, medical, or educational issues) and not their professional services. They may interact actively with individuals on these sites primarily from the perspective of public education and advocacy, and there may be no reason to suspect that the individuals participating on these sites are or were clients of the psychologist who created the site. Psychologists who use social media are encouraged to consider the specific risks of multiple relationships that their social media use creates and incorporate this issue into their informed consent policy and procedures (see Guideline 2.5 below).

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Guideline 2.5. Psychologists are aware of the benefits of establishing a policy regarding their participation in social media and discussing this policy and their use of social media as part of the informed consent process with clients.

Rationale. Psychologists who use social media consider when it is important to adopt a policy that they can then communicate to their clients. Many psychologists work in agencies or

540 institutions that have explicit policies on social media use. Some of these policies are far more
541 detailed and comprehensive than others and many agencies have no social media use policy.
542 When considering the adequacy of particular social media policies, psychologists give attention
543 to the Human Relations standards of the APA Ethics Code including multiple relationships
544 (3.05), conflicts of interest (3.06), exploitative relationships (3.08), cooperation with other
545 professionals (3.09), informed consent (3.10), and psychological services delivered to or
546 through organizations (3.11). Additionally, their policies should attend to the APA Ethics Code
547 Privacy and Confidentiality standards including maintaining confidentially (4.01), discussing the
548 limits of confidentiality (4.02), recording (4.03), minimizing intrusions on privacy (4.04),
549 disclosures (4.05), and use of confidential information for didactic or other purposes (4.07). The
550 present guidelines provide many useful suggestions for incorporating into one's social media
551 use policy.

552 **Application.** Psychologists are mindful of their role and responsibilities when providing
553 professional services and when their involvement with a client requires an informed consent
554 agreement that specifies their approach to using social media. A particularly pertinent issue in
555 this regard concerns multiple relationships (see Guideline 2.3 above). Many psychologists work
556 in agencies where institutional informed consent procedures address these issues, but other
557 psychologists must navigate these issues independently (for a sample policy, see Kolmes, 2010).
558 When appropriate, psychologists inform their clients of their social media use policies at the
559 outset of their relationship and throughout the course of their relationship as needed.
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561 **Guideline 2.6. Psychologists are aware that social media provide many opportunities for**
562 **investigating important research questions but are mindful of the need to guard against the**
563 **misuse of research involving social media.**

564 **Rationale.** Social media provide many opportunities to collect data and investigate
565 important research questions into a wide range of topics across the social sciences and human
566 service fields. But social media can also be used to develop tools that, like any other tool, can
567 be used for purposes that undermine individual, community, and societal functioning. Recent
568 controversies involving the use of psychological research and social media tools to promote
569 particular political candidates or parties in U.S. elections (Cadwalladr, 2018) highlight the
570 potential for this problem. Such unconstructive purposes are inconsistent with the overarching
571 purpose of the discipline of psychology. Psychologists are reminded that "The mission of the
572 APA is to advance the creation, communication and application of psychological knowledge to
573 benefit society and improve people's lives" (APA Mission Statement, 2018).

574 **Application.** Research that takes advantage of the great efficiency and reach of social
575 media provides many important opportunities to advance the mission and goals of psychology.
576 But social media also provide opportunities to collect and use personal information to target
577 individuals and groups for purposes of manipulating their behavior in ways that do not support
578 the mission and goals of the field. Social media clearly can be used for unconstructive as well as
579 constructive purposes.

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580 Though it is perhaps unlikely that psychologists would intentionally participate in
581 inappropriate manipulative uses of social media, psychologists who are insufficiently diligent
582 about learning the motivations and purposes of particular individuals or organizations could be
583 asked to share their expertise in ways that actively support unconstructive purposes. Therefore,
584 psychologists need to remain mindful that their research and/or their research skills can be
585 exploited for purposes that do not support the mission of the field. As noted in the APA Ethics
586 Code *General Principle A: Beneficence and Nonmaleficence,* "Because psychologists' scientific
587 and professional judgments and actions may affect the lives of others, they are alert to and
588 guard against personal, financial, social, organizational, or political factors that might lead to
589 misuse of their influence" (APA Ethics Code, 2010).

590

591 **Guideline 2.7. Psychologists strive to maintain accurate and truthful statements on social**
592 **media about their own practice, colleagues, the profession of psychology, and other issues,**
593 **and give special attention to the scientific support and empirical basis for statements made**
594 **and the limitations of available evidence regarding particular topics.**

595 **Rationale.** The use of social media affords psychologists the opportunity to make public
596 statements about themselves, their practice, and issues in the field of psychology that reach a
597 broad population. As a result, the public has greatly increased access to valuable psychological
598 information, serving purposes of general education as well as practice promotion. The
599 extremely quick and easy distribution of this information to the public, however, also increases

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600 the potential for statements and information to be misinterpreted and/or be perceived as
601 misleading, deceptive, or even fraudulent. As a result, psychologists are encouraged to carefully
602 review statements concerning one's practice, research, expertise, and issues in the field of
603 psychology generally prior to posting them on social media or other online platforms (see APA
604 Ethics Code 5.01 and 5.04).

605 Psychologists are governed by the same rights and limitations to public speech that
606 apply to all citizens, including both rights related to freedom of expression and restrictions
607 related to defamation, falsehoods, and other types of damaging statements that may harm the
608 reputation of an individual or the profession. Therefore, psychologists strive to engage in the
609 use of social media with civility and respect. Psychologists recognize the possibility of
610 professional disagreement but refrain from engaging in ad hominin attacks of colleagues. They
611 use social media to present psychological research accurately and fairly, including both its
612 strengths and limitations.

613 **Application.** According to the APA Ethics Codes Section 5, public statements and
614 advertising by psychologists are permitted, and social media can be a powerful tool for doing so
615 given their great reach and highly interactive capabilities. Psychologists are aware, however,
616 that inappropriate online actions and posted content may negatively affect their reputations
617 among clients and colleagues, may have consequences for their careers, and can undermine
618 public trust in psychology.

619 Psychologists hold a position of trust and authority with the public. When using social
620 media to educate the public, psychologists strive to present information that is relevant, valid,

621 and reasonably current. Psychologists strive to present an accurate and balanced view of
622 research, including both its strengths and limitations. When offering public advice or comment
623 on social media, psychologists are obligated to make statements that are informed through
624 their professional knowledge, training, and experience (APA Ethic Code 5.04). When sharing
625 psychological information and advertising their services, psychologists make reasonable efforts
626 to avoid giving specific advice, offering diagnoses, or otherwise behaving as if they were
627 conducting treatment. Psychologists provide appropriate citations to the authors of any studies
628 discussed and are diligent to avoid plagiarism. They also need to be careful about copyright
629 infringement when using images or content in their social media posts that were generated by
630 others.

631 Marketing materials on social media or other internet platforms should be developed
632 with the same care as print advertisements or promotions. Just as with print or other media,
633 psychologists are responsible for the accuracy of information about their training, experience,
634 credentials, and qualifications (Ethics Code 5.01), and the accuracy of information included in
635 online promotions of workshops and seminars (Ethics Code 5.03) and media-based
636 presentations (Ethics Code 5.04). As in other forms of advertising and public statements,
637 psychologists do not solicit testimonials from individuals who are vulnerable to undue
638 influence, including current clients (Ethics Code 5.05), nor do they solicit business or clients,
639 directly or indirectly, through another agent (Ethics Code 5.06).

640 To help fulfill these various standards, psychologists who use social media are
641 encouraged to track, manage, update, and maintain their personal and professional websites,

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642 digital identity, articles, profiles, and digital images. To the extent that is reasonable and
643 practicable, psychologists can also monitor the online information that others have posted
644 about them and verify its accuracy. If they discover inaccurate or inappropriate personal
645 information online, they can consider whether contacting the person who posted the
646 information and/or the website administrator would be appropriate. Students entering the
647 profession may need to remove postings that are dated or no longer appropriate. Faculty and
648 supervisors of students and staff should be aware of this concern as well and address it during
649 training and supervision (see also Section 3 below). Due to the complex skills required to
650 maintain an online social media presence, many psychologists seek the assistance of technology
651 professionals to help optimize their social media presence. Psychologists who utilize others to
652 assist in their social media use and presence are nonetheless responsible for the content of the
653 information (see also Guideline 3.3 below).

654 Psychologists also consider when it is appropriate to state whether they are or are not
655 representing their employer, institution, or profession when posting particular types of online
656 content. Psychologists strive to be clear when sharing personal opinions on social media versus
657 the findings of empirical research or the positions of employers or institutions and professional
658 organizations with which they affiliate. This is also important when communicating personal
659 support for or endorsement of individuals, groups, products, services, or activities.

660 Though psychologists frequently share their expertise about psychological topics with
661 the general public, they are mindful of the limitations associated with offering professional
662 opinions about public figures in social or other forms of media. Psychologists offering opinions

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663 based on publicly available information need to ensure that there is appropriate and adequate
664 information to substantiate their statements and conclusions (Ethics Code 5.04, 9.01; for
665 further discussion of this issue, see also Martin-Joy, 2017).
666

667 Section 3. Education, Training, and Professional Development Issues

668 Guideline 3.1. Psychologists are mindful of the need to stay current regarding the benefits
669 and limitations of social media technologies as they evolve and the ethical and professional
670 implications of using these technologies.

671 **Rationale.** The creation, development and proliferation of social media technologies is
672 evolving at a rapid rate, and each new social media technology carries with it new benefits and
673 limitations. Therefore, the implications of using these tools in an ethical and professional
674 manner for both personal and professional purposes is also evolving. When considering use of
675 social media, psychologists strive to demonstrate due diligence in their appraisal of these
676 factors to ensure that their use is in a manner consistent with best practices and ethical
677 standards.

678 **Application.** To become and remain competent in the use of social media, psychologists
679 receive training on appropriate and ethical uses of social media throughout their career,
680 including graduate school, internship, post-doctoral training, and beyond, as the nature of
681 social media is evolving at a rapid pace relative to many other aspects of psychological practice.

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682 This training often includes attention to the ways social media use impacts confidentiality, risks
683 of blurred professional relationships, and impacts on the therapeutic relationship.

684 Social media tools are used for a variety of marketing, public education, and advocacy
685 purposes, and their ability to easily target specific segments of the population makes them
686 particularly useful for serving multiple purposes. Professionals can research which social media
687 tools are best for reaching specific groups for particular purposes. Ratings and reviews are
688 available for many social media tools and psychologists can also consult with technical experts
689 on issues related to their strengths and limitations, ways to avoid their misuse, and any related
690 legal issues. Psychologists remain mindful, however, that advice from sources that advocate
691 social media marketing tactics used in contexts other than professional psychology practice
692 (e.g., retail sales, political campaigns) may not be in keeping with the ethical and professional
693 practices of psychologists. Therefore, psychologists should consider consulting with technical
694 experts and sources of information specifically related to professional psychology practice. They
695 might also form their own learning communities around social media topics. Psychologists who
696 use social media strive to be familiar with reliable sources of education, training and
697 professional guidance that are relevant to their use within the context of professional
698 psychology and behavioral health care.

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700 **Guideline 3.2. Psychologists are aware of the need to educate and train students and staff**
701 **under their supervision in the ethical and professional use of social media appropriate to**
702 **their roles and responsibilities.**

703 **Rationale.** Many organizations rely heavily on social media platforms to help advance
704 the goals of the organization. Given the ethical and professional considerations discussed
705 throughout these guidelines, psychologists are aware of the training and supervision needs of
706 the students and staff under their supervision in how to use social media effectively, ethically,
707 and professionally. Providing guidance and oversight are essential for ensuring that staff and
708 students represent their organizations accurately, responsibly, and consistent with ethical and
709 professional guidelines.

710 **Application.** Clear instructions and ongoing training on new social media tools should be
711 part of one's organizational culture as well as procedures for correcting any unethical or
712 unprofessional behavior that occurs. Distinctions between personal and professional uses of
713 social media should be clarified as well as the benefits and risks to one's self, the organization,
714 and its consumers. The guidelines discussed above should be helpful for addressing these
715 issues. As social media platforms evolve, additional training and the updating of policies may
716 also be appropriate. Training could also be considered regarding ways to safeguard the use of
717 social media from viruses, malware, and hackers, and procedures for handling these situations
718 if they occur.

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719 Some psychologists maintain blogs or Twitter accounts to help educate the public and
720 attract potential clients, and the maintenance of these social media sites may be assigned to a
721 supervisee. In these cases, it will be important to maintain clear guidance and perhaps also
722 written policies about the types of content and information that can be posted on these
723 platforms. Psychologists should also be aware that they may need to use "business associate
724 agreements" with web designers, billing services, information technology support services, or
725 others who have access to HIPAA-protected client information from their practices to ensure
726 that the security and confidentiality of client information is protected (Health and Human
727 Services, 2013).

728

729 **Guideline 3.3. Psychologists consider the needs for education, training, and professional**
730 **development among their professional colleagues and collaborators regarding the ethical and**
731 **professional use of social media.**

732 **Rationale.** Psychologists frequently collaborate with colleagues in using social media for
733 marketing, teaching, research, public education, advocacy, and other purposes. Psychologists
734 naturally vary in their experience and knowledge of social media and the risks and benefits
735 associated with using particular social media tools. As a result, they may find that some of their
736 collaborators use social media tools in a manner inconsistent with ethical and professional
737 principles and guidelines. Clients, students, managers, administrators, as well as colleagues and
738 the public generally may expect that psychologists should make attempts to notify

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739 collaborators of their problematic social media use and educate them in the appropriate use of
740 these tools (see Ethics Code 1.04).

741 **Application.** The misuse of social media is perhaps frequently unintentional and may
742 arise from a lack of understanding of how to use internet-based platforms and tools
743 appropriately. For example, psychologists may unwittingly put themselves in compromising
744 positions when they are included on a Twitter feed regarding ideas to which they do not agree,
745 or a client connects with them on a platform such as LinkedIn and leaves a message that reveals
746 confidential information. Collaborators of the psychologist may want to enhance their social
747 media presence to generate business and might describe work they did that is not accurately
748 portrayed or they might post unprofessional or inappropriate content that represents an
749 organization or the profession poorly. If psychologists notice their collaborators using social
750 media in these ways, they should consider informing them of the potential ethical and
751 professional issues involved so that the collaborators have a chance to change and rectify the
752 behavior (see Ethics Code 1.04).

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755 Note: The authors of the above guidelines have no financial or other conflicts of interest related
756 to potential benefits associated with developing or implementing these guidelines.

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[1] Optimal social media use in professional psychological practice was completed by the Committee on Professional Practice and Standards (COPPS), in consultation with the Board of Professional Affairs. Members of COPPS during the development of this document were (insert Chairs (by year); Members (by year); BPA liaison (by year). COPPS is grateful for the support and guidance of BPA, particularly to BPA Chairs (insert Chairs (by year). COPPS also acknowledges the consultation of (insert staff in Legal and Reg/other departments. COPPS extends its appreciation to the APA staff members who facilitated the work of COPPS: (insert Governance Operations staff).

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