Virginia Department of
Health Professions
Board of Psychology

Agenda

**Regulatory Committee Meeting-
VIRTUAL
July 13, 2020
10:00 a.m.**

*****Refer to the 2nd page of the Agenda for meeting access information******

Call to Order – J.D. Ball, Ph.D, Committee Chair

- Welcome and Introductions
- Mission of the Board

Approval of Minutes

- Regulatory Committee Meeting – February 10, 2019*

Ordering of Agenda

Public Comment

The Board will receive public comment related to agenda items at this time. The Board 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.

Chair Report – J.D. Ball, Ph.D.

Unfinished Business

- Reviewing Association of State and Provincial Psychology Boards (ASPPB) provisions for closing a practice ---- Dr. Ball
- Surveying Directors of Training about EPPP Part 2 – Dr. Ball
- Consideration of any waiver of experience requiremetns fo spouse of active duty military or veteran*---- Elaine Yeatts, Department of Health Professions, Sr. Policy Analyst
- Update on Regulatory Advisory Panel (RAP) for Periodic Review of Regulations Governing Certified Sex Offender Treatment Providers --- Jaime Hoyle, Executive Director, Board of Psychology

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New Business

- Consideration of Emergency Regulations for Implementation of Psychology Interjurisdictional Compact (PSYPACT) * --- Elaine Yeatts
- Discussion of 2021 General Assembly Legislation to require criminal background checks pursuant to PSYPACT* - Elaine Yeatts
- Consideration of amendment or waivers to permit unlimited online continuing education – Elaine Yeatts

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- Consideration of any legislative or regulatory changes needed in case of future States of Emergency --- Jaime Hoyle

- Discussion of inactive Residents in Psychology on License Lookup – Dr. Ball

- Comparison of ASPPB Social Media Guidelines and the Board's Telepsychology Guidance Document.— Dr. Ball

Next Meeting – October 26, 2020

*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 public body at the meeting and will be available to the public pursuant to Virginia Code Section 2.2-3708(D).

Virginia Board of Psychology

Instructions for Accessing July 13, 2020 Virtual Regulatory Meeting and Providing Public Comment

- **Access:** Perimeter Center building access is closed to the public due to the COVID-19 pandemic. To observe this virtual meeting, use one of the options below. Participation capacity is limited and is on a first come, first serve basis due to the capacity of CISCO WebEx technology.
- **Public comment:** Comments will be received during the public comment period from those persons who have submitted an email to jaime.hoyle@dhp.virginia.gov **no later than 5 pm on July 10, 2020** indicating that they wish to offer comment. Comment may be offered by these individuals when their names are announced by the Chair. Comments must be restricted to 3-5 minutes each.
- Public participation connections will be muted following the public comment periods.
- Please call from a location without background noise and ensure your line is muted.
- Dial (804) 938-6243 to report an interruption during the broadcast.
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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
DRAFT MEETING MINUTES
February 10, 2020

TIME AND PLACE: The Regulatory Committee of the Virginia Board of Psychology (“Board”) convened for a meeting on Monday, February 10, 2020, 1:00 p.m. at the Department of Health Professions (DHP), 9960 Mayland Drive, 2nd Floor, Board Room 2, Henrico, Virginia 23233.

PRESIDING OFFICER: J.D. Ball, Ph.D., ABPP, Regulatory Committee Chair

MEMBERS PRESENT:
Christine Payne, BSN, MBA
Herbert Stewart, Ph.D.
Susan Brown Wallace, Ph.D.
James Werth, Jr. Ph.D., ABPP

STAFF PRESENT:
Deborah Harris, Licensing Manager
Jaime Hoyle, JD, Executive Director
Jennifer Lang, Deputy Executive Director
Charlotte Lenart, Deputy Executive Director - Licensing
Elaine Yeatts, DHP Senior Policy Analyst

CALL TO ORDER: Dr. Ball called the meeting to order at 1:02 p.m. and read the emergency egress instructions.

Dr. Ball introduced and welcomed Christine Payne, the newly appointed citizen member. Board members, staff, and members of the public introduced themselves. A quorum was established.

APPROVAL OF MINUTES: Dr. Wallace moved to approve the October 28, 2019 Regulatory Committee Meeting minutes as written. The motion carried unanimously.

ORDERING OF AGENDA: Dr. Ball proceeded with the Agenda with no changes.

PUBLIC COMMENT PERIOD: There was no public comment**.**

CHAIR REPORT: Dr. Ball discussed his research related to master’s level programs. Dr. Ball’s research found that 29 states have some type of master’s level license or certification. Of the 29 states, six allow master’s level licensees to call themselves psychologists and engage in independent practice. Three do so with a modified title (Alaska, Kentucky, Maine) and three do so with added qualifying stipulations (Texas – if greater than 3,000 post-graduate hours, Vermont, if greater than 4,000 supervised hours plus passing the EPPP, and West Virginia if pass state oral examination plus 50 supervised hours plus passing the EPPP).

Dr. Ball provided an overview of his discussions with Virginia Academy Clinical Psychologist (VACP) regarding HB 303.

UNFINISHED BUSINESS:

Consideration of Stakeholders' Meeting on EPPP – Part 2 and APA accreditation of Master's level programs

The Association of State and Provincial Psychology Boards (ASPPB) delayed the roll out of the EPPP-Part 2 for early adopters until November 1, 2020.

After discussion, the Committee agreed to postpone the stakeholders' meeting related to the EPPP-Part 2 and the American Psychological Association (APA) Master's level program accreditations until next year.

NEW BUSINESS:

Regulatory/Legislative Update

Ms. Yeatts discussed the 2020 General Assembly legislation chart that she included in the agenda packet. Ms. Yeatts discussed SB760 related to the Psychology Interjurisdictional Compact (PSYPACT). This legislation, if approved, will take effect on January 1, 2021. Ms. Yeatts suggested that the Board look to the Physical Therapy Compact to gain more understanding of the regulatory impact, and steps needed for implementation.

PSYPACT Commission Rules

After a lengthy discussion, the Committee discussed areas of concern related to the PSYPACT articles and the need for the Board to provide public comment to the Commission.

Chart of Regulatory Actions --- Elaine Yeatts, DHP Sr. Policy Analyst

Ms. Yeatts provided information on the chart of current regulatory actions as listed in the agenda packet.

- 18VAC 125-20 Regulations Governing the Practice of Psychology: Results of Periodic Review (action4897);
  Proposed – Register Date: 11/25/19
  Board to adopt final regulations 2/11/20

- 18VAC 125-20 Regulations Governing the Practice of Psychology: Unprofessional conduct/conversion (action 5218);
  Proposed – At Secretary's Office for 42 days

- 18VAC 125-20 Regulations Governing the Practice of Psychology and 18VAC 125-30 Regulations Governing Certification of Sex Offender Treatment Providers: Handling fee (action 5417);
  Fast-Track – Register Date: 1/20/20

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Effective: 3/5/20

- 18VAC 125-20 Regulations Governing the Practice of Psychology: Reduction in renewal fee (action 5416); Final – Register Date: 12/9/19
  Effective: 1/8/2020

Consideration of Public Comment on Proposed Regulations and Adoption of Final Regulations

Ms. Yeatts reviewed seven the public comments regarding the proposed Regulations from the Virginia Association of Clinical Psychologists (VACP). The committee tabled a comment pertaining to a new regulation on psychologist participation in torture, pending direct input from Board Counsel at the full Board meeting. Of the remaining six VACP comments, after extensive discussion, Dr. Wallace proposed and Dr. Werth seconded a motion that then passed with four members in favor and Dr. Stewart abstaining to recommend to the full Board the following: (a) no change to capitalizing the word "Board" as state guidelines require that "board" is not to be capitalized in administrative guidelines even though it is to be capitalized in legislation; (b) no change to a variable use of the words "client" and "patient" throughout the regulations because the intent was to sometimes refer to agencies and forensic clients who are not patients; (c) no change to wording requiring that there be a specific designation of CE that is meant to address ethics, standards of practice, laws, and regulations governing the profession; (d) no change to wording on record keeping; (e) a modification to wording asserting the board's authority to take a wide range of actions for prior "disciplinary" actions in Virginia or other states; and (e) a modification to wording on informing patients of alternative services so as to specify that it is the board's intent for psychologists to inform clients of alternative services "in the case of a novel or experimental treatment."

The Committee discussed the public comment from Capella and Walden Universities. After a lengthy discussion, Dr. Stewart moved to recommend to the full Board to keep the proposed regulations related to education as written. The motion was seconded and carried unanimously.

The Board considered the acceptance of the Psychological Clinical Science Accreditation System (PSCAS) as an accredited body approved by the Board. After discussion, Dr. Stewart moved to recommend to the full Board not to consider PCSAS as an accredited body. The motion was seconded and carried unanimously.

Adoption of Notice of Intended Periodic Review of the Regulations Governing the Certification of Sex Offender Treatment Providers (CSOTP)

Ms. Yeatts advised that the regulations related to CSOTPs have not been reviewed for 4 years. Dr. Stewart moved to recommend to the full Board to distribute a Notice of Intended Regulatory Action (NOIRA) with the creation of a Regulatory Advisory Panel (RAP) to provide guidance for the period review. The motion was seconded and carried unanimously.

Bylaws -- Jennifer Lang, Deputy Executive Director

The Committee discussed changes to the Bylaws. After a detailed discussion, Dr. Stewart moved to recommend to the full Board to add language to the Bylaws to exclude committee membership or holding an office with the Association of State and Provincial Psychology Boards (ASPPB) as a conflict of interest and abstaining from voting. The motion was seconded and carried unanimously.

Dr. Ball moved to recommend to the full Board to change the required membership of the Regulatory/Legislation Committee from four to three, as well as make the staff recommendations. The motion was seconded and carried unanimously.

NEXT MEETING: The next Regulatory Committee meeting is scheduled for April 6, 2020.

ADJOURNMENT: The meeting adjourned at 4:30 p.m.

_________________________________ _________________________
J.D. Ball, Ph.D., ABPP, Chair Date

_________________________________ _________________________
Jaime Hoyle, J.D., Executive Director Date

DRAFT

GUIDELINES FOR CLOSING A PSYCHOLOGICAL PRACTICE

If a psychologist knows they will temporarily withdraw from practice, this withdrawal should be made clear to clients/patients as soon as possible and no later than the outset of the psychologist's absence. When the psychologist returns to practice, clients/patients should be so informed.

Planning for permanently closing a psychological practice begins with the identification of a professional executor who, in essence, is given the keys to the "house." The professional executor will need specific instructions and access to all hard copy and electronic files/records, any needed keys, and any needed software/website user-names and passwords; this information and associated accessibility will need to be updated annually. Consistent with the psychologist's responsibility to not abandon clients/patients, the naming of a professional executor ensures that clients/patients have access to continuing care and their health records. A professional will is a wise way to maintain these protections even in the event of the psychologists' unanticipated death or disabling health condition. At the time of closure of a practice, the psychologist and/or the professional executor, should take these actions:

- Immediately secure all client/patient records,
- Identify and catalogue all clients/patients' records,
- Arrange for the secure retention of records in keeping with state legal mandates regarding healthcare record keeping,
- Determine outstanding client/patient issues
- Provide written notification to clients/patients
- Provide written notice to parties of all open contracts, professional organizations, and the Virginia Board of Psychology
- Facilitate access to ongoing services for active patients
- Facilitate access to patient records as necessary, following all relevant Virginia statutory and regulatory mandates
- Document all steps taken

Guidelines for Closing a Psychology Practice

ASPPB

Association of State and Provincial Psychology Boards

April 2020

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ASPPB
Association of State and Provincial Psychology Boards

Guidelines for Closing a Psychology Practice

April 2020

Approved by the ASPPB Board of Directors April 24, 2020

Introduction

Inevitably, a psychologist will, at some point, have to contemplate closing down their practice. In doing so, the psychologist may confront a number of legal, ethical, emotional, and personal challenges, quite different from those that were required to open their practice (Thomas, 2015). There are many reasons why a practitioner may need to close their practice including a planned retirement, sudden incapacitation, gradual cognitive decline, disciplinary action, or death (Thomas, 2015; Good Practice, 2014/2015). These circumstances raise unique ethical and legal challenges. Both the American Psychological Association (APA) and Canadian Psychological Association (CPA) have identified a number of the ethical issues related to this (APA, 2017; CPA 2017). Several jurisdictions offer guidance to licensees/registrants to assist with the task of closing down a practice. Drawing on the wealth of experience of these jurisdictions, and the extant literature, these guidelines have been developed to outline the issues that a practitioner may confront in addressing this career milestone, and to offer suggestions on processes to be followed.

For the first time in its history, Canada has more senior citizens than youth under the age of 15 (Statistics Canada, 2016). In addition, data from the APA Center for Workforce Studies (2013) indicated that the majority of Psychologists in the United States were aged 61 to 65. Professions in Canada and the USA are experiencing a "greying" of their licensees, and this makes the need for clear guidelines for closing a professional practice imperative. Some professions already have guidelines to address this issue. The American Psychiatric Association (2006) published a document on the necessary steps to close a professional practice that addresses business, regulatory, ethical, and personal issues. Similarly, the National Association of Social Workers Center for Workforce Studies (2012) published a document entitled "Retiring? Tips for closing your private practice".

In this document, step-by-step guidance is offered to practitioners that address a variety of issues including professional wills, malpractice insurance, transfer and closing of documentation, as well as a checklist to guide the process. Other professions have followed suit, including psychology, and offered various guidelines to the practitioner (Good Practice, 2014/2015; The National Psychologist, 2015). In fact, psychology identified this issue quite some time ago (Koocher, 2003), however absent from the discussion in psychology has been guidance from the regulatory community whose ultimate responsibility is the enforcement of the standards, rules, and statutes that govern activities in this area. It is hoped that this document will fill this void.

This guiding document was prepared in response to discussions that occurred within the ASPPB Board Administrators and Registrars Committee (BARC) regarding the desirability of having consistency, across jurisdictions, in terms of the guidance provided to practitioners about closing a practice. The aging demographics of the psychology profession coupled with the growing numbers of practitioners who are

entering private practice have created challenges for regulatory boards and practitioners alike. It has been noted anecdotally that, in the absence of clear guidance about how to manage records at the close of a practice, unfortunate instances of abandoned records emerge, further highlighting the need for these guidelines.

To consider these issues, the Professional Termination Task Force was formed in April 2018. Members of the task force include: Dr. Alan Slusky, Chair (Registrar of the Psychological Association of Manitoba and ASPPB Board of Directors Member at Large), Dr. Jamie Hopkins (Kentucky Board of Examiners in Psychology), Ms. Karen Messer Engel (Registrar and Executive Director, Saskatchewan College of Psychologists), and Mr. Darrel Spinks (Executive Director of the Texas Board of Examiners in Psychology). The task force's efforts were supported by Ms. Janet Orwig (ASPPB Associate Executive Director Member Services).

It was the goal of this Task Force to develop a document that will aid practitioners in wisely and proactively addressing what will be a need for all at some point in their professional careers. In so doing it is also the task force's hope to mitigate the potential for "abandoned records" and other issues of concern, and the obvious negative impact that this has on client/patient populations.

The intent of this document is to highlight the relevant issues associated with both the planned and sudden closing of a psychology practice, placing an emphasis on providing practical guidelines to licensees. In addition, the Task Force hopes this document will assist regulators in their work and will reduce the need for their intervention. It is important for regulators to keep in mind to allow time for compliance before initiating these guidelines.

The document reviews the current literature on the processes and requirements of closing of practice, highlights ethical issues where appropriate, as promulgated by the ethical codes of both the APA and CPA, and provide sample forms for practitioner use. In accomplishing the above, the Task Force hopes that this document which fulfill its mandate which was:

1. Survey the ASPPB membership in regard to issues, common needs, and concerns relating to the closing down of a psychology practice;
2. Consider the literature on this topic and through this research identify issues which must be considered in developing guidelines and regulatory language;
3. Consider APA and CPA Codes of Ethics, practice guidelines, and practice guidelines developed by other health professions and regulators;
4. Create guidelines for jurisdictions in regard to closing the psychology practice in a variety of circumstances; and;
5. Recommend consideration of specific regulatory language.

Definitions

Access to Information – is the ability for an individual to seek, receive and impart information effectively. A client's right to access their own health information is protected under privacy legislation in both Canada and the USA.

Incapacity – the state of not being able to do something such as a job, usually because of an illness or injury.

Indemnification – security against legal liability for one's actions.

Immunity (legal) – a legal status wherein an individual or entity cannot be held liable for a violation of the law, in order to facilitate societal aims that outweigh the value of the imposing liability on such cases.

Impairment – diminishment or loss of function or ability.

Professional Executor: refers to the person selected to carry out the terms of a professional will, a transition plan, or another comprehensive plan intended to address the cessation, whether temporary or permanent, of professional practice by a licensee.

Professional Practice: refers to the activities or services directly related to the delivery of psychology services to clients/patients, including typical business functions or operations such as payroll, taxes, accounts payable or receivable, and building or office maintenance.

Personal Will: A legal document intended to address the final wishes of the individual regarding their personal property and the maintenance of any dependents.

Professional Will: A legal document intended to outline the provisions made, and the process to be undertaken, to close the practice of a professional (a psychologist for the purposes of this document) if they are unable to do this for themselves.

Secure Storage – manual and automated computing processes and technologies used to ensure stored data security and integrity.

Reasons for Termination

The termination or closure of a psychologist's practice may happen for a variety of reasons. Sometimes this change is looked forward to and carefully planned and may be eased into, as in the case of a retirement, or it may be entirely unplanned as in the case of death or sudden impairment. Closure may also happen permanently, or temporarily, as may be the case with temporary disability, impairment, or discipline. Regardless, having a plan and policy in place before such an event occurs can ease the transition for everyone involved, from psychologists, to their clients/patients, to collateral staff, and colleagues. Preparation is key and should be considered as part of the training of new psychologists, to the opening of a practice, and to the initiation of services with new clients/patients.

Planned termination of a practice may be accomplished gradually as one moves toward retirement. Psychologists may reduce their client/patient loads over time and stop taking on new clients/patients. They may also begin referring clients/patients to other providers in the area but remain available to assist in the transition process. Psychologists planning to relocate may follow some of the same procedures as those moving toward retirement. When providers are planning to relocate to another community, they may refer all of their clients/patients to another provider or service (selling a practice), or simply offer referrals in the area to their clients/patients one by one.

If a psychologist knows that they will be temporarily withdrawing from practice due to a health condition, a temporary disability, or as part of disciplinary sanctions this should be made clear to clients/patients as soon as is practical, and no later than the outset of the absence. When a provider is forced to cease their practice for disciplinary reasons, there may be legal requirements around

disclosure of the reasons, and/or edicts not to disclose. Ideally, how notice is to be provided should be made clear in the disciplinary process. When a psychologist expects to return to practice, clients/patients should be informed and provided with information regarding the procedures for re-initiating psychological services.

In the case of incapacity and impairment, a provider's ability to recognize and acknowledge that the practice is being negatively impacted may be compromised. The potential for this to occur underscores the importance of advanced preparation. Impairment may have a gradual onset that is difficult to spot (as with some substance use disorders, or gradual cognitive decline), or maybe be sudden (as with a stroke or other significant health condition). Such impairments may be permanent or temporary - when permanent they may be thought of as an incapacity to practice psychology.

Often more distressing is the unplanned termination of a practice, especially if it is the result of a death. In addition to unexpected death, there are other reasons for the abrupt, unplanned termination of practice including sudden disability, incapacity or impairment of the psychologist or within the psychologist's family. These issues may be present for the psychologist or with a loved one, leading to the emergent need to close a practice. Finally, larger environmental and/or sociopolitical issues may emerge that require the closure of a practice, including natural and man-made disasters such as hurricanes, storms, and war. Unplanned termination of practice need not equate to an unprepared cessation of practice.

Ethical Considerations in Closing a Practice

Psychologists have a contract with society that requires that they act in the best interests of those served, be ethical in their actions and decision making, and adhere to prevailing legislation and the standards of the profession. Planning for the closure of a practice is a component of this contract and is paramount and supported by the CPA "Canadian Code of Ethics for Psychologists 4th Edition" (CPA Code) and the APA "Ethical Principles of Psychologists and Code of Conduct" (APA Code).

Both the CPA and APA Codes speak to the profession's responsibilities to do no harm and when within one's control, to mitigate any potential risk to clients/patients. Not planning for the closure of a psychologist's practice whether it occurs as a result of retirement, relocation, incapacity, termination by an employer, or death creates immediate problems for the continuity of service to clients/patients, management of client health records, and the handling of administrative responsibilities. Most importantly, the failure to plan for the closure potentially may result in a negative impact on the wellbeing of clients/patients

Identifying a Professional Executor

The psychologist's ethical responsibility for planning for the close of their own practice begins with the identification of a professional executor. This individual is in essence given the "keys to the house" and has agreed to take on the responsibility of managing the business affairs of the psychologist and to close their "house" (practice) should they not be available to do this themselves. Identification of such an individual is congruent with a psychologist's ethical responsibilities to not abandon clients/patients, to facilitate continuing care when necessary, to ensure the confidentiality of client health records, and to ensure client access to their own personal health information (PHI). The APA Code requires that:

3.12 Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist's illness, death, unavailability, relocation, or retirement or by the client's/patient's relocation or financial limitations.

10.9 When entering into employment or contractual relationships, psychologists make reasonable efforts to provide for orderly and appropriate resolution of responsibility for client/patient care in the event that the employment or contractual relationship ends, with paramount consideration given to the welfare of the client/patient.

Similarly, the CPA Code contains the following directives:

II.33 Give reasonable assistance to secure needed psychological services or activities, if personally unable to meet requests for needed psychological services or activities.

II.36 Give reasonable notice and be reasonably assured that discontinuation will cause no foreseeable material harm to the primary client, before discontinuing services.

II.37 Establish suitable procedures for responding to emergencies, including procedures for situations in which they are unavailable due to illness, absence, death, or technology failure.

In addressing the psychologist’s ethical responsibility for planning for the closure of their practice, the Task Force suggests including the articulation of that plan to the client during the initial contact when informed consent is being sought. Sections 3.10 and 4.02 of the APA Code and section I.23 of the CPA Code identify the responsibility to seek informed consent from those legally entitled to provide it, and, as part of that process, to discuss confidentiality and its limits. Sections I.44 and I.45 of the CPA Code speak to the responsibility to identify “what measures will be taken to protect privacy and confidentiality…” and that a psychologist should “share confidential information with others only to the extent reasonably needed for the purpose of sharing, and only with the informed consent of those involved,…” In addition, the conventional standard in health service environments when seeking informed consent is to also address the issues of the collection, storage, access, and disclosure of PHI. This standard would be supported by privacy legislation such as the Health Insurance Portability and Accountability Act (HIPAA, 1996) in the USA, or in Canada, in provincial legislation governing the collection, access, storage and disclosure of PHI.

Record creation and maintenance are important to the issue of planning for the close of a psychologist’s practice. The Codes of Ethics and the privacy legislation in Canada and the USA and individual state or provincial codes of ethics as well as the standards of the profession, identify a psychologist’s responsibility for the creation and maintenance of complete records regarding the work they undertake (i.e. client records, supervision records, billing records), and in particular, client health records. This imperative is in part to ensure that continuity of care can occur, and to the extent possible risk for clients/patients is mitigated when practices are closed or practitioners change. Section 6.01 of the APA Code and section II.21 of the CPA Code speak to this responsibility and state the following respectively:

6.01 … Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional

requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law. (See also Standard 4.01, Maintaining Confidentiality.)

II.21 Create and maintain records relating to their activities that are sufficient to support continuity and coordination over time and to manage risks.

Imperative in the planning for the close of a psychologist's practice is consideration of how to ensure that, to the greatest extent possible, all client health records are complete and up to date, congruent with the ethical directive of non-maleficence. Other records of importance also worthy of consideration in terms of whether they are complete and current are those that pertain to the financial status of the practice (e.g. billing information, outstanding debt, bank accounts), lease information, insurance information, partnership agreements, technology utilized, external storage of client records, passwords, contact information etc. Examples of how to identify and provide this information to professional executors is provided in the appendices.

In addition to the responsibility to create complete records, is the responsibility to securely store, manage and maintain client health records ensuring confidentiality as well as appropriate access. Consideration of legislative imperatives, professional standards, and regulatory standards regarding record storage and retention need to be considered in planning for practice closure. Included in the issue of record storage, management and maintenance is the responsibility to ensure that the professional executor understands the ongoing ethical and legal responsibilities in relation to client health records. Congruent with privacy legislation in both countries, the APA and CPA Codes direct that client information and their health records must be securely stored and maintained. The APA Code states:

4.01 … Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship.

6.02 … (a) Psychologists maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium.

(b) If confidential information concerning recipients of psychological services is entered into databases or systems of records available to persons whose access has not been consented to by the recipient, psychologists use coding or other techniques to avoid the inclusion of personal identifiers.

(c) Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice.

The CPA Code states that the Psychologist must:

I.41 Collect, record, store, handle, and transfer all private information, whether written or unwritten (e.g., paper or electronic records, e-mail or fax communications, computer files,

> *recordings), in a way that attends to the needs for privacy, confidentiality, and security. This would include protection from loss or unauthorized access, appropriate education of staff or other agents, and having adequate plans in circumstances of one's own serious illness, termination of employment, or death*

When the closure of practice is anticipated due to situations such as relocation or retirement, and the professional relationship is necessarily being terminated by the psychologist, there is an ethical responsibility to discuss this directly with the clients/patients. The psychologist has a responsibility to discuss the close of a practice and the ending of the therapeutic relationship with clients/patients prior to its occurrence and to assist them in accessing other service providers should this be desired. The professional executor would not have a role in such cases, as it would be important for the psychologist to be directly involved in making arrangements for active clients/patients should this be desired, and for the ongoing storage, management and maintenance of client health records. Regarding this responsibility the APA Code states:

> *0.10 ... (c) Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pre-termination counseling and suggest alternative service providers as appropriate.*

Congruently, the CPA Code states that Psychologists in terminating services must:

> *II.33 Give reasonable assistance to secure needed psychological services or activities, if personally unable to meet requests for needed psychological services or activities.*
>
> *II.36 Give reasonable notice and be reasonably assured that discontinuation will cause no foreseeable material harm to the primary client, before discontinuing services.*

Professional Will and Other Necessary Documentation

Why should a psychologist have a professional will?

Psychologists have a professional and ethical responsibility to ensure that their actions are in the best interests of those served and do not intentionally or unintentionally cause them harm. A professional will is a way to put in place protections for clients/patients to ensure that there is continuity of care should this be desired, and ensure that client personal health records are secured, maintained and appropriately accessed. In addition, a professional will minimizes the risk to the psychologist's personal estate and reduces the burden on colleagues and family members to manage the professional affairs of the psychologist when they are unable to do so themselves.

What is the difference between a professional will and a personal will?

A professional will is intended to address the closure of the practice of a professional (here a psychologist) to ensure that it will be closed appropriately, when this is required, and they are unable to do so themselves. A professional will ensures that client wellbeing is addressed. A personal will is

intended to address the final wishes of the individual regarding their personal property and the maintenance of any dependents.

What are the necessary components of a professional will?

1) Authorities Statement

   There must be a clear statement providing the professional executor with the necessary authority to access the psychologist's practice and to take possession of all practice records, including client health records. The authority must also allow for the professional executor to make decisions regarding the closure of the practice and to allow for the administration of the will.

2) Identification of a Professional Executor

   The professional will must identify the professional executor and provide their current contact information. In choosing a professional executor, psychologists should choose an individual that is trusted, someone who they are confident fully understands and appreciates the responsibility being agreed to, including an understanding of prevailing legislation and the standards of the profession as related to client care and client health records. Ideally this individual should be a member of the profession or if this is not possible a member of another regulated health profession. The professional executor ideally should not be a member of the psychologist's own family due to the inherent conflict of interest that exists. More information regarding requirements for the professional executor is further explained later in this document.

3) Responsibilities of the Professional Executor

   - Upon notification of the need to close a colleague's practice, immediately secure client health records congruent with prevailing privacy legislation and the jurisdictional regulatory requirements of the profession.
   - Identify and catalogue all active clients/patients (i.e. open health records, and/or active as defined by the jurisdictional regulator) and all non-active/closed client cases.
   - Arrange for the secure retention of all client health records according to the record retention/maintenance/destruction requirements outlined in prevailing legislation or, if this is not clearly addressed in legislation, according to the regulatory standard of the jurisdiction. Where both a legislative and regulatory standard for record retention and destruction exist, the higher standard should be followed.
   - Determine any outstanding issues that may need to be addressed in regard to active clients/patients (e.g. provide information to another health provider, provide documentation for insurance, provide a report to facilitate a client's access to programs and services etc.).
   - Provide all active clients/patients with individual written notification of the close of the practice that includes:
     - notice of who has responsibility for their health record;
     - contact information for the professional executor;

  - notice of where their health record is stored and how it can be accessed; and,
  - an offer to send the record to another health provider or assist in finding another provider, and the date by which if no request has been received to transfer it, the record will be put into long term storage.

- Facilitating ongoing services for a colleague's clients/patients may involve:
  - Making a referral to another resource or service provider or psychologist;
  - Referring a client back to the primary care physician for referral to another psychologist;
  - Providing clients/patients who request it with a list of publicly funded services and a list of private "fee-for-service" providers;
  - Providing another health provider of the client's choice with a copy of the health record; and,
  - Integrating the client into the professional executor's own practice should that be an option and agreed to by the client.

- Arrange for a general notice of the close of practice to appear in the local paper in the communities in which the colleague practiced identifying who has control of the records and how the records can be assessed.
- If a website, email system, voice mail system, and/or answering service was used for the practice, provide notice of closure on these systems and maintain the systems for a reasonable period of time before shutting them down.
- Maintain an accurate record of all client health record transfers and destructions, including what was requested and what was transferred.
- Address any administrative issues pertaining to the close of the practice e.g. cancellation of leases, closing of the financial accounts, payment of outstanding debts from the business account.

4) Lists of Locations/Passwords/Contacts
   A professional will should clearly identify information that will be essential in closing the practice, including but not limited to, the location of all records (client, financial, insurance etc.); contact information for clients/patients and professional contacts; passwords for all accounts, records and technology; the location of any keys; the location of test materials, appointment book, electronic devices, etc.

5) Specific Instructions for the Professional Executor
   A professional will should also include any specific instructions for the professional executor. These might include and explanation of how costs incurred in the course of the administration of the will shall be covered, an honorarium for the professional executor's time and work, and who, in addition to active clients/patients, should be notified of the closure, etc.

6) Responsibilities in Establishing A Professional Will
   - legal consultation;
   - consideration of relevant legislation e.g. privacy, incorporation etc.;

- identification of a professional executor and ensuring that the professional executor understands and agrees to the role;
- establish and maintain full and current client health records;
- establish and maintain full and current practice records (e.g. financial, billing, insurance records, contact information, partnership records);
- maintain adequate liability insurance;
- ensure that financial resources are available to allow for record retention and management, addressing any liability claims against the practice, and the administrative costs for the close of the practice;
- provide the professional executor with passwords, keys, information about location of records, accounts etc. – anything that may be required to close the practice;
- provide a copy of the professional will to their professional executor;
- ensure that a copy of the professional will is filed with the personal will; and
- ensure that family members have been apprised of the plans regarding the closure of the practice.

General Requirements for Professional Executors

Why the need for a Profession Executor?

Psychologists have an obligation to their clients/patients to have an organized plan to ensure that any cessation of professional practice, whether temporary or permanent, does not harm or impose an undue hardship on them. As stated in the section above an organized, comprehensive plan includes the selection of a professional executor who will be responsible to respond to requests for records or information; to maintain the confidentiality of mental health records and dispose of same in an appropriate manner where necessary; to facilitate or assist with the transition of clients/patients to other providers; to assist with billing for services rendered, if requested; to direct or assist the closing of the practice; and to respond effectively to any other unforeseen issues arising out of the cessation of professional practice.

Selection of Professional Executor

A professional executor must be an individual whom the licensee believes can carry out their duties in a competent and efficient manner without feeling overwhelmed. Given the importance of the tasks to be assigned, a professional executor should ideally be a psychologist, but may also be a staff person from the practice, other colleague, a lawyer, or business associate. Ideally the professional executor should not be a relative given the potential for concerns regarding conflict of interest and bias.

When selecting a professional executor, a psychologist should consider factors such as professional and business acumen; familiarity with the psychologist's practice; similarities between the parties' practices; age differences between the parties; number of clients/patients involved; the psychologist's client population; and physical distance between the parties' practices. A psychologist should also take into account the disciplinary history, if any, of the individual(s) being considered.

When deciding whether to serve as a professional executor, a person should consider all of the above factors as well as the level of preparation shown by the other party. A psychologist should also consider

the amount of time available to carry out the duties of a professional executor; any financial burden associated with serving as the professional executor; and the amount of funds set aside or available to cover expenses (e.g. third-party document storage/management).

While a professional executor may serve as the guardian, attorney-in-fact, or personal representative of an estate, serving in one of these capacities is not a prerequisite to serving as a professional executor.

Agreement with Professional Executor

To ensure that the ethical duties of the profession are fulfilled following death or incapacity, a psychologist may enter into a legal agreement with a professional executor. This agreement should outline the responsibilities as described in the psychologist's professional will and should reflect the professional executor's understanding of the commitment necessary to carry these out. The agreement should also indicate any compensation to be paid to the professional executor, as well as any funds set aside or available to cover expenses incurred by the professional executor (e.g. third-party document storage/management).

The agreement should contain language providing indemnification for the professional executor against any claims or causes of action brought by third parties arising out of their performance under the agreement.

Lastly, the agreement should make clear that the professional executor may not act in direct contravention to lawful directives of the psychologist, or in the event of the psychologist's death, or incapacity, the psychologist's guardian, attorney-in-fact, or personal representative of the estate.

Notice to Clients/Patients of Professional Executor

As stated previously, it is important that a psychologist, as part of the informed consent process, seek client understanding and agreement to the access and control of the client's records by the professional executor in the event of the psychologist's death or incapacity. This language should make reasonably clear that the professional executor is tasked with assuming responsibility for access and confidentiality of the client's mental health records. The notice may, but need not, identify the professional executor. The client can be informed that they would be contacted by the professional executor should the need arise.

Ethical Considerations

In lieu of providing initial referrals to other providers, a professional executor may offer to provide their services to clients/patients so long as doing so would not constitute a conflict or dual relationship under other applicable statute, the relevant Codes of Ethics, and relevant jurisdictional practice standards. In the event of a conflict or dual relationship, or if requested, the professional executor shall provide the client with assistance in accessing an appropriate provider.

Sample Regulatory Language

A licensee shall affirm that they have prepared a professional will, transition plan, or other comprehensive plan intended to address the cessation of professional practice when renewing their license. Licensees shall also identify the professional executor selected to carry out the plan and provide that individual's contact information.

At license renewal psychologists shall list those colleagues for whom they have agreed to serve as a professional executor.

Other Important Points for Consideration

A review of both American and Canadian jurisdictional statutes and regulations on the issues of record retention, record disposal, and (for those jurisdictions with more current regulatory language) statements speaking to professional wills and executors, reveals that language is lacking requiring that licensees adhere to these regulations. As the essence of a self-regulating profession is public protection through oversight, it is important to ensure compliance with these guidelines.

In many jurisdictions, regulators have the legislative authority to conduct practice audits, particularly in cases of disciplinary action. These audits are often time-limited and may be restricted to clients/patients and/or issues relevant to the disciplinary matter under consideration. Still other jurisdictions provide for random audits of their licensees' practices, to ensure general adherence to a variety of regulatory requirements such as record-keeping, informed consent, clarity of notetaking, and confidentiality. Nowhere, however, could the Task Force find statements that speak specifically to compliance audits for the establishment of professional wills or for the appointment of executors. While this may reflect on how audits are traditionally conceptualized (i.e. to step in after the fact and determine if improper practice is occurring), the Task Force would argue that an additional and vital role for practice audits should be to ensure that the necessary steps have been taken by practitioners to prepare for the inevitable.

The importance of practice audits is underscored by the variety of provisions within jurisdictional legislation that address the issue of abandoned records. While many jurisdictions have specific clauses in their statutes or regulations, that speak to how client/patient records must be retained, little guidance is given about when a professional executor must assume custody of client/patient records. A notable exception however exists in Manitoba, where the provincial government has stated that if a healthcare practitioner abandons their client/patient records, the college (regulator) automatically becomes custodian of the records unless a specific professional executor has been appointed. The implications for the regulator here are clear, and in smaller jurisdictions, could prove to be financially perilous for that regulator. For that reason, the Task Force recommends consideration of regulatory language that permits the auditing of a licensee's practice to ensure compliance with the appointment of an individual who will take on the responsibilities noted above. (i.e., a professional executor).

Sample regulatory language to address the issue of practice audits:

> *Notwithstanding any other provisions for practice audits contained in the statute, regulations, or rules governing the practice of Psychology in (insert jurisdiction here], the regulator reserves the right to undertake random practice audits of its licensees/registrants, to ensure that a professional executor has been appointed and that sufficient information has been provided to that executor (e.g., a professional will) to ensure the safe and ethical storage, transfer, and/or disposal of patient/client records in the event of the closure of that licensee's/registrant's professional practice.*

Group and/or Multidisciplinary Practices

An additional issue for consideration when planning the closing of a practice is whether the practice is part of a broader group practice, solo in nature, or embedded within an institution (e.g., a hospital or community clinic). The answer to this question will have a significant impact on the steps a practitioner must take in order to ensure that their practice is closed appropriately, and records are maintained.

The majority of the recommendations in this document speak to the solo practitioner, or the practitioner who works in a group practice but who has taken sole responsibility for their client/patient records. But what of the emerging phenomena of interprofessional collaboration/practices, where professionals from multiple disciplines team to provide integrated and holistic client/patient care? In such cases there may be conflicting regulatory and ethical requirements for these issues, depending upon the profession in question. The issue may then become one of whose profession takes precedence (i.e. the practitioner who has left practice or the one left responsible for the records)? This is a challenging issue and speaks clearly to the importance of both seeking competent legal advice in the initial stages of establishing such a multidisciplinary group practice, as well planning for the eventuality of a practice closure. Similar issues have been discussed in the literature (e.g. differing professional malpractice insurance requirements in the context of multidisciplinary clinics), however little attention has been paid to the differences across professions in addressing practice termination and record retention. Moreover, what of the psychologist who operates a private practice within the context of an institution (e.g. community clinic or hospital). Psychologists must adhere to the statutes and regulations of the profession and the psychology regulatory board, however what if those statutes and regulations conflict with clinic/hospital policies around issues of record retention, access to records, and transfer of client/patient care? In such cases, adherence to the higher standard is recommended and that a request to adhere to that standard be embedded in the practitioner's professional will.

In many cases there are no clear answers to these points for consideration. Consultation with legal counsel can provide guidance, and licensees are strongly encouraged to consult with colleagues to ensure that their practice is consistent with others. In this area however, where awareness of the inherent need appears to still be somewhat in its infancy, inter-practitioner variability is likely to be high. In such cases, the Task Force recommends consideration of the following:

1. In cases of multidisciplinary group practice, licensees should ensure that their practice termination preparation meets with any local psychology regulatory standards or guidelines.
2. In cases where a psychologist's obligations under the jurisdiction's rules or statutes conflict with those of other practitioners (who may eventually become responsible for that psychologists records), it is recommended that the psychologist's professional will acknowledges these discrepancies, speaks to steps taken to reconcile the differences (if any), and where appropriate, provide guidance to clients/patients who may consequently struggle to access their records under divergent regulatory requirements.
3. If legal consultation has at any time been obtained to guide the psychologist in addressing these conflicting requirements, practitioners are urged to retain copies of that guidance, along with the contact information of the lawyers who offered it, so as to protect (as much as possible) those who may need to act on this advice.
4. For the case of a private practice embedded within an institution (e.g. hospital), it is recommended that the psychologist ensure their record-keeping practices adhere to regulatory standards and if for any reason, diverge from those outlined in the hospital policies,

documentation exist to highlight the discrepancy and the reasons for whatever course of action is taken. Psychologists prior to the creation of the professional will have the responsibility to identify for the employer and client where there is a discrepancy between the profession and the institution. Hospitals will frequently have legal counsel available to provide advice in circumstances where a practitioner's regulatory authority and hospital policies diverge.

5. If uncertainty persists, the best suggestion is to work to the higher standard of care.

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Appendix I: Sample Professional Will

A number of ASPPB member jurisdictions have generously shared their current templates for professional wills. The following represents two examples (Manitoba and Pennsylvania) of the many submitted.

SAMPLE PROFESSIONAL WILL #1 (MB)

I, [enter your name here], a resident of [enter name of city here], Province/State of [enter jurisdiction here], being of sound mind and memory, do hereby declare this to be my Professional Will. This supersedes all prior Professional Wills, in the event there are any. This is not a substitute for a Personal Last Will and Testament. It is intended to give authority and instructions to my Professional Executor regarding my psychology practice in the event of my incapacitation or death.

1. Registrant/Licensee Name

I am a [registered/licensed psychologist], in [enter jurisdiction(s) here] Registration #(s)_ _ _ _. My office address is:

[enter office address here]

I also maintain a [second, home, alternate] office at:

[enter additional office addresses here]

2. Appointment of Professional Executor

In the event of my death or incapacitation, I hereby appoint [enter name of registrant], Registration # _ _ _ _ (or identifying information of other qualified individual), whose phone number is:

[enter phone number here]

and whose office is located at:

[enter office address here]

as my Professional Executor.

In the event that [enter name of above registrant here] is unavailable or unable to perform this function, or requires assistance, I hereby appoint [enter name of alternate professional executor] Registration # _ _ _ _ , (or identifying information of other qualified individual), whose phone number is: [enter phone number here] and whose office is located at:

[enter office address here] as a back-up Professional Executor.

3. <u>Authority of Professional Executor</u>

I hereby grant my Professional Executor full authority to:

a. Act on my behalf in making decisions about storing, releasing and/or disposing of my professional records.

b. Carry out any activities deemed necessary to properly administer this Professional Will.

c. Delegate and authorize other persons determined by them to assist and carry out any activities deemed necessary to properly administer this Professional Will.

4. <u>Name of Legal Counsel and Personal Will Executor</u>

*A. My lawyer for my Personal Will is [enter name of your lawyer here]
whose phone number is: [enter phone number here] and whose offices are located at:
[enter office address here].*

*B. The executor of my current personal will is [enter name of executor of personal will], whose phone number is: [enter phone number here] and who is located at:
[enter address here]*

5. <u>Essential Professional Practice Information</u>

*A. My current client records are located at my office:
[enter office address here]*

*B. My past client records are located at:
[enter address(es) here]*

C. My Psychological Test materials are located [enter location here].

*D. Billing and financial records related to my psychology practice are located here:
[enter address here].*

*E. Some or all of my client, billing and financial records are on a computer, located at
[enter address here] and my password (s) are as follows: [enter any passwords here].*

F. My appointment calendar is located [enter location here], and client phone numbers are located [enter location(s) here].

G. My e-mail address(es) is/are [enter e-mail address(es) here], and the password(s) is/are: [enter password(s) here]

H. My office voice mail number is: [enter office voicemail here]

and the voice mail access code is: [enter voice mail access code here]

I. Any necessary keys you will need for access to my office are [enter location of keys]. Keys for the filing cabinet are located [enter location here].

J. For assistance in locating/accessing my records you may contact [enter contact phone number(s) and address here].

K. In addition, the following person(s) may be helpful in locating/accessing my records: [enter any additional names, addresses and phone numbers here].

6. Specific instructions for my Professional Executor are:

A. First of all, I would like to express my deep appreciation for your willingness to serve as the Professional Executor for this will.

B. There are four copies of this Professional Will. They are located as follows:
[enter locations of all copies of the will, for example]:

> *a. One is in your possession.*
> *b. One is in the possession of my lawyer.*
> *c. One is with my personal will.*
> *d. One is with my professional liability insurance policy, filed [insert location here].*

C. The files, telephone numbers and addresses of current and selected past clients who can be notified about my death are located [here] in my office [enter office address here].

> *a. Please use your professional judgment and discretion in deciding how you want to notify current and (if necessary) past clients and whether or not to publish a notice in the newspaper notifying clients of my death, incapacity or other unavailability and who to contact for further information. You should contact our regulatory body [contact information here] to ensure this decision meets our jurisdictional regulatory requirements.*
>
> *b. If clinically indicated, you may wish to offer a face-to-face meeting with some clients. You may also wish to provide three referral sources, which can, of course, include yourself [if appropriate].*

D. My professional liability insurance is currently provided by:
[enter name of insurance provider and address and phone number here]

My policy # is: [enter number of insurance policy here]

Please notify my professional liability carrier in writing of my death as expeditiously as possible and arrange for any additional coverage that may be appropriate. The professional liability carrier may require a copy of my death certificate or other proof of my death. Please also notify the jurisdictional regulator of my passing.

E. If requested and authorized by the client, arrange for copies of referred clients' records to go to their new therapists. All remaining records should be maintained according to the requirements of our jurisdictional regulator, which are (at the time of writing) as follows: [insert regulatory requirements here].

F. For immediate assistance, it is recommended that you contact, the Board Administrator/Registrar.

G. Arrangements have been made in my Personal Will so that you may bill my estate for your time and any other expenses you may incur in executing these instructions.

I declare that the foregoing is true and correct.

***Signatures**:*

Executed at ______________________________ _________________________.
(location) *(Date)*

_____________________________________ ___________________________
(Signature of Registrant) *(Date)*

I agree to serve as Executor for this Professional Will:

____
(Printed Name of Professional Executor)

_____________________________________ ___________________________
(Signature of Professional Executor) *(Date)*

I agree to serve as Back-up Executor for this Professional Will:

____
(Printed Name of Back-up Executor)

_____________________________________ ___________________________
(Signature of Back-up Executor) *(Date)*

WITNESSES: _____________________________________
(Printed Name of Witness)

_____________________________________ ___________________________
(Signature of Witness) *(Date)*

<u>Sample Professional Will #2 (PA)</u>

Instructions for the disposition of __________________________________ professional practice, in the event of death or disability.

<u>1. Professional Executor</u>

Who do you trust to carry out your professional directives? Who would be willing to do so? Who is stable and likely to be around when/if you are not? Pick two individuals, first line and back-up person.

Name	Address	Phone	Agrees?	Date Discussed
______________	________________________	_______________	Yes No	___________
______________	________________________	_______________	Yes No	___________
______________	________________________	_______________	Yes No	___________

<u>2. Professional Contacts:</u>

<u>a) Professional practice attorney:</u>

Name	Address	Phone
______________	________________________	_______________

<u>b). Tax accountant:</u>

Name	Address	Phone
______________	________________________	_______________

<u>c). Malpractice insurance:</u>

Name	Address	Phone	Policy Number
______________	________________________	_______________	____________________<u>d).</u>

Billing agency:

Name	Address	Phone	Policy Number
______________	________________________	_______________	____________________

3. Patient Records Location(s):

a) address of office where files are located: ___________________________________
_

1) office key location:____

2) who else has access to office key ____ _____________

3) security code to de-activate office alarm:____

b) location of open patient files within office ____
1) open file drawer(s) key location: ____

c) location of closed patient files within office _________________________________ __________________

1) closed file drawer(s) key location:____

d) location of current patient schedule:____

1) instructions to access patient schedule ____________________________________ _____________

e) location of patient billing files and records:____

1) instructions to access patient billing records: _________________________________
_

f). voice mail access instructions ____

4. Specific Instructions for Professional Executor:

Location of cop(ies) of this professional will:____

a. Thank you very much for your assistance with a difficult task.

b. In the event of a serious illness or injury, when I am unable to work for more than two weeks but am able to communicate effectively: Please contact me as soon as I am able to communicate, to determine how to proceed with temporarily putting my practice on hold, contacting patients, etc. **Whatever I communicate to you at that time will take precedence over this document.**

c. In the event of my death, or my temporary or permanent decisional incapacitation as determined by a physician or licensed psychologist:

1. Please telephone all scheduled patients and notify them discretely, with minimal necessary details, of my current circumstances. Any limitations to contacting patients via telephone will be stipulated on their contact information pages, found ______. Assess their psychological vulnerability and need for ongoing psychological intervention via recent therapy notes and your telephone conversation. Make professional referrals as appropriate and acceptable to the patient, after obtaining their permission to release their name and records. Please make an effort to match each patient to a provider who is approved or is on the panel of that patient's insurance company. Please offer each patient at least one face-to-face therapy session, individual or group format, with yourself or another professional therapist that you designate, to process the event of my death or incapacitation. In the event that any patient is unable to pay for this session, and/or insurance coverage for the session is denied, it is my wish and direction that my professional corporation's funds be used to compensate you or the designated professional therapist at their current hourly rate, for this one session. Patient permission should be obtained to forward relevant case records to this therapist prior to the scheduled session.

2. Should patients request information regarding attendance at a memorial service, or contributions, please direct them to any professional service/collections being arranged. It is my wish that my personal services remain a private affair for family, friends and colleagues.

3. Records of patients referred to a new therapist should be forwarded to their new therapist if the therapist so chooses. All remaining records should be maintained in a safe, confidential place for the minimum number of years currently required by current state or federal law. Please dispose of all records

not required to be maintained by such laws in a manner which destroys completely all identifying patient information, such as shredding or burning.

4. Please notify my malpractice insurance carrier of my death or incapacitation. Request that my billing service notify managed care companies with whom I have current contracts.

5. Please refer to____*(stipulate party you wish to handle your financial affairs)*, at address and telephone number ____________, any financial decisions be made regarding payment of any outstanding bills, and patient bill collections for amounts over $100.00. I request that any patient uncollected accounts under $100.00 be waived. In the event of their concurrent incapacitation or death, please refer these decisions to the designated Executor of my personal estate. If there is a clinical component to these patient-based financial decisions, please review the file and share the minimal pertinent information necessary to make an informed decision.

6. Be sure to bill my professional corporation for your time and any other expenses that you incur in executing these instructions, as well as the time of anyone you designate to

assist you in these efforts.

7. In addition to this copy of the Professional Executor Instructions, given to________________as my Professional Executor, there are two other copies, located in____________________.

____

____

Date (Notarized Signature)

Appendix II: Sample Preparation Checklist

To assist licensees/registrants in ensuring they have addressed all necessary steps in the process of retiring/closing a practice, the following from the BC College of Psychologists is offered as a sample of a checklist that licensees may find helpful.

Planning for Retirement, Relocation, or Extended Absence from Practice Checklist

This document is intended to be of assistance to registrants with respect to their planning for retirement, relocation, or extended absence from practice. Relevant Code standards are indicated in brackets following the checklist items.

☐ *I have notified clients of the expected date of my retirement, relocation, or extended absence well in advance to allow time for questions and concerns, and for processing reactions to the transition. I have set a specific date for termination and have been consistent in my discussions with clients.* ***(3.29, 5.1, 5.17, 5.18, 5.19, 8.2, 14.6, 14.7)***

☐ *I have planned a clinically appropriate termination for each current client and have made an assessment of each client's future needs and discussed my recommendations with them. I have made plans to transfer clients requiring continued care to another registrant or mental health professional.* ***(3.6, 5.1, 5.19, 5.26, 8.2)***

☐ *[For registrants in private practice] I have offered clients who are to be transferred several referrals, and have obtained a release to forward a copy of the record or a summary of the record to the new clinician.* ***(3.6, 5.1, 5.19, 6.2, 8.2)***

☐ *[For registrants in public or institutional practice] I have, if I was able to, provided several options to clients depending on the organizational structure, including introducing clients to the new clinician. I have determined whether I need to make arrangements to transfer records information. I have considered the option of preparing a letter to clients and selected former clients about my plans and have taken action in accordance with the clients' best interest.* ***(3.6, 5.1, 5.19, 6.2, 8.2)***

☐ *I have prepared or updated instructions for my professional executor in the event of my death or incapacity. I have ensured that my executor has a copy of these instructions and will provide to them any updates I make to it.* ***(14.6, 14.7)***

☐ *I have provided written information to current and selected former clients regarding how to access their records, and have specified that records will be destroyed once the required recordkeeping interval has elapsed. I have made arrangements for access to my records by providing to these clients an appropriate means by which to contact me or my professional executor (e.g., telephone number or mailing address).* ***(14.6, 14.7)***

☐ *I have consulted with respected colleagues as appropriate during the transition period, regarding client welfare, transition process issues, or other matters.* ***(3.2)***

☐ *[For registrants in private practice] I have informed relevant referral sources about my plans and provided alternate referral information as appropriate.* ***(3.2, 5.1)***

☐ *[For registrants in private practice] I have ensured secure storage of my practice records, appointment books, financial records, and any test materials, including computerized testing materials, I plan to retain.* ***(14.1, 14.2, 14.3, 14.4)***

☐ *[For registrants working in institutions where records are kept and managed by a central records office] I have*

reviewed the need to ensure that client test protocols and test materials are clearly marked for review only by a qualified professional and have taken action, if appropriate. ***(14.8)***

- ☐ *I have made, and will retain and regularly update, a list of records that have been stored, and the date on which these should be destroyed. I will destroy outdated files or have them destroyed by a confidential shredding company. I have reviewed computer-based records, and destroyed outdated files and outdated files on computers that will be out of my dominion and control.* ***(14.4)***

- ☐ *I have ensured adequate professional insurance to cover time I am not practicing, including 'tail' insurance to cover liability after retirement. I understand that this coverage is important, as lawsuits or ethics complaints may be filed after I stop practicing, regarding services I provided while in active practice.* ***(3.8)***

- ☐ *I have notified the College of Psychologists of B.C. in writing if I wish to apply to move into the Non-Practicing class of registration (e.g., Non-Practising, Out-of-Province, or Retired) or if I wish to be taken off the register. I have consulted current policies regarding any status changes, as my ability to return to the active practice in the future, should my circumstances change, may be impacted by my decision.* ***(3.8)***

Appendix III – Notices & Letters Templates

When closing a practice, a practitioner may choose to write each client, with an outline of the planned closure and steps to be taken to transition them and their records to a new practitioner. Of course, in the event of an unplanned closure (death or incapacity), the letter's contents will be different, however this sample from Pennsylvania offers an example of how this may be addressed.

April 15, 2000

Jane Smith, Ph.D.
123 Anywhere St
Pretty Place, PA 16602

Dear (Patient first name):

I am writing to let you know that I will be closing my practice in Psychology during the summer of 2000. My partner is unexpectedly facing a major job change, and we have decided to move to Western Pennsylvania to be closer to our families.

I have very much enjoyed working with each of you during my six years of practice in Pretty Place. I have learned a great deal from you, and I hope that our work has improved the quality of your life.

At this time, I anticipate that I will be leaving the area in mid-July. For those clients whose work with me has ended, I am happy to schedule a session for those who may want to discuss my leaving and your future therapeutic plans. For those with whom I am still working, we will discuss my leaving and plans for your transfer to a new therapist over the next several weeks. It is very important to me that you be established with your new therapist before I leave, and that this new therapist be someone that we both respect and trust. I will assist in this transition as much as I possibly can.

Please call me at (555) 123-4567, so we can discuss how or if my transition will have an effect on you. If I do not hear from you and you do not arrange for transfer of your psychological records, I will take them with me. I will send each of you a change of address before I leave the area.

Although this transition was quite unexpected in my life, I am feeling very positive about our move. However, it is still with deep sadness that I will close my practice here in Pretty Place.

Sincerely,
Jane Smith, Ph.D.

Active Client/patient Notice Template for Professional Exectutors

Dear (client/patient's name):

I am writing to inform you that the practice of NAME is closed effective immediately due to REASON (illness; that they are no longer employed with ORGANIZATION NAME; as they have passed away). Please be advised that I am NAME'S Professional Executor. I am contacting you in that role and as you are on record as an active client/patient of NAME.

Please be assured that your personal health record has been secured by me and will be handled in accordance with the requirements of the NAME OF LEGISLATION/professional standards as required by NAME of REGULATORY BODY. Your record is securely housed at LOCATION.

As NAME'S Professional Executor I am available to assist you in arranging for your continued care should you wish this. If you would like my assistance in accessing another Psychologist/service provider please notify me in writing prior to DATE, and I will make every effort to accommodate your needs.

If you would like a copy of your health record to be transferred to another Psychologist/health service provider, please sign the enclosed authorization form and return it to my office as soon as possible prior to DATE. Upon receipt of your authorization form, I will make the appropriate arrangements concerning your file.

Should you have any questions in regard to this letter please do not hesitate to contact me directly at NUMBER and/or ADDRESS.

Sincerely,

NAME

Notice of Close of Practice (Colleagues, Professional Associations) Template

Dear (name of individual or agency):

I am writing to inform you that the practice of NAME is closed effective immediately due to REASON (illness; that they are no longer is employed with ORGANIZATION NAME; as they have passed away).

Please be advised that I am NAME'S Professional Executor. Should you have any questions in regard to the close of their practice or management of their client/patient records please do not hesitate to contact me at TELEPHONE NUMBER/EMAIL ADDRESS/MAILING ADDRESS.

Sincerely,

NAME

Draft Advertisement Announcing the Closure of Practice

<u>CLOSURE OF PRACTICE NOTICE</u>

Please be advised that the psychological practice of NAME has been closed effective DATE. Client/patient health records have been securely maintained in accordance with NAME OF PRIVACY LEGISLATION and the professional standards required by NAME OF REGULATORY BODY. Requests for information or transfer of the client/patient health record should be sent in writing to NAME/ADDRESS identifying what is being requested, who the information is to be transferred to, along with a signed consent for the transfer.

DOCTORAL CLINICAL PSYCHOLOGY PROGRAMS IN VIRGINIA

PROGRAM	DEGREE
Capella University (Online Program)	Psy.D.
Curry School of Education and Human Development, U. Va.	Ph.D.
George Mason University	Ph.D.
James Madison University Clinical and School Psychology	Psy.D.
Regent University	Psy.D.
University of Virginia - Dept. of Psychology	Ph.D.
Virginia Commonwealth University	Ph.D.
Virginia Consortium Program in Clinical Psychology	Ph.D.
Virginia Tech - Clinical Science Doctoral Program	Ph.D.
Walden University	Psy.D.

CLINICAL PSYCHOLOGY INTERNSHIPS IN VIRGINIA

PROGRAM
Counseling and Psychological Services, George Mason University
Eastern Virginia Medical School Clinical Psychology Internship
Hampton VA Psychology Predoctoral Internship Program
Health Service Psychology, U. Va.
Health Service Psychology, Va. Beach City Public Schools
McGuire VA Medical Center
Salem VA Medical Center
University Counseling Services, VCU

POST-DOCTORAL FELLOWSHIPS IN CLINICAL PSYCHOLOGY IN VIRG

McGuire VA Medical Center

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William Hathaway	Dean	willhat@regent.edu
Daniel Willingham	Director of Graduate Studies	willingham@virginia.edu
Rosalie Corona	Director of Graduate Studies	racorona@vcu.edu
Robin Lewis	Director of Clinical Training	rlewis@odu.edu
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CONTACT PERSON	TITLE	EMAIL
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Serina Neumann	Director	NeumanSA@evms.edu
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Matt Zimmerman	Assistant Director for Training	mz8u@virginia.edu
Scott M. Bell	Training Director	scott.bell@vbschools.com
Thomas Campbell	Director	Thomas.Campbell4@va.gov
Dana Holohon	Director of Training for Psychology	Dana.Holohon@va.gov
	Associate Director of Training	uccounseling@vcu.edu

;INIA

Scott M. Bell	Training Director	Thomas.Campbell4@va.gov

PHONE
1-877-884-0733
434-924-0792
703-993-1548
540-588-6439
800-373-5504
434-928-4938
804-828-8059
757-451-7733
866-924-0304

PHONE
703-993-2380
757-446-5888
757-722-9961
434-243-5150
757-263-2700
804-675-5106
540-982-2463, ext 1578
804-828-6200

804-675-5106

Consideration of any waiver of experience requirements for spouse of active duty military or veteran

VIRGINIA ACTS OF ASSEMBLY -- 2020 SESSION

CHAPTER 28

An Act to amend and reenact § 54.1-119 of the Code of Virginia, relating to professions and occupations; expediting the issuance of credentials to spouses of military service members.

[H 967]

Approved March 2, 2020

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-119 of the Code of Virginia is amended and reenacted as follows:

§ 54.1-119. Expediting the issuance of licenses, etc., to spouses of military service members; issuance of temporary licenses, etc.

A. Notwithstanding any other law to the contrary and unless an applicant is found by the board to have engaged in any act that would constitute grounds for disciplinary action, a regulatory board within the Department of Professional and Occupational Regulation or the Department of Health Professions or any other board named in this title shall expedite the issuance of a license, permit, certificate, or other document, however styled or denominated, required for the practice of any business, profession, or occupation in the Commonwealth to an applicant whose application has been deemed complete by the board and (i) who holds the same or similar license, permit, certificate, or other document required for the practice of any business, profession, or occupation issued by another jurisdiction; (ii) whose spouse is ~~the subject of a military transfer to the Commonwealth~~ *(a) on federal active duty orders pursuant to Title 10 of the United States Code or (b) a veteran, as that term is defined in § 2.2-2000.1, who has left active-duty service within one year of the submission of an application to a board*; and (iii) who accompanies the applicant's spouse to ~~Virginia~~ *the Commonwealth or an adjoining state or the District of Columbia*, if, in the opinion of the board, the requirements for the issuance of the license, permit, certificate, or other document in such other jurisdiction are substantially equivalent to those required in the Commonwealth. *A board may waive any requirement relating to experience if the board determines that the documentation provided by the applicant supports such a waiver.*

B. If a board is unable to (i) complete the review of the documentation provided by the applicant or (ii) make a final determination regarding substantial equivalency within 20 days of the receipt of a completed application, the board shall issue a temporary license, permit, or certificate, provided the applicant otherwise meets the qualifications set out in subsection A. Any temporary license, permit, or certification issued pursuant to this subsection shall be limited for a period not to exceed 12 months and shall authorize the applicant to engage in the profession or occupation while the board completes its review of the documentation provided by the applicant or the applicant completes any specific requirements that may be required in Virginia that were not required in the jurisdiction in which the applicant holds the license, permit, or certificate.

C. The provisions of this section shall apply regardless of whether a regulatory board has entered into a reciprocal agreement with the other jurisdiction pursuant to subsection B of § 54.1-103.

D. Any regulatory board may require the applicant to provide documentation it deems necessary to make a determination of substantial equivalency.

Experience requirement for licensure

18VAC125-20-41. Requirements for licensure by examination.

A. Every applicant for examination for licensure by the board shall:

1. Meet the education requirements prescribed in 18VAC125-20-54, 18VAC125-20-55, or 18VAC125-20-56 and the experience requirement prescribed in 18VAC125-20-65 as applicable for the particular license sought; and

2. Submit the following:

a. A completed application on forms provided by the board;

b. A completed residency agreement or documentation of having fulfilled the experience requirements of 18VAC125-20-65;

c. The application processing fee prescribed by the board;

d. Official transcripts documenting the graduate work completed and the degree awarded; transcripts previously submitted for registration of supervision do not have to be resubmitted unless additional coursework was subsequently obtained. Applicants who are graduates of institutions that are not regionally accredited shall submit documentation from an accrediting agency acceptable to the board that their education meets the requirements set forth in 18VAC125-20-54, 18VAC125-20-55 or 18VAC125-20-56; and

e. Verification of any other health or mental health professional license or certificate ever held in another jurisdiction.

B. In addition to fulfillment of the education and experience requirements, each applicant for licensure by examination must achieve a passing score on the Examination for Professional Practice of Psychology.

C. Every applicant shall attest to having read and agreed to comply with the current standards of practice and laws governing the practice of psychology in Virginia.

18VAC125-20-42. Prerequisites for licensure by endorsement.

Every applicant for licensure by endorsement shall submit:

1. A completed application;

2. The application processing fee prescribed by the board;

3. An attestation of having read and agreed to comply with the current Standards of Practice and laws governing the practice of psychology in Virginia;

4. Verification of all other health and mental health professional licenses or certificates ever held in any jurisdiction. In order to qualify for endorsement, the applicant shall not have surrendered a license or certificate while under investigation and shall have no unresolved action against a license or certificate;

5. A current report from the National Practitioner Data Bank; and

6. Further documentation of one of the following:

a. A current listing in the National Register of Health Service Psychologists;

b. Current diplomate status in good standing with the American Board of Professional Psychology in a category comparable to the one in which licensure is sought;

c. A Certificate of Professional Qualification in Psychology (CPQ) issued by the Association of State and Provincial Psychology Boards;

d. Ten years of active licensure in a category comparable to the one in which licensure is sought, with an appropriate degree as required in this chapter documented by an official transcript; or

e. If less than 10 years of active licensure, documentation of current psychologist licensure in good standing obtained by standards substantially equivalent to the education, experience and examination requirements set forth in this chapter for the category in which licensure is sought as verified by a certified copy of the original application submitted directly from the out-of-state licensing agency or a copy of the regulations in effect at the time of initial licensure and the following:

(1) Documentation of post-licensure active practice for at least 24 of the last sixty months immediately preceding licensure application;

(2) Verification of a passing score on the Examination for Professional Practice of Psychology as established in Virginia for the year of that administration; and

(3) Official transcripts documenting the graduate work completed and the degree awarded in the category in which licensure is sought.

Agency **Department of Health Professions**

Board **Board of Psychology**

Chapter **Regulations Governing the Certification of Sex Offender Treatment Providers [18 VAC 125 - 30]**

Edit Review Review 1900

Periodic Review of this Chapter

Includes a Small Business Impact Review

Date Filed: 2/19/2020

Review Announcement

Pursuant to Executive Order 14 (as amended July 16, 2018) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, this regulation is undergoing a periodic review.

The review of this regulation will be guided by the principles in Executive Order 14 (as amended July 16, 2018). http://TownHall.Virginia.Gov/EO-14.pdf.

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

In order for you to receive a response to your comment, your contact information (preferably an email address or, alternatively, a U.S. mailing address) must accompany your comment. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

Contact Information	
Name / Title:	Jaime Hoyle / *Executive Director*
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Publication Information and Public Comment Period

Published in the Virginia Register on 3/16/2020 [Volume: 36 Issue: 15]

Comment Period begins on the publication date and ends on 4/6/2020

Comments Received: 0

Review Result

Pending

Attorney General Certification

Consideration of Emergency regulations for implementation of Psychology Interjurisdictional Compact

VIRGINIA ACTS OF ASSEMBLY -- 2020 SESSION

CHAPTER 1162

An Act to amend the Code of Virginia by adding a section numbered 54.1-3606.2, relating to Psychology Interjurisdictional Compact.

[S 760]

Approved April 11, 2020

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 54.1-3606.2 as follows:

§ 54.1-3606.2. Psychology Interjurisdictional Compact.

ARTICLE I.

PURPOSE.

Whereas, states license psychologists, in order to protect the public through verification of education, training, and experience and ensure accountability for professional practice; and

Whereas, this Compact is intended to regulate the day-to-day practice of telepsychology (i.e., the provision of psychological services using telecommunication technologies) by psychologists across state boundaries in the performance of their psychological practice as assigned by an appropriate authority; and

Whereas, this Compact is intended to regulate the temporary in-person, face-to-face practice of psychology by psychologists across state boundaries for 30 days within a calendar year in the performance of their psychological practice as assigned by an appropriate authority; and

Whereas, this Compact is intended to authorize State Psychology Regulatory Authorities to afford legal recognition, in a manner consistent with the terms of the Compact, to psychologists licensed in another state; and

Whereas, this Compact recognizes that states have a vested interest in protecting the public's health and safety through their licensing and regulation of psychologists and that such state regulation will best protect public health and safety; and

Whereas, this Compact does not apply when a psychologist is licensed in both the Home and Receiving States; and

Whereas, this Compact does not apply to permanent in-person, face-to-face practice, it does allow for authorization of temporary psychological practice.

Consistent with these principles, this Compact is designed to achieve the following purposes and objectives:

1. Increase public access to professional psychological services by allowing for telepsychological practice across state lines, as well as temporary in-person, face-to-face services into a state in which the psychologist is not licensed to practice psychology;

2. Enhance the states' ability to protect the public's health and safety, especially client/patient safety;

3. Encourage the cooperation of Compact States in the areas of psychology licensure and regulation;

4. Facilitate the exchange of information between Compact States regarding psychologist licensure, adverse actions, and disciplinary history;

5. Promote compliance with the laws governing psychological practice in each Compact State; and

6. Invest all Compact States with the authority to hold licensed psychologists accountable through the mutual recognition of Compact State licenses.

ARTICLE II.

DEFINITIONS.

A. "Adverse Action" means any action taken by a State Psychology Regulatory Authority that finds a violation of a statute or regulation that is identified by the State Psychology Regulatory Authority as discipline and is a matter of public record.

B. "Association of State and Provincial Psychology Boards" (ASPPB) means the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities responsible for the licensure and registration of psychologists throughout the United States and Canada.

C. "Authority to Practice Interjurisdictional Telepsychology" means a licensed psychologist's authority to practice telepsychology, within the limits authorized under this Compact, in another Compact State.

D. "Bylaws" means those bylaws established by the Psychology Interjurisdictional Compact Commission pursuant to Article X for its governance, or for directing and controlling its actions and conduct.

E. "Client/Patient" means the recipient of psychological services, whether psychological services are delivered in the context of health care, corporate, supervision, and/or consulting services.

F. "Commissioner" means the voting representative appointed by each State Psychology Regulatory

Authority pursuant to Article X.

G. "Compact State" means a state, the District of Columbia, or United States territory that has enacted this Compact legislation and which has not withdrawn pursuant to Article XIII, Section C or been terminated pursuant to Article XII, Section B.

H. "Coordinated Licensure Information System," also referred to as "Coordinated Database," means an integrated process for collecting, storing, and sharing information on psychologists' licensure and enforcement activities related to psychology licensure laws, which is administered by the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

I. "Confidentiality" means the principle that data or information is not made available or disclosed to unauthorized persons and/or processes.

J. "Day" means any part of a day in which psychological work is performed.

K. "Distant State" means the Compact State where a psychologist is physically present (not through the use of telecommunications technologies) to provide temporary in-person, face-to-face psychological services.

L. "E.Passport" means a certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that promotes the standardization in the criteria of interjurisdictional telepsychology practice and facilitates the process for licensed psychologists to provide telepsychological services across state lines.

M. "Executive Board" means a group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the Commission.

N. "Home State" means a Compact State where a psychologist is licensed to practice psychology. If the psychologist is licensed in more than one Compact State and is practicing under the Authorization to Practice Interjurisdictional Telepsychology, the Home State is the Compact State where the psychologist is physically present when the telepsychological services are delivered. If the psychologist is licensed in more than one Compact State and is practicing under the Temporary Authorization to Practice, the Home State is any Compact State where the psychologist is licensed.

O. "Identity History Summary" means: a summary of information retained by the FBI, or other designee with similar authority, in connection with arrests and, in some instances, federal employment, naturalization, or military service.

P. "In-Person, Face-to-Face" means interactions in which the psychologist and the client/patient are in the same physical space and which does not include interactions that may occur through the use of telecommunication technologies.

Q. "Interjurisdictional Practice Certificate (IPC)" means a certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that grants temporary authority to practice based on notification to the State Psychology Regulatory Authority of intention to practice temporarily, and verification of one's qualifications for such practice.

R. "License" means authorization by a State Psychology Regulatory Authority to engage in the independent practice of psychology, which would be unlawful without the authorization.

S. "Non-Compact State" means any State which is not at the time a Compact State.

T. "Psychologist" means an individual licensed for the independent practice of psychology.

U. "Psychology Interjurisdictional Compact Commission" also referred to as "Commission" means the national administration of which all Compact States are members.

V. "Receiving State" means a Compact State where the client/patient is physically located when the telepsychological services are delivered.

W. "Rule" means a written statement by the Psychology Interjurisdictional Compact Commission promulgated pursuant to Article XI of the Compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the Compact, or an organizational, procedural, or practice requirement of the Commission and has the force and effect of statutory law in a Compact State, and includes the amendment, repeal or suspension of an existing rule.

X. "Significant Investigatory Information" means:

1. Investigative information that a State Psychology Regulatory Authority, after a preliminary inquiry that includes notification and an opportunity to respond if required by state law, has reason to believe, if proven true, would indicate more than a violation of state statute or ethics code that would be considered more substantial than minor infraction; or

2. Investigative information that indicates that the psychologist represents an immediate threat to public health and safety regardless of whether the psychologist has been notified and/or had an opportunity to respond.

Y. "State" means a state, commonwealth, territory, or possession of the United States.

Z. "State Psychology Regulatory Authority" means the Board, office, or other agency with the legislative mandate to license and regulate the practice of psychology.

AA. "Telepsychology" means the provision of psychological services using telecommunication technologies.

BB. "Temporary Authorization to Practice" means a licensed psychologist's authority to conduct temporary in-person, face-to-face practice, within the limits authorized under this Compact, in another

Compact State.

CC. "Temporary In-Person, Face-to-Face Practice" means where a psychologist is physically present (not through the use of telecommunications technologies) in the Distant State to provide for the practice of psychology for 30 days within a calendar year and based on notification to the Distant State.

ARTICLE III.

HOME STATE LICENSURE.

A. The Home State shall be a Compact State where a psychologist is licensed to practice psychology.

B. A psychologist may hold one or more Compact State licenses at a time. If the psychologist is licensed in more than one Compact State, the Home State is the Compact State where the psychologist is physically present when the services are delivered as authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

C. Any Compact State may require a psychologist not previously licensed in a Compact State to obtain and retain a license to be authorized to practice in the Compact State under circumstances not authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

D. Any Compact State may require a psychologist to obtain and retain a license to be authorized to practice in a Compact State under circumstances not authorized by Temporary Authorization to Practice under the terms of this Compact.

E. A Home State's license authorizes a psychologist to practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only if the Compact State:

1. Currently requires the psychologist to hold an active E.Passport;

2. Has a mechanism in place for receiving and investigating complaints about licensed individuals;

3. Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

4. Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI), or other designee with similar authority, no later than 10 years after activation of the Compact; and

5. Complies with the Bylaws and Rules of the Commission.

F. A Home State's license grants Temporary Authorization to Practice to a psychologist in a Distant State only if the Compact State:

1. Currently requires the psychologist to hold an active IPC;

2. Has a mechanism in place for receiving and investigating complaints about licensed individuals;

3. Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

4. Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the FBI, or other designee with similar authority, no later than 10 years after activation of the Compact; and

5. Complies with the Bylaws and Rules of the Commission.

ARTICLE IV.

COMPACT PRIVILEGE TO PRACTICE TELEPSYCHOLOGY.

A. Compact States shall recognize the right of a psychologist, licensed in a Compact State in conformance with Article III, to practice telepsychology in other Compact States (Receiving States) in which the psychologist is not licensed, under the Authority to Practice Interjurisdictional Telepsychology as provided in the Compact.

B. To exercise the Authority to Practice Interjurisdictional Telepsychology under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

1. Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or

b. A foreign college or university deemed to be equivalent to 1 a by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and

2. Hold a graduate degree in psychology that meets the following criteria:

a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;

e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

f. The designated director of the program must be a psychologist and a member of the core faculty;

g. The program must have an identifiable body of students who are matriculated in that program for a degree;

h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;

i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degree and a minimum of one academic year of full-time graduate study for master's degree; and

j. The program includes an acceptable residency as defined by the Rules of the Commission;

3. Possess a current, full, and unrestricted license to practice psychology in a Home State which is a Compact State;

4. Have no history of adverse action that violate the Rules of the Commission;

5. Have no criminal record history reported on an Identity History Summary that violates the Rules of the Commission;

6. Possess a current, active E.Passport;

7. Provide attestations in regard to areas of intended practice, conformity with standards of practice, competence in telepsychology technology; criminal background; and knowledge and adherence to legal requirements in the home and receiving states, and provide a release of information to allow for primary source verification in a manner specified by the Commission; and

8. Meet other criteria as defined by the Rules of the Commission.

C. The Home State maintains authority over the license of any psychologist practicing into a Receiving State under the Authority to Practice Interjurisdictional Telepsychology.

D. A psychologist practicing into a Receiving State under the Authority to Practice Interjurisdictional Telepsychology will be subject to the Receiving State's scope of practice. A Receiving State may, in accordance with that state's due process law, limit or revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology in the Receiving State and may take any other necessary actions under the Receiving State's applicable law to protect the health and safety of the Receiving State's citizens. If a Receiving State takes action, the state shall promptly notify the Home State and the Commission.

E. If a psychologist's license in any Home State, another Compact State, or any Authority to Practice Interjurisdictional Telepsychology in any Receiving State, is restricted, suspended or otherwise limited, the E.Passport shall be revoked and therefore the psychologist shall not be eligible to practice telepsychology in a Compact State under the Authority to Practice Interjurisdictional Telepsychology.

ARTICLE V.

COMPACT TEMPORARY AUTHORIZATION TO PRACTICE.

A. Compact States shall also recognize the right of a psychologist, licensed in a Compact State in conformance with Article III, to practice temporarily in other Compact States (Distant States) in which the psychologist is not licensed, as provided in the Compact.

B. To exercise the Temporary Authorization to Practice under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

1. Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, OR authorized by Provincial Statute or Royal Charter to grant doctoral degrees; OR

b. A foreign college or university deemed to be equivalent to 1 a above by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; AND

2. Hold a graduate degree in psychology that meets the following criteria:

a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;

e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

f. The designated director of the program must be a psychologist and a member of the core faculty;

g. The program must have an identifiable body of students who are matriculated in that program for a degree;

h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;

i. The curriculum shall encompass a minimum of three academic years of full- time graduate study for doctoral degrees and a minimum of one academic year of full-time graduate study for master's degrees;

j. The program includes an acceptable residency as defined by the Rules of the Commission;

3. Possess a current, full, and unrestricted license to practice psychology in a Home State which is a Compact State;

4. No history of adverse action that violate the Rules of the Commission;

5. No criminal record history that violates the Rules of the Commission;

6. Possess a current, active IPC;

7. Provide attestations in regard to areas of intended practice and work experience and provide a release of information to allow for primary source verification in a manner specified by the Commission; and

8. Meet other criteria as defined by the Rules of the Commission.

C. A psychologist practicing into a Distant State under the Temporary Authorization to Practice shall practice within the scope of practice authorized by the Distant State.

D. A psychologist practicing into a Distant State under the Temporary Authorization to Practice will be subject to the Distant State's authority and law. A Distant State may, in accordance with that state's due process law, limit or revoke a psychologist's Temporary Authorization to Practice in the Distant State and may take any other necessary actions under the Distant State's applicable law to protect the health and safety of the Distant State's citizens. If a Distant State takes action, the state shall promptly notify the Home State and the Commission.

E. If a psychologist's license in any Home State, another Compact State, or any Temporary Authorization to Practice in any Distant State, is restricted, suspended or otherwise limited, the IPC shall be revoked and therefore the psychologist shall not be eligible to practice in a Compact State under the Temporary Authorization to Practice.

ARTICLE VI.

CONDITIONS OF TELEPSYCHOLOGY PRACTICE IN A RECEIVING STATE.

A. A psychologist may practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only in the performance of the scope of practice for psychology as assigned by an appropriate State Psychology Regulatory Authority, as defined in the Rules of the Commission, and under the following circumstances:

1. The psychologist initiates a client/patient contact in a Home State via telecommunications technologies with a client/patient in a Receiving State;

2. Other conditions regarding telepsychology as determined by Rules promulgated by the Commission.

ARTICLE VII.

ADVERSE ACTIONS.

A. A Home State shall have the power to impose adverse action against a psychologist's license issued by the Home State. A Distant State shall have the power to take adverse action on a psychologist's Temporary Authorization to Practice within that Distant State.

B. A Receiving State may take adverse action on a psychologist's Authority to Practice Interjurisdictional Telepsychology within that Receiving State. A Home State may take adverse action against a psychologist based on an adverse action taken by a Distant State regarding temporary in-person, face-to-face practice.

C. If a Home State takes adverse action against a psychologist's license, that psychologist's Authority to Practice Interjurisdictional Telepsychology is terminated and the E.Passport is revoked. Furthermore, that psychologist's Temporary Authorization to Practice is terminated and the IPC is revoked.

1. All Home State disciplinary orders that impose adverse action shall be reported to the Commission in accordance with the Rules promulgated by the Commission. A Compact State shall report adverse actions in accordance with the Rules of the Commission.

2. In the event discipline is reported on a psychologist, the psychologist will not be eligible for telepsychology or temporary in-person, face-to-face practice in accordance with the Rules of the Commission.

3. Other actions may be imposed as determined by the Rules promulgated by the Commission.

D. A Home State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a licensee which occurred in a Receiving State as it would if such conduct had occurred by a licensee within the Home State. In such cases, the Home State's law shall control in determining any adverse action against a psychologist's license.

E. A Distant State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a psychologist practicing under Temporary Authorization Practice that occurred in that Distant State as it would if such conduct had occurred by a licensee within the Home State. In such cases, Distant State's law shall control in

determining any adverse action against a psychologist's Temporary Authorization to Practice.

F. Nothing in this Compact shall override a Compact State's decision that a psychologist's participation in an alternative program may be used in lieu of adverse action and that such participation shall remain non-public if required by the Compact State's law. Compact States must require psychologists who enter any alternative programs to not provide telepsychology services under the Authority to Practice Interjurisdictional Telepsychology or provide temporary psychological services under the Temporary Authorization to Practice in any other Compact State during the term of the alternative program.

G. No other judicial or administrative remedies shall be available to a psychologist in the event a Compact State imposes an adverse action pursuant to subsection C.

ARTICLE VIII.

ADDITIONAL AUTHORITIES INVESTED IN A COMPACT STATE'S PSYCHOLOGY REGULATORY AUTHORITY.

A. In addition to any other powers granted under state law, a Compact State's Psychology Regulatory Authority shall have the authority under this Compact to:

1. Issue subpoenas, for both hearings and investigations, which require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a Compact State's Psychology Regulatory Authority for the attendance and testimony of witnesses, and/or the production of evidence from another Compact State shall be enforced in the latter state by any court of competent jurisdiction, according to that court's practice and procedure in considering subpoenas issued in its own proceedings. The issuing State Psychology Regulatory Authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state where the witnesses and/or evidence are located; and

2. Issue cease and desist and/or injunctive relief orders to revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice.

B. During the course of any investigation, a psychologist may not change his Home State licensure. A Home State Psychology Regulatory Authority is authorized to complete any pending investigations of a psychologist and to take any actions appropriate under its law. The Home State Psychology Regulatory Authority shall promptly report the conclusions of such investigations to the Commission. Once an investigation has been completed, and pending the outcome of said investigation, the psychologist may change his Home State licensure. The Commission shall promptly notify the new Home State of any such decisions as provided in the Rules of the Commission. All information provided to the Commission or distributed by Compact States pursuant to the psychologist shall be confidential, filed under seal and used for investigatory or disciplinary matters. The Commission may create additional rules for mandated or discretionary sharing of information by Compact States.

ARTICLE IX.

COORDINATED LICENSURE INFORMATION SYSTEM.

A. The Commission shall provide for the development and maintenance of a Coordinated Licensure Information System (Coordinated Database) and reporting system containing licensure and disciplinary action information on all psychologists individuals to whom this Compact is applicable in all Compact States as defined by the Rules of the Commission.

B. Notwithstanding any other provision of state law to the contrary, a Compact State shall submit a uniform data set to the Coordinated Database on all licensees as required by the Rules of the Commission, including:

1. Identifying information;

2. Licensure data;

3. Significant investigatory information;

4. Adverse actions against a psychologist's license;

5. An indicator that a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice is revoked;

6. Non-confidential information related to alternative program participation information;

7. Any denial of application for licensure, and the reasons for such denial; and

8. Other information that may facilitate the administration of this Compact, as determined by the Rules of the Commission.

C. The Coordinated Database administrator shall promptly notify all Compact States of any adverse action taken against, or significant investigative information on, any licensee in a Compact State.

D. Compact States reporting information to the Coordinated Database may designate information that may not be shared with the public without the express permission of the Compact State reporting the information.

E. Any information submitted to the Coordinated Database that is subsequently required to be expunged by the law of the Compact State reporting the information shall be removed from the Coordinated Database.

ARTICLE X.

ESTABLISHMENT OF THE PSYCHOLOGY INTERJURISDICTIONAL COMPACT COMMISSION.

A. The Compact States hereby create and establish a joint public agency known as the Psychology Interjurisdictional Compact Commission.

1. The Commission is a body politic and an instrumentality of the Compact States.

2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

B. Membership, Voting, and Meetings.

1. The Commission shall consist of one voting representative appointed by each Compact State who shall serve as that state's Commissioner. The State Psychology Regulatory Authority shall appoint its delegate. This delegate shall be empowered to act on behalf of the Compact State. This delegate shall be limited to:

a. Executive Director, Executive Secretary or similar executive;

b. Current member of the State Psychology Regulatory Authority of a Compact State; OR

c. Designee empowered with the appropriate delegate authority to act on behalf of the Compact State.

2. Any Commissioner may be removed or suspended from office as provided by the law of the state from which the Commissioner is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compact State in which the vacancy exists.

3. Each Commissioner shall be entitled to one (1) vote with regard to the promulgation of Rules and creation of Bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. A Commissioner shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Commissioners' participation in meetings by telephone or other means of communication.

4. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

5. All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in Article XI.

6. The Commission may convene in a closed, non-public meeting if the Commission must discuss:

a. Non-compliance of a Compact State with its obligations under the Compact;

b. The employment, compensation, discipline or other personnel matters, or practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

c. Current, threatened, or reasonably anticipated litigation against the Commission;

d. Negotiation of contracts for the purchase or sale of goods, services, or real estate;

e. Accusation against any person of a crime or formally censuring any person;

f. Disclosure of trade secrets or commercial or financial information which is privileged or confidential;

g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

h. Disclosure of investigatory records compiled for law-enforcement purposes;

i. Disclosure of information related to any investigatory reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility for investigation or determination of compliance issues pursuant to the Compact; or

j. Matters specifically exempted from disclosure by federal and state statute.

7. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes which fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, of any person participating in the meeting, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release only by a majority vote of the Commission or order of a court of competent jurisdiction.

C. The Commission shall, by a majority vote of the Commissioners, prescribe Bylaws and/or Rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the Compact, including but not limited to:

1. Establishing the fiscal year of the Commission;

2. Providing reasonable standards and procedures:

a. For the establishment and meetings of other committees; and

b. Governing any general or specific delegation of any authority or function of the Commission;

3. Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of

individuals of such proceedings, and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the Commissioners vote to close a meeting to the public in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each Commissioner with no proxy votes allowed;

4. Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the Commission;

5. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar law of any Compact State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

6. Promulgating a Code of Ethics to address permissible and prohibited activities of Commission members and employees;

7. Providing a mechanism for concluding the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations;

8. The Commission shall publish its Bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the Compact States;

9. The Commission shall maintain its financial records in accordance with the Bylaws; and

10. The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

D. The Commission shall have the following powers:

1. The authority to promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rule shall have the force and effect of law and shall be binding in all Compact States;

2. To bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any State Psychology Regulatory Authority or other regulatory body responsible for psychology licensure to sue or be sued under applicable law shall not be affected;

3. To purchase and maintain insurance and bonds;

4. To borrow, accept or contract for services of personnel, including, but not limited to, employees of a Compact State;

5. To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and to establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

6. To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the Commission shall strive to avoid any appearance of impropriety and/or conflict of interest;

7. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or mixed; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

8. To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property real, personal or mixed;

9. To establish a budget and make expenditures;

10. To borrow money;

11. To appoint committees, including advisory committees comprised of Members, State regulators, State legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the Bylaws;

12. To provide and receive information from, and to cooperate with, law enforcement agencies;

13. To adopt and use an official seal; and

14. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of psychology licensure, temporary in-person, face-to-face practice and telepsychology practice.

E. The Executive Board.

1. The elected officers shall serve as the Executive Board, which shall have the power to act on behalf of the Commission according to the terms of this Compact. The Executive Board shall be comprised of six members:

a. Five voting members who are elected from the current membership of the Commission by the Commission;

b. One ex-officio, nonvoting member from the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

2. The ex-officio member must have served as staff or member on a State Psychology Regulatory Authority and will be selected by its respective organization.

3. The Commission may remove any member of the Executive Board as provided in Bylaws.

4. The Executive Board shall meet at least annually.

5. The Executive Board shall have the following duties and responsibilities:

a. Recommend to the entire Commission changes to the Rules or Bylaws, changes to this Compact legislation, fees paid by Compact States such as annual dues, and any other applicable fees;

b. Ensure Compact administration services are appropriately provided, contractual or otherwise;

c. Prepare and recommend the budget;

d. Maintain financial records on behalf of the Commission;

e. Monitor Compact compliance of member states and provide compliance reports to the Commission;

f. Establish additional committees as necessary; and

g. Other duties as provided in Rules or Bylaws.

F. Financing of the Commission.

1. The Commission shall pay, or provide for the payment of the reasonable expenses of its establishment, organization, and ongoing activities.

2. The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

3. The Commission may levy on and collect an annual assessment from each Compact State or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission which shall promulgate a rule binding upon all Compact States.

4. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any of the Compact States, except by and with the authority of the Compact State. 5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its Bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant and the report of the audit shall be included in and become part of the annual report of the Commission.

G. Qualified Immunity, Defense, and Indemnification..

1. The members, officers, Executive Director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury or liability caused by the intentional or willful or wanton misconduct of that person.

2. The Commission shall defend any member, officer, Executive Director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error or omission did not result from that person's intentional or willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any member, officer, Executive Director, employee or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, provided that the actual or alleged act, error or omission did not result from the intentional or willful or wanton misconduct of that person.

ARTICLE XI.
RULEMAKING.

A. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in this Article and the Rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

B. If a majority of the legislatures of the Compact States rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact, then such rule shall have no further force and effect in any Compact State.

C. Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

D. Prior to promulgation and adoption of a final rule or Rules by the Commission, and at least 60 days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a Notice of Proposed Rulemaking:

1. On the website of the Commission; and

2. On the website of each Compact States' Psychology Regulatory Authority or the publication in which each state would otherwise publish proposed rules.

E. The Notice of Proposed Rulemaking shall include:

1. The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;

2. The text of the proposed rule or amendment and the reason for the proposed rule;

3. A request for comments on the proposed rule from any interested person; and

4. The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

F. Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions and arguments, which shall be made available to the public.

G. The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

1. At least 25 persons who submit comments independently of each other;

2. A governmental subdivision or agency; or

3. A duly-appointed person in an association that has having at least 25 members.

H. If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing.

1. All persons wishing to be heard at the hearing shall notify the Executive Director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not fewer than five business days before the scheduled date of the hearing.

2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

3. No transcript of the hearing is required, unless a written request for a transcript is made, in which case the person requesting the transcript shall bear the cost of producing the transcript. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. This subsection shall not preclude the Commission from making a transcript or recording of the hearing if it so chooses.

4. Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

I. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

J. The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

K. If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

L. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety, or welfare;

2. Prevent a loss of Commission or Compact State funds;

3. Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or

4. Protect public health and safety.

M. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing, and delivered to the Chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

ARTICLE XII.

OVERSIGHT, DISPUTE RESOLUTION AND ENFORCEMENT.

A. Oversight.

1. The executive, legislative, and judicial branches of state government in each Compact State shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder shall have

standing as statutory law.

2. All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a Compact State pertaining to the subject matter of this Compact which may affect the powers, responsibilities or actions of the Commission.

3. The Commission shall be entitled to receive service of process in any such proceeding, and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact or promulgated rules.

B. Default, Technical Assistance, and Termination.

1. If the Commission determines that a Compact State has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:

a. Provide written notice to the defaulting state and other Compact States of the nature of the default, the proposed means of remedying the default and/or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

2. If a state in default fails to remedy the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the Compact States, and all rights, privileges and benefits conferred by this Compact shall be terminated on the effective date of termination. A remedy of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

3. Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be submitted by the Commission to the Governor, the majority and minority leaders of the defaulting state's legislature, and each of the Compact States.

4. A Compact State which has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations which extend beyond the effective date of termination.

5. The Commission shall not bear any costs incurred by the state which is found to be in default or which has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting state.

6. The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the state of Georgia or the federal district where the Compact has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorney's fees.

C. Dispute Resolution.

1. Upon request by a Compact State, the Commission shall attempt to resolve disputes related to the Compact which arise among Compact States and between Compact and Non-Compact States. 2. The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes that arise before the commission.

D. Enforcement.

1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and Rules of this Compact.

2. By majority vote, the Commission may initiate legal action in the United States District Court for the State of Georgia or the federal district where the Compact has its principal offices against a Compact State in default to enforce compliance with the provisions of the Compact and its promulgated Rules and Bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorney's fees.

3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

ARTICLE XIII.

DATE OF IMPLEMENTATION OF THE PSYCHOLOGY INTERJURISDICTIONAL COMPACT COMMISSION AND ASSOCIATED RULES, WITHDRAWAL, AND AMENDMENTS.

A. The Compact shall come into effect on the date on which the Compact is enacted into law in the seventh Compact State. The provisions which become effective at that time shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rulemaking powers necessary to the implementation and administration of the Compact.

B. Any state which joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any rule which has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

C. Any Compact State may withdraw from this Compact by enacting a statute repealing the same.

1. A Compact State's withdrawal shall not take effect until six months after enactment of the repealing statute.

2. Withdrawal shall not affect the continuing requirement of the withdrawing State's Psychology Regulatory Authority to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

D. Nothing contained in this Compact shall be construed to invalidate or prevent any psychology licensure agreement or other cooperative arrangement between a Compact State and a Non-Compact State which does not conflict with the provisions of this Compact.

E. This Compact may be amended by the Compact States. No amendment to this Compact shall become effective and binding upon any Compact State until it is enacted into the law of all Compact States.

ARTICLE XIV.
CONSTRUCTION AND SEVERABILITY.

This Compact shall be liberally construed so as to effectuate the purposes thereof. If this Compact shall be held contrary to the constitution of any state member thereto, the Compact shall remain in full force and effect as to the remaining Compact States.

2. That the Board of Psychology shall promulgate regulations to implement the provisions of this act to be effective within 280 days of its enactment.

3. That the provisions of this act shall become effective on January 1, 2021.

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Project 6421 - none

BOARD OF PSYCHOLOGY

Implementing PsyPact

Part I

General Provisions

18VAC125-20-10. Definitions.

The following words and terms, in addition to the words and terms defined in § §§ 54.1-3600 and 54.1-3606.2 of the Code of Virginia, when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

"APA" means the American Psychological Association.

"ASPPB" means the Association of State and Provincial Psychology Boards.

"APPIC" means the Association of Psychology Postdoctoral and Internship Centers.

"Board" means the Virginia Board of Psychology.

"Candidate for licensure" means a person who has satisfactorily completed the appropriate educational and experience requirements for licensure and has been deemed eligible by the board to sit for the required examinations.

"Compact" means the Psychology Interjurisdictional Compact.

"Demonstrable areas of competence" means those therapeutic and assessment methods and techniques, and populations served, for which one can document adequate graduate training, workshops, or appropriate supervised experience.

"E.Passport" means a certificate issued by ASPPB that authorizes telepsychology services in a Compact state.

"Internship" means an ongoing, supervised and organized practical experience obtained in an integrated training program identified as a psychology internship. Other supervised experience or on-the-job training does not constitute an internship.

"IPC" means an interjurisdictional practice certification issued by ASPPB that grants temporary authority to practice in a Compact state.

"NASP" means the National Association of School Psychologists.

"NCATE" means the National Council for the Accreditation of Teacher Education.

"Practicum" means the pre-internship clinical experience that is part of a graduate educational program.

"Professional psychology program" means an integrated program of doctoral study designed to train professional psychologists to deliver services in psychology.

"Regional accrediting agency" means one of the six regional accrediting agencies recognized by the United States Secretary of Education established to accredit senior institutions of higher education.

"Residency" means a post-internship, post-terminal degree, supervised experience approved by the board.

"School psychologist-limited" means a person licensed pursuant to § 54.1-3606 of the Code of Virginia to provide school psychology services solely in public school divisions.

"Supervision" means the ongoing process performed by a supervisor who monitors the performance of the person supervised and provides regular, documented individual consultation, guidance and instruction with respect to the skills and competencies of the person supervised.

"Supervisor" means an individual who assumes full responsibility for the education and training activities of a person and provides the supervision required by such a person.

Part VI

Standards of Practice; Unprofessional Conduct; Disciplinary Actions; Reinstatement

18VAC125-20-150. Standards of practice.

A. The protection of the public health, safety, and welfare and the best interest of the public shall be the primary guide in determining the appropriate professional conduct of all persons whose activities are regulated by the board. Psychologists respect the rights, dignity and worth of all people, and are mindful of individual differences.

B. Persons licensed by the board and persons practicing in Virginia with an E.Passport or an IPC shall:

1. Provide and supervise only those services and use only those techniques for which they are qualified by training and appropriate experience. Delegate to their employees, supervisees, residents and research assistants only those responsibilities such persons can be expected to perform competently by education, training and experience. Take ongoing steps to maintain competence in the skills they use;

2. When making public statements regarding credentials, published findings, directory listings, curriculum vitae, etc., ensure that such statements are neither fraudulent nor misleading;

3. Neither accept nor give commissions, rebates or other forms of remuneration for referral of clients for professional services. Make appropriate consultations and referrals consistent with the law and based on the interest of patients or clients;

4. Refrain from undertaking any activity in which their personal problems are likely to lead to inadequate or harmful services;

5. Avoid harming patients or clients, research participants, students and others for whom they provide professional services and minimize harm when it is foreseeable and unavoidable. Not exploit or mislead people for whom they provide professional services. Be alert to and guard against misuse of influence;

6. Avoid dual relationships with patients, clients, residents or supervisees that could impair professional judgment or compromise their well-being (to include but not limited to treatment of close friends, relatives, employees);

7. Withdraw from, adjust or clarify conflicting roles with due regard for the best interest of the affected party or parties and maximal compliance with these standards;

8. Not engage in sexual intimacies or a romantic relationship with a student, supervisee, resident, therapy patient, client, or those included in collateral therapeutic services (such as a parent, spouse, or significant other) while providing professional services. For at least five years after cessation or termination of professional services, not engage in sexual intimacies or a romantic relationship with a therapy patient, client, or those included in collateral therapeutic services. Consent to, initiation of, or participation in sexual behavior or romantic involvement with a psychologist does not change the exploitative nature of the conduct nor lift the prohibition. Since sexual or romantic relationships are potentially exploitative, psychologists shall bear the burden of demonstrating that there has been no exploitation;

9. Keep confidential their professional relationships with patients or clients and disclose client records to others only with written consent except: (i) when a patient or client is a danger to self or others, (ii) as required under § 32.1-127.1:03 of the Code of Virginia, or (iii) as permitted by law for a valid purpose;

10. Make reasonable efforts to provide for continuity of care when services must be interrupted or terminated;

11. Inform clients of professional services, fees, billing arrangements and limits of confidentiality before rendering services. Inform the consumer prior to the use of collection agencies or legal measures to collect fees and provide opportunity for prompt payment. Avoid bartering goods and services. Participate in bartering only if it is not clinically contraindicated and is not exploitative;

12. Construct, maintain, administer, interpret and report testing and diagnostic services in a manner and for purposes which are appropriate;

13. Keep pertinent, confidential records for at least five years after termination of services to any consumer;

14. Design, conduct and report research in accordance with recognized standards of scientific competence and research ethics; and

15. Report to the board known or suspected violations of the laws and regulations governing the practice of psychology.

18VAC125-20-160. Grounds for disciplinary action or denial of licensure.

The board may take disciplinary action or deny a license or authorization to practice in Virginia with an E.Passport or an IPC for any of the following causes:

1. Conviction of a felony, or a misdemeanor involving moral turpitude;

2. Procuring of a license by fraud or misrepresentation;

3. Misuse of drugs or alcohol to the extent that it interferes with professional functioning;

4. Negligence in professional conduct or violation of practice standards including but not limited to this chapter;

5. Performing functions outside areas of competency;

6. Mental, emotional, or physical incompetence to practice the profession;

7. Failure to comply with the continued competency requirements set forth in this chapter; or

8. Violating or aiding and abetting another to violate any statute applicable to the practice of the profession regulated or any provision of this chapter.

Continuing education requirements – Consideration of amendment or waivers to permit unlimited on-line CE

Law and Regulation on Continuing Education

§ 54.1-3606.1. Continuing education.

A. The Board shall promulgate regulations governing continuing education requirements for psychologists licensed by the Board. Such regulations shall require the completion of the equivalent of 14 hours annually in Board-approved continuing education courses for any license renewal or reinstatement after the effective date.

B. The Board shall include in its regulations governing continuing education requirements for licensees a provision allowing a licensee who completes continuing education hours in excess of the hours required by subsection A to carry up to seven hours of continuing education credit forward to meet the requirements of subsection A for the next annual renewal cycle.

C. The Board shall approve criteria for continuing education courses that are directly related to the respective license and scope of practice of school psychology, applied psychology and clinical psychology. Approved continuing education courses for clinical psychologists shall emphasize, but not be limited to, the diagnosis, treatment and care of patients with moderate and severe mental disorders. Any licensed hospital, accredited institution of higher education, or national, state or local health, medical, psychological or mental health association or organization may submit applications to the Board for approval as a provider of continuing education courses satisfying the requirements of the Board's regulations. Approved course providers may be required to register continuing education courses with the Board pursuant to Board regulations. Only courses meeting criteria approved by the Board and offered by a Board-approved provider of continuing education courses may be designated by the Board as qualifying for continuing education course credit.

D. All course providers shall furnish written certification to licensed psychologists attending and completing respective courses, indicating the satisfactory completion of an approved continuing education course. Each course provider shall retain records of all persons attending and those persons satisfactorily completing such continuing education courses for a period of four years following each course. Applicants for renewal or reinstatement of licenses issued pursuant to this article shall retain for a period of four years the written certification issued by any course provider. The Board may require course providers or licensees to submit copies of such records or certification, as it deems necessary to ensure compliance with continuing education requirements.

E. The Board shall have the authority to grant exemptions or waivers or to reduce the number of continuing education hours required in cases of certified illness or undue hardship.
2000, c. 83; 2015, c. 359.

18VAC125-20-121. Continuing education course requirements for renewal of an active license.

A. Licensees shall be required to have completed a minimum of 14 hours of board-approved continuing education courses each year for annual licensure renewal. A minimum of 1.5 of these hours shall be in courses that emphasize the ethics, laws, and regulations governing the profession of psychology, including the standards of practice set out in 18VAC125-20-150. A licensee who completes continuing education hours in excess of the 14 hours may carry up to seven hours of continuing education credit forward to meet the requirements for the next annual renewal cycle.

B. For the purpose of this section, "course" means an organized program of study, classroom experience or similar educational experience that is directly related to the practice of psychology and is provided by a board-approved provider that meets the criteria specified in 18VAC125-20-122.

1. At least six of the required hours shall be earned in face-to-face or real-time interactive educational experiences. Real-time interactive shall include a course in which the learner has the opportunity to interact with the presenter and participants during the time of the presentation.

2. The board may approve up to four hours per renewal cycle for specific educational experiences to include:

a. Preparation for or presentation of a continuing education program, seminar, workshop or course offered by an approved provider and directly related to the practice of psychology. Hours may only be credited one time, regardless of the number of times the presentation is given, and may not be credited toward the face-to-face requirement.

b. Publication of an article or book in a recognized publication directly related to the practice of psychology. Hours may only be credited one time, regardless of the number of times the writing is published, and may not be credited toward the face-to-face requirement.

3. The board may approve up to two hours per renewal cycle for membership on a state licensing board in psychology.

C. Courses must be directly related to the scope of practice in the category of licensure held. Continuing education courses for clinical psychologists shall emphasize, but not be limited to, the diagnosis, treatment and care of patients with moderate and severe mental disorders.

D. The board may grant an extension for good cause of up to one year for the completion of continuing education requirements upon written request from the licensee prior to the renewal date. Such extension shall not relieve the licensee of the continuing education requirement.

E. The board may grant an exemption for all or part of the continuing education requirements for one renewal cycle due to circumstances determined by the board to be beyond the control of the licensee.

ASPPB

Association of State and Provincial Psychology Boards

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ASPPB Social Media Task Force (SMTF)

Guidelines for the Use of Social Media by
Psychologists in Practice and by Psychology Regulatory Bodies
March 10, 2020

Table of Contents

Executive Summary 0
Jurisdictional Social Media Survey 2
Social Media Standards and Guidelines Literature Review 8
Legislation 9
Ethics and Social Media 9
Personal Use of Social Media 14
ASPPB Social Media Guidelines 15
References 19
APPENDIX A – Glossary of Terms 22
APENDIX B – Literature Re: Social Media Guidelines and Standards 25
APPENDIX C – Statutes, Regulations or Policies Adopted in U.S. Jurisdictions 46
APPENDIX D – Statutes, Regulations or Policies Adopted in Canadian Jurisdictions 54
APPENDIX E – Codes Relevant to Social Media Use 55
APPENDIX F – Example of Informed Consent Disclaimer 56
APPENDIX G – Sample of Social Media Policy 57
APPENDIX H – Social Media Vignettes 59

DRAFT

Executive Summary

Social media use is increasingly commonplace in professional psychological practice. Appropriate use of this modality can enhance a practice and benefit the public in multiple ways, such as increasing access to qualified psychological practitioners, potentially reducing overall cost of service delivery, and providing another mode of service delivery for those who are reticent to attend in person. The potential also exists, however, for harm to occur when members of the profession are not aware of their ethical responsibilities in delivering services via social media. Regulators must be prepared to address concerns that arise from social media use by their licensees. Currently there is limited guidance available to psychology regulators about how to regulate the use of social media by their licensees. This white paper addresses the current state of the regulation of social media use by the profession, reviews current health professional social media standards, guidelines and regulations, and provides guidelines and recommendations for social media regulation by psychology regulators.

In the fall of 2017, the Board of Directors of the Association of State and Provincial Psychology Boards (ASPPB) approved the creation of the Social Media Task Force (SMTF) with the following charges:

1. Survey of the membership in regard to issues, needs and concerns related to social media and the use of it by psychologists.
2. Consideration of the literature on social media, in particular issues that need to be considered in developing guidelines and regulatory language.
3. Consideration of Codes of Ethics (APA/CPA), APA/CPA practice guidelines, practice guidelines developed by other health professions/organizations, and relevant legislation.
4. Creation of a background report identifying the literature, issues, concerns, needs and recommendations.
5. Creation of guidelines for jurisdictions in regard to the use of social media by psychologists.
6. Recommendations/consideration of regulatory language.

The SMFT members appointed initially were Kenneth Drude, PhD (OH); Jamie Hopkins, PhD (KY); Sara Ledgerwood, J.D. (MO); and Karen Messer-Engel, M.A., Registered Psychologist (SK), Chair. Linda Nishi-Strattner, PhD (OR) joined the SMTF in 2019 in place of Sarah Ledgerwood who had to step down. The Task Force was very ably staffed by Jacqueline Horn, PhD, ASPPB Director of Educational Affairs, Stacey Camp, ASPPB Member Relations Coordinator, and Emily Hensler, ASPPB PLUS Coordinator. The SMFT began its work in the summer of 2018.

A survey of Regulatory Boards and Colleges in Canada and the United States was conducted by the SMFT in July 2018 to determine the scope of concern for regulators, the specific areas of their concern, what would be helpful for them in addressing social media issues/ concerns, and to gather information about the use of social media by them in their own work. A 44% response rate was obtained (28/64 jurisdictions). Regulators indicated that they had been

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receiving increasing numbers of queries and complaints that included social media use by licensees as an element of that communication (58% of respondents had received such queries/complaints). The areas of greatest concern identified were confidentiality, security, appropriate boundaries, and record keeping. The concerns identified pointed to the need for guidance for licensees about appropriate practices when using social media, as well as the need for guidelines that would assist regulators in educating their licensees and adjudicating complaints. The survey also noted that regulators have been slow to adopt social media in their own work. Information about social media options and guidance about possible pitfalls with social media use is needed.

There is a dearth of literature specific to the use of social media in psychological practice; however, other professions are ahead of psychology in addressing the issues that arise with the use of social media in professional practice. The SMFT examined the available literature, and many important lessons taken from the work carried out by other professions have been incorporated into these *Guidelines*. The ASPPB Code of Conduct and the Canadian and American Psychological Associations' ethical codes were also considered in the development of these *Guidelines*. It was apparent that, while there are some unique considerations for the use of social media in practice (e.g., competency in the use of the modality, appropriateness to the client), the ethical requirements for using this modality are generally no different than they are for face-to-face practice and connection with clients. This White Paper also explored personal social media use by licensees, an area not typically viewed as being within the jurisdiction of the regulator. The SMFT determined that it was important to address this issue since, in our view it becomes a regulatory issue when personal social media use intersects with a professional's practice (e.g., "friending" clients). With the increasing complexity and number of social media platforms available for communication, it is anticipated that there will increasingly be a blurring of boundaries between professional and personal use, and regulators will be called upon to address this.

Legislation specific to the regulation of social media use by the profession appears to be largely limited to the practice of telepsychology or telehealth and does not typically address all of the other possibilities of social media use. This White Paper does not provide recommended regulatory language; however, the SMTF recommends that ASPPB consider the development of model regulatory language that addresses the regulation of social media use that could be added to the model regulatory language for the practice of telepsychology.

In conclusion, this White Paper provides specific guidelines for the use of social media by psychologists in their professional practice as well as in their personal use of social media and offers guidance to regulators when disciplining psychologists because of inappropriate or unethical social media use. The *Guidelines* are aligned with the ASPPB Code of Conduct and the Canadian and American Psychological Associations' codes of ethics, and with best practices identified in the current literature. Member jurisdictions are encouraged to consider adoption of these *Guidelines* for their use in regulating the profession.

(See **Appendix A** for Glossary of Terms)

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Jurisdictional Social Media Survey

In exploring the issue of social media use by psychologists and how to address its regulation, the SMTF conducted a jurisdictional survey of psychology regulators in Canada and the U.S. to identify regulator concerns about the uses of social media by licensees and to learn what would be of most assistance in helping them address such issues. A secondary purpose was to examine the current uses of social media by boards and colleges with the goal of providing useful information about how they might most effectively use social media in their regulatory efforts.

In July 2018 an online survey was sent to all ASPPB member jurisdictions. Responses were collected between July and August 2018. Responses were received from 28 (44%) of ASPPB's 64 member jurisdictions. Approximately 64% percent of Canadian regulatory jurisdictions (7/11) and 39% (21/54) percent of U.S. jurisdictions responded to the survey. Responses were received from a total of 38 individuals with some jurisdictions having more than one respondent. The respondents were diverse and included registrars/board administrators, licensed and public board members, enforcement representatives, administrative personnel, and legal counsel. Those who deal directly with regulation and enforcement (i.e., administrators, administrative personnel, legal counsel, and enforcement representatives) were well represented among the respondents (approximately 57% of the respondents).

The survey questions were as follows:

- Q1 What is your jurisdiction?

- Q2 What is your role in your Board / College?

- Q3 Does your Board / College use any of the following forms of media/telecommunication? Check all that apply.
    - Web Conferencing
    - Live Streaming of Meetings
    - Email
    - Twitter
    - Facebook
    - YouTube
    - Listserv
    - Website
    - Other (please specify)

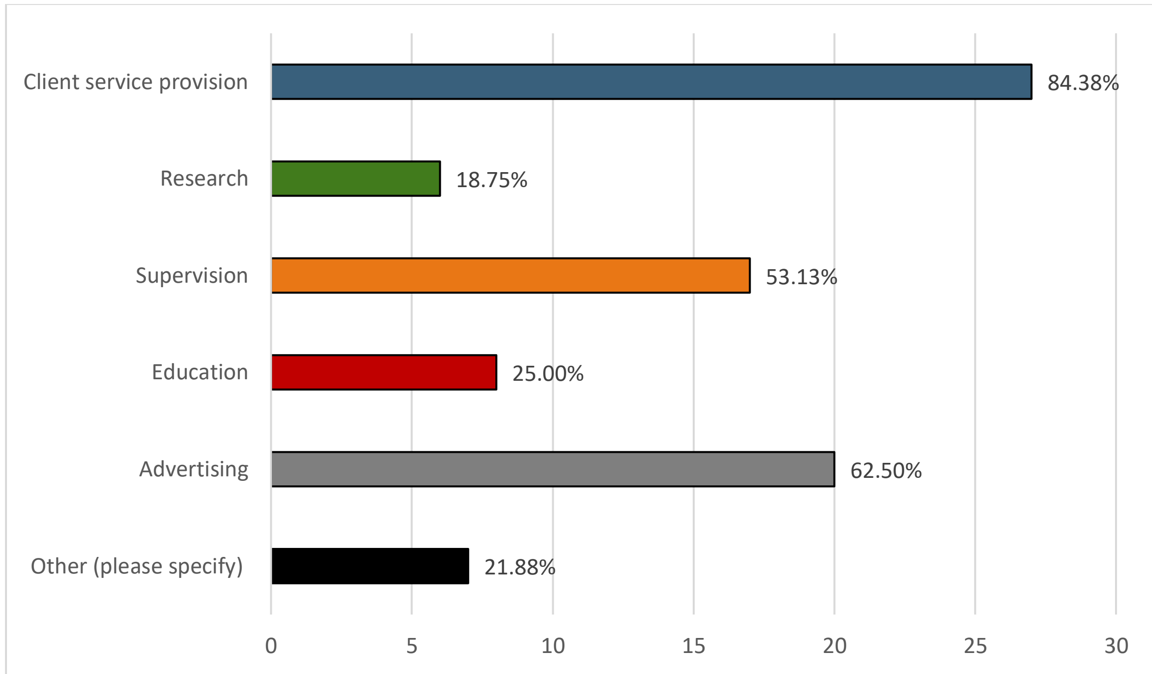
- Q4 Does your Board / College have any concerns about licensee use of social media / telecommunication in any of the following practice areas? Check all that apply.

DRAFT

129 ○ Client Service Provision
130 ○ Research
131 ○ Supervision
132 ○ Education
133 ○ Advertising
134 ○ Other (please specify)
135
136 ● Q5 Does your Board / College have any concerns about licensee use of social media /
137 telecommunication in any of the following practice competency areas? Check all that
138 apply.
139 o Confidentiality
140 o Consent
141 o Security
142 o Record Keeping
143 o Boundaries
144 o Professional Language
145 o Other (please specify)
146
147 ● Q6 Has your Board / College received any complaints or inquiries that involved licensee
148 use of social media / telecommunication?
149 o Yes (if yes please explain)
150 o No
151
152 **Regulator Concerns About Licensee Social Media Use:**
153
154 Regulators were asked to identify their concerns about licensee social media use in the practice
155 areas of client service provision, research, supervision, education, and advertising. If the
156 concerns fell outside of these identified practice areas, they were asked to use the "other"
157 category to respond. Overwhelmingly, the most frequently endorsed areas of concern were in
158 the areas of the provision of services to clients (84%), advertising (63%) and supervision (53%)
159 (See Table 1). The next most frequently endorsed practice area was education (25%). The
160 endorsement of the "other" category was low (22%), but some interesting concerns were noted
161 in this category: unprofessional behavior over social media, "communications with clients that
162 may be shared by the client with others", personal social media postings, ethical behavior, and
163 health privacy legislation.
164
165 While social media has existed since the 1980's, an upsurge in its use has been noted with each
166 subsequent generation, and it appears to be used increasingly in psychological practice.
167 Examples of the blurring of boundaries between licensee personal and professional use of
168 social media are increasingly coming to light. Anecdotally, regulators have reported that
169 complaints that include concerns about social media use by psychologists are becoming more

DRAFT

170 frequent; therefore, it is not unreasonable to expect that this will become an increasingly
171 common issue that regulators will have to address.
172
173
174 **Table1: Regulator Concerns Re: Licensee Use of Social Media / Telecommunications**
175 **Relative to the General Practice Areas (n=32)**
176

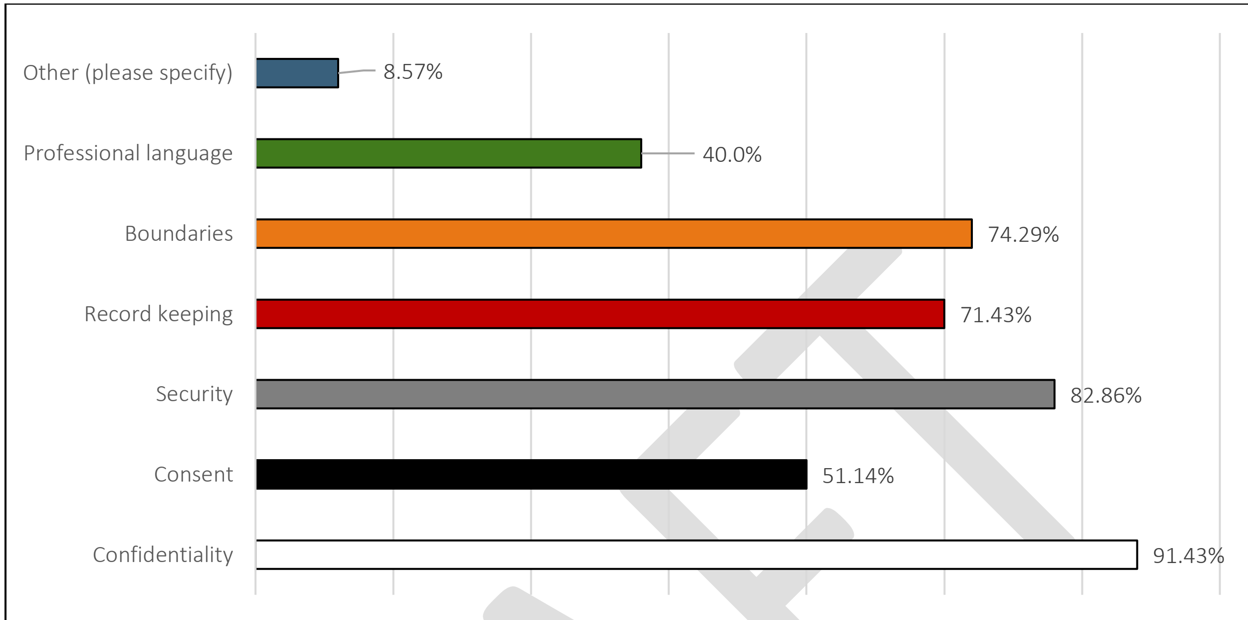


177
178

Other (please specify)
Unprofessional behavior over social media
Publication of legal discipline decisions
Social Media communications with clients that may be shared by the client with other parties.
Personal social media postings – ethical behavior
None identified as significant concerns – we have guidelines
HIPPA
No. We consider this a form of practice, i.e., mode for which all our rules and regulations apply.

179
180 Respondents were asked to further sort their concerns about licensee use of social media
181 according to practice competency areas. The forced choice responses were confidentiality,
182 consent, security, record keeping, boundaries, professional language, and if none fit, "other"
183 (See Table 2). The three most significant concerns were noted in the following key areas:
184 confidentiality (91%), security (83%), and boundaries (74%). Record keeping was a close fourth
185 (71%). Not surprisingly, these are areas that are commonly reported to the ASPPB Disciplinary
186 Data System and are the issues for which licensees are often formally disciplined.

187 **Table 2: Regulator Concerns Re: Licensee Use of Social Media / Telecommunications**
188 **Relative to Specific Practice Competencies (n=35)**
189



190
191

Other (please specify)
Privacy
None identified as significant concerns – we have guidelines
No. This is treated as a mode of practice and is handled as that if needed in complaint.

192
193 The survey explored whether regulators have received specific complaints or inquiries about
194 social media use by licensees (See Table 3). Approximately 58% of respondents indicated that
195 they have received complaints that included concerns about licensees' social media use.
196 Concerns frequently pertained to boundary violations, advertising, and unprofessional
197 language. It was unclear from the responses whether the behaviors occurred solely in relation
198 to licensees' professional use of social media, or whether they also pertained to personal use of
199 the modality. Regardless, what was apparent is that this is an issue for regulators, and that
200 clear expectations for licensees with regard to their use of social media would be helpful for
201 regulators to have in meeting their mandate of public protection.
202
203
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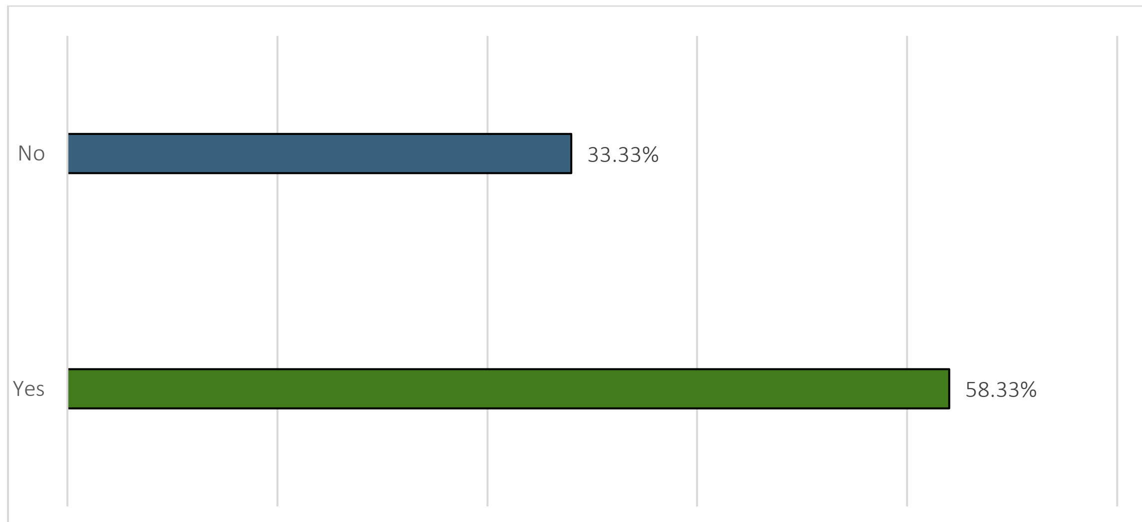
211 **Table 3: Complaints / Inquiries Involving the Use of Social Media / Telecommunication**
212 **by Licensees Received by Regulators (n=35)**
213



214
215

If yes, please explain.
Complaints and three actions recently for violating sexual/personal boundaries via texting. Rooted in loneliness and getting needs met.
Don't know
Typically advertising related or listing of unlicensed supervisees as being licensed.
Unofficial complaints from other members about some psychologists using Facebook for live presentations where "attendees" can ask questions in real-time, anyone on FB can observe both the questions and answers and the names of the attendees are easy to see
Advertising, communication that is unbecoming of the profession
Disrespectful language in YouTube, boundary issues with email, texts, Facebook
Blogging, advertising and use of testimonials
We've had several complaints regarding Facebook – mostly boundary problems. We've had some cases of sexual misconduct that were proven using text messages. Out board regulates several disciplines. I do not believe any of these cases have involved psychologists.
Not exclusively but there have been complaints about involving descriptions of services.
Licensee making extremely strange, deranged comments on Facebook resulted in calls about their competency and frame of mind.
Inquires. See our Practice Alerts: http://www.op.nysed.gov/prof/psych/psychalerts.htm
Advertising
The complaint involved a variety of allegations; some of the evidence provided was Facebook messages.
As part of a complaint, records of text messages were used as evidence of misconduct.

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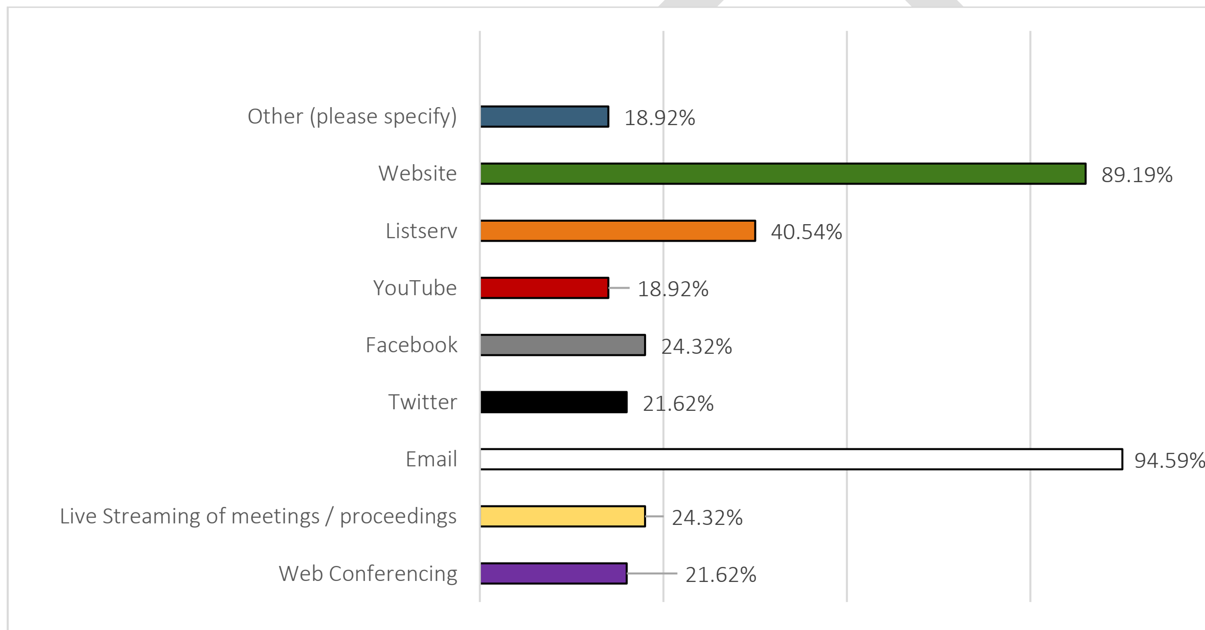
DRAFT

220 **Regulator Social Media Use:**
221
222 Survey data identified that regulators are primarily using email (95%) and websites (89%) to
223 engage their constituents, with other forms of social media engagement being less common.
224 The lack of utilization of other social media platforms to engage the profession, the public, and
225 other stakeholders may be reflective of various factors: limited financial and human resources
226 to implement and/or monitor the social media platforms, legislative barriers, and a possible
227 lack of knowledge and understanding of how various social media platforms could support and
228 enhance regulatory efforts. Data suggest that additional information about the options for
229 social media engagement and any cautions for using social media would likely be useful to
230 regulators.
231
232 **Table 4: Regulator Use of Social Media / Telecommunications (n=37)**
233



234
235

Other (please specify)
Dropbox
Considering text messaging
A secure web file repository
Google Hangout, UberConference
Teleconferencing
Public Television – Regents regulate Public Television
Video - conferencing between locations for meeting

236
237
238
239

240 ## Social Media Standards and Guidelines Literature Review
241
242 Psychologists, like other members of society, increasingly are using various forms of social
243 media (e.g., Deen, Withers & Hellerstein, 2013; Harris, S. & Robinson Kurpius, 2014) such as
244 email, texting, Facebook, Instagram, LinkedIn, YouTube, Twitter, and WhatsApp in their
245 personal lives. This is especially true of younger psychologists; however, psychologists are also
246 increasingly using social media to market their services and as a means of communicating with
247 clients. Until recently, little guidance from the profession was available for members using
248 social media in professional practice beyond "be careful". The important differences between
249 using social media in personal contexts (e.g., with family and friends) and using it in
250 professional contexts are not always obvious to psychologists. Understanding where personal
251 social media use ends, and professional standards must apply, is not always clear. Increasingly,
252 regulators are becoming aware of licensees using social media in their professional lives and at
253 times in ways that are questionable or inappropriate (Drude, 2016). Inappropriate social media
254 use has resulted in adverse licensing board disciplinary actions affecting not only the individual
255 psychologist who is the subject of discipline by the regulator, but such use may also have a
256 serious negative impact on how the public perceives the profession.
257
258 The ethical codes and telepsychology guidelines of the Canadian Psychological Association
259 (CPA, 2017 and 2013) and the American Psychological Association (APA, 2017 and 2013), as well
260 as the Association of Canadian Psychological Regulatory Organizations (ACPRO, 2011) and the
261 Association of State and Provincial Psychology Boards' *Telepsychology Task Force Principles and*
262 *Standards* (ASPPB, 2013) provide general ethical standards and guidelines that also apply to
263 social media use. These guiding documents, however, do not address issues specific to
264 professional uses of social media other than telepsychology. Consequently, this leaves the
265 individual psychologist to interpret how to apply such guidelines when using social media in
266 professional practice. Education and training in the uses of technology or telepsychology is
267 typically not provided to psychology graduate students (Gluekauf, Maheu, Drude, Wells, Wang,
268 Gustafson, & Nelson, 2018). Psychologists must, therefore, rely upon their own self-directed
269 professional development efforts to obtain the necessary competencies for using
270 telepsychology and social media in their practices.
271
272 Over the last decade, national professional health organizations and professional regulatory
273 bodies have begun providing guidance to members of health professions about the use of social
274 media in a manner that is compliant with professional ethical standards. The earliest
275 telepsychology guidelines applicable to social media were developed and published in a draft
276 form by the Canadian Psychological Association in 2006 (CPA, 2006) and by the Australian
277 Psychological Society in 2011 (APS, 2011). The more recent American Psychological Association
278 telepsychology guidelines (APA, 2013) provided a caution about risks when using social
279 networking sites. The most comprehensive set of social media guidelines for psychologists are
280 those published by the Oregon Board of Psychology in 2018 and revised in 2019 (OBP, 2019).
281 Other health professions - physicians (AMA, 2010; OSMA, 2010; FSMB, 2012, CMA, 2011),
282 nurses (NCSBN, 2011), counselors (ACA, 2014), and social workers (NASW, 2017) - have

DRAFT

283 incorporated guidance about the use of telecommunications (including social media) into their
284 ethical standards as they have updated them, or have developed separate telepractice
285 guidelines. In general, the published social media standards, guidelines, and recommended
286 practices are attempts to provide clarity to members of professions about what are appropriate
287 professional social media practices, to provide a list of "dos" and "don'ts", and to advise
288 professionals to be thoughtful when using social media.
289
290 **Appendix B** summarizes social media standards and guidelines that have been published by
291 various health professions, as well as several journal articles that include recommended social
292 media practices. There are a number of common elements that are often found in these
293 standards and guidelines. They include reference to major ethical issues such as informed
294 consent, confidentiality, competence, security, risk management, documentation, competence,
295 multiple relationships, and professional boundaries. Some documents identify the need for
296 professionals to have a social media policy, and they provide guidance about what ought to be
297 included in such a policy. Several documents include vignettes that illustrate professional social
298 media practices as examples of how to apply ethical standards to social media. The importance
299 of maintaining appropriate professional boundaries, as well as having an awareness of potential
300 implications of all electronic communications that are either public or potentially public, are key
301 issues that are repeatedly emphasized.
302

303 Legislation

304
305 Many psychology regulatory bodies have either statues or regulations that provide
306 telepsychology/telemedicine/telehealth/telepractice guidance; however, very few jurisdictions
307 address broader areas of social media use. **Appendices C** and **D** provide a list of the
308 jurisdictions and links to websites, statutes and regulations, that provide rules for using "tele"
309 means of service delivery in the practice of psychology. The guidelines included in the
310 appendices address the broader use of technology in psychological service delivery,
311 professional communication, and personal communication.
312

313 Ethics and Social Media

314
315 Social media usage has become commonplace in the work of many psychologists. This mode of
316 communication affects how psychologists obtain information, interact as professionals, and
317 ultimately how they present themselves as members of the profession. Social media is a
318 powerful tool and resource for psychologists to use in their practice.
319
320 Psychologists have an implicit contract with society and with the public they serve. This
321 contract identifies a duty and an obligation to protect, and to work in the best interests of, the
322 public. Regardless of the modality of service delivery, information dissemination, or
323 communication, psychologists are held to this contract and to a high standard of conduct and

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ethics in their professional lives, and potentially in their personal lives also. This standard of behavior and ethics is typically higher than that for the average person, and this is one of the realities of being a member of a regulated profession.

The ***ASPPB Code of Conduct*** (hereafter identified as the ASPPB Code) (2018) was written specifically for psychology regulatory boards/colleges to use as a standard for evaluating the conduct of licensees or registrants. It was designed to be used in concert with the ethics codes promulgated by the Canadian and American Psychological Associations whenever clarification might be needed to help interpret the ASPPB Code. The ASBBP Code, the ***Canadian Code of Ethics for Psychologists*, 4th Edition** (2017) and the American Psychological Association's ***Ethical Principles and Code of Conduct*** (2017) (hereafter identified as the CPA Code and APA Code) do not explicitly address the issue of social media use by the profession; however, each Code identifies the expectations for how psychologists should conduct themselves as members of the profession and outlines the general standards for ethical practice. Accordingly, directions for the use of social media can be extrapolated from the general guidance in all three Codes.

ASPPB Code

The ASPPB Code is divided into major **Rules of Conduct** (Rules), each with its own separate areas of conduct within. The major Rules outlined in the ASPPB Code are:

A. Competence
B. Multiple Relationships
C. Impairment
D. Welfare of Client
E. Welfare of Supervisees, Research Participants and Students
F. Protecting Confidentiality of Clients

It is within each of the separate areas of conduct for each major Rule that guidance for the use of social media can be discerned. Again, the ASPPB Code of Conduct is to be used to assist psychology regulators in determining appropriate behaviors for their licensees and registrants. The CPA and APA Codes might further elaborate the process for how to determine appropriate actions for licensees or registrants.

CPA Code

The CPA Code is divided into four ethical principles that psychologists must consider when determining how to proceed in practice. These represent the values of the profession. Under each principle and its value statement, are ethical standards which are intended to illustrate the application of the principle. The principles are listed in descending order of significance, from most significant (Principle 1) to least significant (Principle 4). Where principles are in

conflict, psychologists are directed to give the most weight to the most significant principle. The four principles outlined in the CPA Code are:

> **Principle I: Respect for the Dignity of Persons and Peoples.** This principle, with its emphasis on inherent worth, non-discrimination, moral rights, distributive, social and natural justice, generally should be given the highest weight, except in circumstances in which there is a clear and imminent danger of bodily harm to someone.
>
> **Principle II: Responsible Caring.** Responsible caring requires competence, maximization of benefit and minimization of harm, and should be carried out only in ways that respect the dignity of persons and peoples.
>
> **Principle III: Integrity in Relationships.** Psychologists are expected to demonstrate the highest integrity in all of their relationships. However, in some circumstances, Principle III values (e.g., openness, straightforwardness) might need to be subordinated to the values contained in the Principles of Respect for the Dignity of Persons and Peoples, and Responsible Caring.
>
> **Principle IV: Responsibility to Society.** Although it is necessary and important to consider responsibility to society in every ethical decision, adherence to this principle needs to be subject to and guided by, Respect for the Dignity of Persons and Peoples, Responsible Caring, and Integrity in Relationships. When the welfare of an individual or group appears to conflict with benefits to society, it is often possible to find ways of working for the benefit of society that do not violate respect for dignity, responsible caring or integrity. If this is not possible, however, the dignity, well-being and best interests of persons and peoples, and integrity in relationships should not be sacrificed to a vision of the greater good of society. (CPA, 2017)

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APA Code

The APA Code outlines five guiding principles that are intended to be aspirational in nature and to "guide and inspire psychologists toward the very highest ethical ideals of the profession" (p. 3). This Code makes a distinction between the aspirational nature of the guidelines and the obligations of the ethical standards. The APA Code is intended to apply only to the conduct and practice of psychologists in their professional lives and is not intended to apply to conduct in their personal lives. The principles in the APA Code are:

> **Principle A: Beneficence and Nonmaleficence**. The focus of this principle is on the responsibility of members of the profession to act to benefit those they serve and to strive to do no harm. This principle calls on psychologists to be aware of, and to avoid influences which may inappropriately impact the work they do (e.g., political, financial).

410 **Principle B: Fidelity and Responsibility**. This principle calls on psychologists to
411 "establish trust with those with whom they work (p. 3)." It asks psychologists to
412 uphold standards of conduct, to be clear with others in regard to their roles and
413 responsibilities, and to take responsibility for their actions.
414
415 **Principle C: Integrity.** This principle asks psychologists to act with honesty and
416 truthfulness, and to work to correct any missteps that they may make.
417
418 **Principle D: Justice**. The focus of this principle is the right of all people to "benefit from
419 the contributions of psychology (p. 4)" and the right to "equal quality" in the service
420 received. Psychologists are called to work only within the areas in which they have
421 established competence, and to be cognizant of the impact that their own experiences
422 may have on their work with others.
423
424 **Principle E: Respect for People's Rights**. This principle asks psychologists to "respect
425 the dignity and worth of all people, and the rights of individuals to privacy,
426 confidentiality, and self-determination (p. 4)." Psychologists are called on to protect
427 the rights of others, especially the vulnerable, and to be aware of their own biases and
428 to mitigate the effect of those biases in their work with others. (APA 2017)
429
430 As with any technique or approach, psychologists who use social media have a responsibility
431 to act ethically, to ensure professional competence, to protect the publics they serve, and to
432 uphold the values of the profession.
433
434 In their professional work, when using social media psychologists must recognize that the
435 potential for harm or abuse of vulnerable people may be increased because of the lack of an
436 in-person relationship, and they must take steps to safeguard against harm when fewer cues
437 are available for accurate perception. They must utilize social media in a responsible way that
438 incorporates approaches that are relevant to the needs of their clients; they must recognize
439 the need for proficiency in the technological skills required for competent and ethical practice
440 when using social media; and they should seek consultation to stay current with emerging
441 technologies. They also must recognize that any conduct via social media should follow the
442 ASPPB Code and/or the APA or CPA ethical guidelines as well as, any local statutes pertaining
443 to the practice of psychology.
444
445 The ASPPB Code and the APA and CPA Codes state that psychologists are responsible for their
446 actions and decisions. While the intent of each Code is not to direct behavior outside of one's
447 professional role as a psychologist, psychology regulation could cover behaviors that occur in a
448 psychologist's personal life but that are harmful to the public. It is important to distinguish
449 between the expectations and mandates of a professional guild (e.g., APA, CPA) versus the

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450 expectations and mandates of a psychology regulatory body, in part because there are
451 sometimes conflicting directions provided by each. A psychologist's personal behavior may be
452 of concern and may warrant intervention by a regulatory body if such behavior undermines the
453 reputation of the profession, undermines the trust the public has in the profession, or results in
454 questions being raised with regard to someone's abilities to perform in the role of psychologist.
455
456 Jurisdictions may have guidelines, standards or formal positions that are used to help regulate
457 social media practices of psychologists. Guidance within the *ASPPB Code of Conduct* and the
458 APA and CPA Ethics Codes helps psychologists to be cognizant of the following issues (See
459 **Appendix E** - Codes Relevant to Social Media Use):
460
461 **I. Confidentiality**
462 Psychologists are required to maintain confidentiality in all communications that contain
463 private or protected information. This includes any information about an individual or
464 individuals that is written, spoken, or in electronic form, and all communications over social
465 media. Psychologists need to be mindful of the public nature of social media, and that privacy
466 and confidentiality are often not protected, nor should they be expected to be protected on
467 social media.
468
469 **II. Informed Consent**
470 Psychologists are required to seek informed consent in their professional work.
471
472 **III. Risk Management**
473 Psychologists must manage and reduce risk whenever feasible with regard to social media use.
474
475 **IV. Multiple Relationships**
476 Psychologists endeavor to avoid multiple relationships when using social media. They clarify the
477 nature of multiple relationships when these relationships are unavoidable.
478
479 **V. Competence**
480 When psychologists use social media technologies, they must be competent in both the
481 technologies employed and the methods by which they are used.
482
483 **VI. Professional Conduct**
484 Psychologists are responsible for their behavior when they use social media.
485
486 **VII. Security of Information**
487 Psychologists have a primary obligation to take reasonable precautions to secure
488 confidential information obtained through or stored in any medium, including all
489 communications over social media.
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491 The current *Guidelines* were developed to assist psychologists and psychology trainees in their
492 use of social media. These guidelines were also developed for psychology regulatory bodies in
493 their efforts to ensure that their publics are being well-served.
494

495 Personal Use of Social Media

496
497 Social media is becoming increasingly complex in its application and management. Even if one
498 decides to stop using social media, an online presence may continue in the absence of their
499 active participation and may continue to exist on other platforms. It is important for
500 psychologists to consider both their professional and their personal social media presence and
501 to actively manage these. Social media policies in the workplace and within professional
502 organizations typically address only organizational or workplace posts and presences. Personal
503 online presence requires regular review and cultivation to ensure that it accurately and
504 appropriately represents the person and does not create unnecessary risk for either their
505 personal or professional life.
506
507 The dearth of literature on the impact that a psychologist's personal social media use can have
508 on their professional life suggests that this is not a common area of consideration for
509 professionals. Younger professionals who have grown up with social media accounts may be
510 confident that they have a full understanding of the intricacies and risks. Accordingly, they may
511 not fully appreciate the potential risks to their professional lives that are posed by their
512 personal online presence. Professionals who are not as well versed about social media and the
513 latest online platforms may not be keeping their various accounts separate. Even those not
514 using social media accounts may have a social media presence by virtue of their connections
515 with others, e.g., they are "tagged" in photographs. Most professionals likely fall somewhere
516 between the two extremes: comfortable with some platforms and not with others, keeping
517 different aspects of themselves on different platforms, and somewhat wary of what and where
518 they post.
519
520 Organizations typically are concerned about employee social media use that may lead to
521 negative press. Posting about one's work life on either a personal or a professional social
522 media site, even if it is an indirect or vague comment, can negatively impact one's employment.
523 Conversely, some workplaces encourage their employees to interact with their "brand" online
524 and to "talk it up" positively to their own networks. This blurring of personal and professional
525 sites (boundaries) can be problematic and result in unintended consequences, such as being
526 held accountable for a comment made on a personal site because that person is also a member
527 of the profession.
528
529 Psychologists must consider the likelihood that when they have both a personal and
530 professional online presence, there may be some cross-pollination between their professional
531 and personal online posts and contacts. The likelihood of this intersection between the
532 professional and personal increases when work groups are large (e.g., hospitals or universities),
533 or particularly close-knit (e.g., group practices, small cities or rural areas). When one posts

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534 online, it is essential to consider that the message sent may not only be accessed by the
535 intended audience but may be shared or accessed by others who were not the intended
536 recipients.
537

538 ASPPB Social Media Guidelines

539

540 These social media *Guidelines* were developed to assist psychologists in their use of social
541 media and for use by psychology regulatory bodies in their efforts to ensure that their publics
542 are being well-served.
543

544 **Confidentiality:**

545 • Psychologists who use social networking sites need to be familiar with, and utilize all
546 available privacy settings to reduce risks to confidentiality.
547 • Psychologists must be respectful of client privacy. In general, psychologists are
548 discouraged from searching social media sites for client information without the client's
549 permission and their informed consent.
550 • In general, psychologists are required to maintain the confidentiality of client protected
551 information. There may be justifiable exceptions to the rule of confidentiality.
552 • Psychologists develop social media use policies that address such issues as informed
553 consent, privacy, and how and if social media will be used in their work.
554

555 **Informed Consent:**

556 • Psychologists must ensure the competence of potential clients to provide informed
557 consent.
558 • When engaging those unable to provide consent, psychologists must seek informed
559 consent from those legally entitled to provide consent.
560 • Elements of informed consent include explanations of:
561 ▪ the possible benefits and risks in using social media to communicate.
562 ▪ emergency procedures that will be followed when the psychologist is not available.
563 ▪ a back-up plan if communication over social media is compromised or fails.
564 ▪ the risk of loss of security and confidentiality with the use of social media.
565 ▪ other modes of communication that were discussed and that the client agrees to use
566 social media.
567

568 (See **Appendix F** – Example of Informed Consent Disclaimer)

569

570 **Risk Management:**

571 • Psychologists are advised to have a social media policy (See **Appendix G** – Sample of
572 Social Media Policy) that explains whether, to what degree, and how they will use

social media in their provision of services. This policy is clarified in consent forms and in discussions with clients.

- Psychologists clarify on their social media sites the jurisdiction(s) where they are licensed to practice, so that it is clear that the intent is not to practice outside of the license scope.
- Psychologists avoid conflicts of interest regarding personal, financial, social, organizational, or political opinions when they use social media in a professional capacity.
- Psychologists manage access to their professional social media and are responsible for those who may access the accounts.
- Psychologists use trusted and secure networks to access professional social media accounts.
- Psychologists use encryption when sending protected and private information over social media when feasible.
- Psychologists understand the privacy settings on every application that is used by them in their practice.
- Psychologists are mindful that any social media post or communication may be forwarded to other recipients.

Multiple Relationships:

- Psychologists are responsible for connections they initiate through social media and for knowing whether or not these connections constitute multiple relationships. If the connection might constitute a multiple relationship, the psychologist considers whether the relationship could be potentially harmful.
- Psychologists minimize the risk of problematic multiple relationships by keeping their personal and professional social media presences separate.

Competence:

- Psychologists familiarize themselves with ethical and legal requirements regarding the use of social media.
- Psychologists maintain current knowledge and skills pertaining to the social media technologies they are using.
- Psychologists evaluate the appropriateness of using specific social media with each client.
- Psychologists ensure that anyone working for them within their practice, and who use social media as part of their work, have adequate training in the appropriate use of social media.

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610 • Psychologists ensure that they have a full understanding of the risks the use of
611 technology presents to the security and confidentiality of client personal health
612 information.
613
614 **Professional Conduct:**
615 • When using social media, psychologists are aware of the impact their communications
616 may have on the public's confidence in the profession.
617 • Psychologists are responsive and timely in their responses when using social media in
618 their professional work.
619 • Psychologists are respectful in what they communicate and in how they communicate
620 when using social media in their professional work.
621 • Psychologists are respectful of professional boundaries, culture, and preferences when
622 using social media.
623 • Psychologists accurately represent themselves in all social media communications.
624 • Psychologists seek to correct any misinformation regarding their social media presence.
625 • Psychologists accurately represent and document the work performed via social media,
626 and maintain records of their professional social media communications, including
627 maintaining all emails and texts with clients.
628
629 **Security of Information:**
630 • Psychologists delegate responsibilities for social media activities only to individuals
631 who can be expected to perform them competently on the basis of their education,
632 training, or experience.
633 • Psychologists maintain confidentiality in creating, storing, accessing, transferring, and
634 disposing of records under their control relating to their professional social media use.
635 • Psychologists use security measures to protect information kept on social media that is
636 vulnerable to loss, damage, or to inappropriate access.
637 • Psychologists maintain up-to-date knowledge of all individuals, devices, and accounts
638 used in their professional social media practice.
639
640 **Personal Use of Social Media:**
641 • Psychologists ensure they have a working knowledge of privacy settings available on any
642 social media platforms used.
643 • Psychologists are cautious about making posts to public comment sites, especially those
644 related to their worksite / employer.
645 • Psychologists maintain their personal online presence distinct from their professional
646 online presence.

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647
- Psychologists maintain clear boundaries between their professional and personal social media accounts.
- Psychologists are aware of any existing social media policies within their organization or practice group (e.g., rules about promoting the organization or practice group via social media).

(See **Appendix H** – Social Media Vignettes)

Regulator Use of Social Media:

- Psychology regulatory boards/colleges develop and implement clear policies regarding social media and its use in regulatory work.
- Regulatory bodies ensure that all employees are familiar with the social media policies and expectations with regard to access and use of social media platforms.
- Regulatory bodies ensure that all employees are trained in the various social media platforms that are used by the board or college.
- Regulatory bodies ensure that all employees have a working knowledge of the privacy settings on the social media platforms used.
- Regulatory bodies manage access to any of their social media accounts.
- Regulatory bodies use trusted and secure networks to access agency social media accounts.
- Regulatory bodies understand the privacy settings on any social media applications used in performing regulatory functions.
- Regulatory bodies use security measures to protect information kept on social media platforms that is vulnerable to loss, damage, or to inappropriate access.

Recommendations:

The SMTF respectfully makes the following recommendations:

1) That ASPPB member jurisdictions consider the adoption of these *Guidelines* for use in providing direction to their licensees about competent practice via technology.
2) That member jurisdictions consider the adoption of these *Guidelines* for use in the adjudication of complaint cases.
3) That the ASPPB Board of Directors consider the development of model regulatory language regarding the regulation of telepsychology that includes the use of social media in practice.

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812 ## APPENDIX A – Glossary of Terms
813
814 **Competent** – being qualified to practice in terms of possessing the necessary skills, knowledge
815 and attitudes of the profession, and consistently applying these to practice. In practice via
816 social media, psychologists also must ensure competency in the delivery of services using this
817 modality.
818
819 **Confidentiality**– ensuring the security of client personal information, including personal health
820 information, and to only share such information with informed consent. Within a social media
821 context, it is necessary to ensure that information is properly secured through encryption,
822 privacy settings, and the use of secure storage sites.
823
824 **Email** – electronic or digital mail sent via the Internet.
825
826 **Facebook** – a popular social networking website that allows registered users to create profiles,
827 to upload photos and video, and to send and to receive messages from other users.
828
829 **Friending** - the act of connecting one account to another's account in an online social or
830 professional network (especially on Facebook).
831
832 **Following** – the act of connecting to an account or topic within a social media platform, such as
833 Twitter, Instagram, and sometimes Facebook.
834
835 **Informed Consent** - a process in which a psychologist educates a client about the risks, benefits,
836 and alternatives of a given procedure or intervention, and seeks their explicit agreement before
837 proceeding. Within the context of service delivery via technology the risks and benefits of using
838 the technology, and alternative for service delivery would be important in obtaining informed
839 consent.
840
841 **Instagram** – an online photo-sharing application and social network platform.
842
843 **Internet Presence** – the existence of personal, professional, or organizational information that
844 is web-based and searchable.
845 LinkedIn – a professional and business oriented social networking site.
846
847 **Listserv** – a form of email communication used by registered subscribers to send messages
848 though a designated server to other registered subscribers.
849
850 **Livestream** – live video broadcasting or streaming via the Internet using videoconferencing
851 software.
852
853 **Online Consultation** - asking for or providing an opinion on one or more specific topics to
854 someone via the internet.
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Online Therapy – any type of therapeutic intervention delivered via the Internet.

Personal Use of Social Media - Use of social media by an individual for the purpose of connection with other individuals such as family, friends, work colleagues, or people with mutual interests.

Privacy - clients have a right to control access to their personal information, and to be free from intrusion or interference. Within a social media context this means that psychologists recognize that it is important to respect that right and to not try to find out information about clients through social media.

Professional Use of Social Media – the use of social media in a professional role.

Snapchat - a social media site that allows subscribers to send to other subscribers, messages, videos, and pictures that later disappear (if they are not saved).

Social Media - social media is an umbrella term that includes the various activities that integrate technology and social interaction such as texting, email, instant messaging, websites, microblogging (e.g., Twitter), and all forms of social networking.

Social Media Presence - existence of a personal, professional, and/ or organizational account on any social media platform(s).

Social Networking – communication with others with common interests via web-based or electronic social media.

Technological Competence – an understanding of social networking and social media, and the technology that supports these. Competence in communicating via technology including appropriate language, etiquette, and the actual use of the technology.

Testimonials - written or verbal statements attesting to the qualifications or value of someone or a service.
Text Messaging - the exchange of brief written messages between electronic devices.

TikTok – a social media platform for creating, sharing and discovering short music videos.

Twitter - a social networking microblogging service that allows registered members to post brief text messages called “tweets”.

Video Conferencing - meeting or conferencing among people in multiple locations using video and audio telecommunications.

Web Conferencing – see videoconferencing.

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900 **Website** – a collection of related networks of web resources, such as webpages multimedia
901 content, which are typically identified with a common domain name and published on at least
902 one webserver (e.g., Wikipedia).
903
904 **WhatsApp** - a messaging service that lets subscribers cite, text, chat, and share media, including
905 voice messages and videos.
906
907 **YouTube** - a popular video sharing website where registered users can upload and share videos
908 with anyone able to access the site.
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APENDIX B – Literature Re: Social Media Guidelines and Standards

Profession	Source	Recommendations	Comments
Counselling and Psychotherapy	**Canadian Counselling and Psychotherapy Association. (2019). Guidelines for uses of Technology in Counselling and Psychotherapy**	Provided guidelines in regard to the best use of technology in counselling and psychotherapy practice. Intended to enhance practice and minimize risk for practitioners. Technology and social media are inevitable elements of practice.	
Nursing	**National Council of State Boards of Nursing (NCSBN).** (2011). White Paper: A Nurses Guide to the Use of Social Media, http://www.ncsbn.org/11_NCSBN_NURSES_Guide_Social_Media.pdf	The following guidelines are intended to minimize the risks of using social media: „„* First and foremost, nurses must recognize that they have an ethical and legal obligation to maintain patient privacy and confidentiality at all times. *Nurses are strictly prohibited from transmitting by way of any electronic media any patient-related image. In addition, nurses are restricted from transmitting any information that may be reasonably anticipated to violate patient rights to confidentiality or privacy, or otherwise degrade or embarrass the patient. *Do not share, post or otherwise disseminate any information, including images, about a patient or information gained in the nurse-patient relationship with anyone unless there is a patient care related need to disclose the information or other legal obligation to do so. *Do not identify patients by name or post or publish information that may lead to the identification of a patient. Limiting access to postings through privacy settings is not sufficient to ensure privacy. *Do not refer to patients in a disparaging manner, even if the patient is not identified. *Do not take photos or videos of patients on personal devices, including cell phones. Follow employer policies for taking photographs or video of patients for treatment	Focus on inappropriate uses of social media outside of the workplace. Issues: privacy and confidentiality. Several example scenarios with questionable SM use are included.

DRAFT

		or other legitimate purposes using employer-provided devices. *Maintain professional boundaries in the use of electronic media. Like in-person relationships, the nurse has the obligation to establish, communicate and enforce professional boundaries with patients in the online environment. Use caution when having online social contact with patients or former patients. Online contact with patients or former patients blurs the distinction between a professional and personal relationship. The fact that a patient may initiate contact with the nurse does not permit the nurse to engage in a personal relationship with the patient. *Consult employer policies or an appropriate leader within the organization for guidance regarding work related postings. *Promptly report any identified breach of confidentiality or privacy. *Be aware of and comply with employer policies regarding use of employer-owned computers, cameras and other electronic devices and use of personal devices in the work place. *Do not make disparaging remarks about employers or co-workers. Do not make threatening, harassing, profane, obscene, sexually explicit, racially derogatory, homophobic or other offensive comments. *Do not post content or otherwise speak on behalf of the employer unless authorized to do so and follow all applicable policies of the employer.	
Physicians	**Federation of State Medical Boards.** (2012). Model Policy Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice. Retrieved at http://www.fsmb.org/siteassets/advocacy/policie	The following Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice are presented: * Interacting with Patients - "Physicians are discouraged from interacting with current or past patients on personal social networking sites such as Facebook." * Discussion of Medicine Online - "it is the responsibility of the physician to ensure, to the best of his or her ability, that professional networks for physicians are secure and that only verified and registered users have access to the information. These websites should be password protected so that non-physicians do not gain access and view discussions as implying medical advice, which may be counter to the physicians' intent in such discussions.	"Such electronic and digital media include, but are not limited to, e-mail, texting, blogs and social networks. The Committee's proposed model guidelines contained in this report also focus on ways that physicians can

DRAFT

	s/model-guidelines-for-the-appropriate-use-of-social-media-and-social-networking.pdf	Physicians should also confirm that any medical information from an online discussion that they plan to incorporate into their medical practice is corroborated and supported by current medical research * Privacy/Confidentiality - "...patient privacy and confidentiality must be protected at all times, especially on social media and social networking websites." * Disclosure - when writing online as a healthcare professional, "physicians must reveal any existing conflicts of interest and they should be honest about their credentials as a physician." * Posting Content - "Physicians should be aware that any information they post on a social networking site may be disseminated (whether intended or not) to a larger audience, and that what they say may be taken out of context or remain publicly available online in perpetuity." * Professionalism - Use separate personal and professional social networking sites. For example, use a personal rather than professional e-mail address for logging on to social networking websites for personal use. Others who view a professional e-mail attached to an online profile may misinterpret the physician's actions as representing the medical profession or a particular institution. · Report any unprofessional behavior that is witnessed to supervisory and/or regulatory authorities. · Always adhere to the same principles of professionalism online as they would offline. · Cyber-bullying by a physician towards any individual is inappropriate and unprofessional. · Refer, as appropriate, to an employer's social media or social networking policy for direction on the proper use of social media and social networking in relation to their employment.	protect the privacy and confidentiality of their patients as well a maintain a standard of professionalism in all social media and social networking interactions." Report gives numerous brief examples of questionable SM behavior
Physicians	**Ohio State Medical Association. (2010).** Social Networking and the Medical Practice: Guidelines for Physicians, Office	General Social Media Guidelines for Employers ● Be mindful of the laws and regulations that apply to everyday work, as a physician, an employer or an administrative assistant and create office policies accordingly. The laws that apply in person will apply within any social media. ●Be careful about who may access your social networking	Sample policies are included. Access to this document is no longer available at the OSMA website.

DRAFT

	Staff and Patients. Journal of the Ohio State Medical Association, 103(10), 517-526.	●Establish guidelines that address privacy expectations.- electronic communications using work computers or systems may be checked by employers ●If you have strict policies on Internet behavior, be explicit and plan to enforce them. ●Make sure all employees understand the risks of deceptive endorsements. ●Have a social media policy and follow Social Media Policy Recommendations 1. Have an explicit policy in an employment manual that addresses the following concepts: a) Accountability and Accuracy. Posts should be factual. Employees should be responsible for their postings and should distinguish between their own opinions and that of the employer's. b) Honesty and Transparency. Identify yourself. Advise employees that any statement must reflect good standards of conduct, judgment, and common sense. If an employee posts a statement that is related to the company or the company's product or service, the employee should disclose their identity and affiliation. c) Respect Advise employees not to post any derogatory, defamatory, or inflammatory content about others for any reason. d) Lawfulness. Train employees so they understand the basic legal and professional framework that governs the e) Management. Notify employees that the company will monitor a broad scope of media, including email and web usage. Conduct in violation of the social media policy is subject to discipline, up to and including termination of employment, and may give rise to legal liability company's policies. 2. Monitor Internet Behavior that is conducted on behalf of the company and have disciplinary actions in place for misuse.	

DRAFT

		3. Be Collaborative. Include employers and employees in formulating a written policy. 4. Contact your liability insurance representative. First, if it is a practice-hosted site, check and see if your malpractice insurance covers social media. 4. Add Value. Provide worthwhile information and perspective.	
Physicians	**American Medical Association (AMA).** (2010). Professionalism in the Use of Social Media. Retrieved at https://www.ama-assn.org/delivering-care/ethics/professionalism-use-social-media	(a) Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable patient information online. (b) When using social media for educational purposes or to exchange information professionally with other physicians, follow ethics guidance regarding confidentiality, privacy and informed consent. (c) When using the internet for social networking, physicians should use privacy settings to safeguard personal information and content to the extent possible, but should realize that privacy settings are not absolute and that once on the internet, content is likely there permanently. Thus, physicians should routinely monitor their own internet presence to ensure that the personal and professional information on their own sites and, to the extent possible, content posted about them by others, is accurate and appropriate. (d) If they interact with patients on the internet, physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethics guidance just as they would in any other context. (e) To maintain appropriate professional boundaries physicians should consider separating personal and professional content online. (f) When physicians see content posted by colleagues that appears unprofessional, they have a responsibility to bring that content to the attention of the individual, so	

DRAFT

		that he or she can remove it and/or take other appropriate actions. If the behavior significantly violates professional norms and the individual does not take appropriate action to resolve the situation, the physician should report the matter to appropriate authorities. (g) Physicians must recognize that actions online and content posted may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers (particularly for physicians-in-training and medical students) and can undermine public trust in the medical profession.	
Physicians	**Canadian Medical Association.** (2011). Social media and Canadian physicians: Issues and rules of engagement. Retrieved at http://policybase.cma.ca/dbtw-wpd/Policypdf/PD12-03.pdf	Rules of engagement • Understand the technology and your audience • Be transparent • Respect others • Focus on areas of expertise	
Psychologists	**American Psychological Association.** (2013). Guidelines for the Practice of Telepsychology. Retrieved at https://www.apa.org/pubs/journals/features/amp-a0035001.pdf	**Guideline 4 - Confidentiality of Data and Information** “Some of the potential risks to confidentiality include considerations related to uses of search engines and participation in social networking sites.” “…boundary issues that may arise as a result of a psychologist’s use of search engines and participation on social networking sites.” “Psychologists who use social networking sites for both professional and personal purposes are encouraged to review and educate themselves about the potential risks to privacy and confidentiality and to consider utilizing all available privacy settings to reduce these risks.”	This is the only reference to social media in the guidelines.
Psychologists	**Association of Canadian Psychology Regulatory Organizations.** (2011). Model	"Regardless of the modality used for service delivery, psychologists are expected to practice according to the Canadian Code of Ethics for Psychologists (3rd Ed.) or the code de déontologie (Québec), standards for practice within their home jurisdiction, and according to local laws and regulations."	Nothing specific regarding social media is included.

DRAFT

	Standards for Telepsychology Service Delivery. Retrieved at http://www.acpro-aocrp.ca/documents/ACPRO%20Model%20Standards%20for%20Telepsychology%20Service%20Delivery.pdf		
Psychologists	**Canadian Psychological Association.** (2006). DRAFT ETHICAL GUIDELINES FOR PSYCHOLOGISTS PROVIDING PSYCHOLOGICAL SERVICES VIA ELECTRONIC MEDIA. Retrieved at https://cpa.ca/docs/File/Ethics/Draft_Guidelines_EServices_31Oct2013.pdf	**Principle II: Responsible Caring** II.5 The client's record includes hard copies of all online communications of a material nature and notes regarding contacts of a material nature using other electronic media. (Maximize Benefit) II.8 Psychologists make adequate plans for accessing and responding to messages left by clients in electronic form during times of psychologists' unavailability, illness, or incapacity. (Maximize Benefit, Minimize Harm)	These draft telepsychology ethical guidelines were approved in principle by the CPA Board in June 2006, and posted on the CPA website but never officially adopted.
Psychologists	**Australian Psychological Society.** (2011). Guidelines for providing psychological services and products using the internet and telecommunications technologies. https://web.archive.org/web/*/ht	**2. Informed consent** 2.4. Where applicable, psychologists clarify with their clients the anticipated extent of SMS or email use, and the operating hours during which a client can expect a response from a text message, for example, "business hours Monday–Friday". SMS and emails are often sent by psychologists as a reminder of a client's imminent appointment. **4. Communication of client information**	The Australian Psychological Society has published since 1999 a series of updated set of telepsychology guidelines. Access currently is limited to APS members but can be accessed via the Internet Archive

DRAFT

	tps://aaswsocialmedia.wikispaces.com/file/view/EG-Internet.pdf	4.1. Internet, email, SMS and other telecommunications from clients are not forwarded by psychologists to others without the consent of the client. Psychologists are particularly aware of „strings of messages‟ contained within communications. 4.2. Clients are encouraged to use the auto-reply function or similar mechanism, which includes the psychologist's previous message, to confirm that clients have received the psychologist's email. 4.3. Psychologists are aware that clients using the internet, telephone or other tele-communications technology may do so anonymously. An anonymous client may disclose information that may be misleading or false. Psychologists clarify as far as possible the source and nature of the information presented. 4.4. To maintain professional boundaries with their clients, psychologists use professional language when sending text messages to clients. Psychologists are aware that use of informal and unprofessional language when communicating by text with a client blurs the professional relationship and can create a more personal relationship or the impression of one. **6. Client use of internet and other telecommunication technologies** 6.1. It is possible that clients may forward to others, messages from their psychologist that have been tailored to clients‟ own particular situations. The possible misuse of psychologists‟ communications can be restricted, but not prevented, by forming a two-way agreement with clients before engaging them in a psychological service that the clients will not forward messages without the consent of the provider of the psychological service. Psychologists address this issue at the commencement of any online interaction with a client, by reminding clients that the email communication is specific to the client	Wayback Machine site using the URL cited in the Profession column

DRAFT

8. Record keeping

8.1. Psychologists keep records of email, online, text messaging, telephone and other work using internet and telecommunication technologies as they do for face-to-face psychological work.

10. Managing professional boundaries when using the internet and telecommunication technologies

10.1. Psychologists are aware of the potential for boundary issues with clients to emerge related to the internet and telecommunication technologies. For example, when using internet and telecommunication technologies to provide psychological services to clients, psychologists use professional language to maintain appropriate boundaries, and convey to clients the anticipated extent of SMS or email use, and the operating hours during which a client can expect a response from a text message, for example, “business hours Monday–Friday”. Where possible, psychologists monitor the personal information about them available on the internet and take steps to remove inappropriate content.

10.2. Psychologists are aware that whatever personal information they post on personal social networking sites and as part of online communities may be more broadly accessible and could even be in the public domain. Even with privacy settings there are ways that information can be accessed. Psychologists protect their own privacy as adequately as possible. If a client requests to be a 'friend' of a psychologist, the psychologist reinforces the need to keep a boundary between the professional and personal.

10.3. Psychologists may seek to gain further information about a client from an internet search. These searches to access information are conducted in the best interests of the client, not to satisfy the curiosity of the psychologist. Such searches may also be conducted when other people are considered at risk.

DRAFT

		10.4. Psychologists who engage in online blogging are aware that they are revealing personal information about themselves and are aware that clients may read the material. Psychologists consider the effect of a client's knowledge of their blog information on the professional relationship,	
Psychologists	**Oregon Board of Psychology.** (June 2, 2019 version). Social Media Guidelines.	**Confidentiality** Psychologists have a primary obligation to maintain confidentiality in all communications that contain protected health information. This includes any information about an individual in written form, that is spoken, and all electronic forms, which include all communications over social media. 1. In accordance with the recommendations set forth in the APA Guidelines for the practice of Telepsychology (2013), psychologists who use social networking sites for both professional and personal purposes should be familiar with and should utilize all available privacy settings to reduce the risks to confidentiality. 2. Psychologist should not search social media sites for client's information without their permission and informed consent. APA Ethical principles state that psychologists obtain the client's informed consent, provide an appropriate explanation, or seek the client's assent hen providing assessment, therapy counseling, or consulting services. 3. Psychologists maintain confidentiality of their clients' protected health information whenever they use social media. 4. Psychologists exercise caution when communicating client information such as names, identifying information, clinical information, or diagnoses over social media. 5. Psychologists use social media with an eye to protecting the reputation of the profession and the public conceptualization of psychologists. Principle B: Fidelity and Responsibility of the APA	This comprehensive set of ethical guidelines includes a sample informed consent form and social media policy. The document lists the APA Ethics Code standards and their application to social media. The content listed in this table is only a short summary of the document and a more detailed review of the full document is advised. A list of Social Media "Do's and Don'ts" is included at the end of the document that are relevant to social media and technology uses.

DRAFT

Ethical Principles directs psychologists to uphold professional standards of conduct. Psychologists maintain an awareness that any of their social media activities may reflect upon themselves as professionals and upon the field of psychology as a whole.

Informed Consent

Psychologists obtain informed consent whenever they use social media with clients. APA Ethical Principles direct psychologists to obtain informed consent from clients, and to appropriately document this consent, permission and assent (APA Ethical Principles 3.10 Informed Consent). In addition, the Canadian Code of Ethics for Psychologists also directs psychologists to respect the dignity of persons and peoples in all communications. At a minimum, informed consent should contain the following elements:

1. An explanation of the possible benefits and risks in using social media to communicate with a psychologist,

2. An explanation of emergency procedures and explanation of how communication over social may be disrupted or fail due to circumstances beyond the psychologist's control.

3. A back-up plan if communication over social media is compromised or fails.

4. An explanation of the increased risks of loss of security and confidentiality with the use of social media and/or with the use of social media over mobile devices.

5. A proposal of an alternative means of communication, should the client decline the offer to use social media.

6. An offer of alternatives to social media usage.

Risk Management

There are several actions that psychologists should avoid

DRAFT

		via social media that is accessible by their patients, including posting full-text versions of published works, potentially libelous accusations, information on business practices that could violate anti-trust laws, advertising, political endorsements, requests for research participation, confidential information or dual relationships. Additionally, there are several actions that psychologists can take to use social media in an ethically and legally responsible manner: 1. Have a social media policy in which you explain whether, to what degree, and how the psychologist will interact and use social media with patients. Clarify this policy in consent forms and via discussions with patients. This includes clarifying what to do if you pop up in the "people you may know" tab or how you handle friend requests. 2. Clarify on social media sites the jurisdiction in which they are licensed to practice, so they are not viewed as intending to practice outside the scope of their licenses. 3. Carefully consider what you post on social media and who has access to this information so as not to influence patients with personal, financial, social, organizational, or political opinions. 4. Use privacy settings that limit levels of interaction. Caution family members about the possibility of social media requests from unknown people. 5. If you share devices, ensure that family members cannot access your device. It is highly recommended that psychologists have exclusive access to social media so others (including family members) cannot access it. 6. Use only trusted and secure WiFi networks (don't use Starbucks or airport WiFi to access work websites).	

DRAFT

		7. Use encrypted email. 8. Discuss the turnaround times of various methods of communication. 9. Let patients know they can turn off location tracking during appointments. 10. Understand the privacy settings on every application that you use as some applications are social media whether or not you know it. **Dual Relationships** Psychologist must avoid multiple relationships when feasible, and they must clarify the nature of multiple relationships to all concerned parties when these relationships are unavoidable. 1. Psychologists are responsible for all connections they make through social media, and to know whether or not these connections establish a dual relationship. Examples of connections types: • A permission-based connection. • A non-permission-based connection. • Systemic relationships built into the social media that propose connections based on shared interests or existing connections indicated by participants. • Access to contact lists available on devices used to log in to social network. 2. Psychologists should familiarize themselves with both the privacy policy and settings of any form of social media they use. 3. Psychologists are responsible for any comments or posts they make on any form of social media they maintain, and the risk any of these comments	

DRAFT

may have in violation of any aspect of the Ethics Code of the American Psychological Association. The old adage, "when in doubt, leave it out" may be a good motto to apply when it comes to any information that might lead to identification of a patient or alter patients' sense of safety and trust in our professional standing.

Competence

When psychologists use social media technologies as an adjunct to their clinical practice, they need to be competent in both the technologies employed and the methods by which they are used. This would include awareness of potential clinical, technical and administrative issues associated with their use and reasonable steps taken to competently use technologies while mitigating risk. By not taking care to address competency issues, Psychologists may be assuming liabilities and risking ethical violations.

1. Psychologists should use social media in ways aligned with upholding the reputation of the profession, consistent with APA ethics and guidelines.

2. Data should be encrypted, passwords should be strong and platforms should be protected from unauthorized digital access. Third-Party Services should be properly vetted to ensure HIPAA compatibility.

3. Social media policies should be adequately detailed and discussed through informed consent.

4. Psychologists need to obtain training which will help them to maintain competence in this ever-changing arena

DRAFT

		Professional Conduct 1. Keep tweets to matters like psychoeducation, health news, or the work of your colleagues; avoid even "de-identified" references to clients. 2. Do not connect with clients on social media (no "friending" on Facebook, implying a professional reference via LinkedIn, or other social media networks). 3. Be aware that the multiple layers in the web of networking may link your information to your clients' even if you don't personally respond or initiate. Anything that is on your personal network may be accessible through the web of previously established relationships. 4. Use a separate email address for your social media account(s) than the one you use to correspond with clients. Only text if it's part of your informed consent. 5. Unless you're a forensic psychologist, "googling" a client must be in the informed consent.	
Social Work	**National Association of Social Workers, Association of Social Work Boards, Council on Social Work Education, & Clinical Social Work Association.** (2017). Standards for Technology in Social Work Practice. Retrieved at https://www.aswb.org/wp-content/uploads	**Standard 2.10: Social Media Policy** Social workers who use social media shall develop a social media policy that they share with clients. **Standard 3.09: Using Search Engines to Locate Information about Clients** Except for compelling professional reasons, social workers shall not gather information about clients from online sources without the client's consent; if they do so, they shall take reasonable steps to verify the accuracy of the found information. **Standard 3.12: Open Access Information** When information is posted or stored electronically in a manner that is intended to be available to certain groups or to the public in general, social workers shall be aware of how that information may be used and interpreted, and take reasonable steps to ensure that the information is accurate, respectful, and complete.	These comprehensive set of social work technology standards were developed by the four different organizations representing educational, regulatory and professional organizations.

DRAFT

	/2013/10/TechnologySWPractice.pdf	**Standard 4.04: Social Media Policies** When using online social media for educational purposes, social work educators shall provide students with social media policies to provide them with guidance about ethical considerations. **Section H Distance Counseling, Technology, and Social Media** **H.1. Knowledge and Legal Considerations** H.1.a. Knowledge and Competency Counselors who engage in the use of distance counseling, technology, and/or social media develop knowledge and skills regarding related technical, ethical, and legal considerations H.1.b. Laws and Statutes Counselors who engage in the use of distance counseling, technology, and social media within their counseling practice understand that they may be subject to laws and regulations of both the counselor's practicing location and the client's place of residence. **H.2. Informed Consent and Security** H.2.a. Informed Consent and Disclosure Clients have the freedom to choose whether to use distance counseling, social media, and/or technology within the counseling process. H.4.b. Professional Boundaries in Distance Counseling Counselors understand the necessity of maintaining a professional relationship with their clients H.4.f. Communication Differences in Electronic Media Counselors consider the differences between face-to-face and electronic communication (nonverbal and verbal cues) and how these may affect the counseling process.	

DRAFT

		H.6. Social Media H.6.a. Virtual Professional Presence In cases where counselors wish to maintain a professional and personal presence for social media use, separate professional and personal web pages and profiles are created to clearly distinguish between the two kinds of virtual presence. H.6.b. Social Media as Part of Informed Consent Counselors clearly explain to their clients, as part of the informed consent procedure, the benefits, limitations, and boundaries of the use of social media. H.6.c. Client Virtual Presence Counselors respect the privacy of their clients' presence on social media unless given consent to view such information. H.6.d. Use of Public Social Media Counselors take precautions to avoid disclosing confidential information through public social media.	
Marriage and Family Therapy	**Ginory, A., , Mayol Sabatier, L., & Eth, S.** (2012). Addressing therapeutic boundaries in social networking. Psychiatry, 75(1), 40-48.	TABLE 3. Summary of Guidelines for Maintaining Professionalism in Social Media 1. Physicians should regularly update their privacy settings. 2. Physicians should remain aware of guidelines regarding patient confidentiality and refrain from posting identifying information about patients, including photographs. 3. When interacting with patients online, all boundaries should be maintained based on previously set forth guidelines. 4. Entering into dual relationships with patients should be avoided.	"This study explored the prevalence of such boundary crossings and offers recommendations for training. An anonymous voluntary survey regarding Facebook use was distributed to current psychiatry residents through the American Psychiatric Association (APA) listserv."

DRAFT

		5. Physicians should maintain adequate separation of personal and professional information, and on personal profile, they should be wary of the pictures and information available, as even with privacy settings items may be visible publicly. 6. Inappropriate behavior online should be discussed with the individual, and if it remains uncorrected, it should be reported to the proper authorities. 7. Physicians should regularly monitor their Internet presence by conducting regular web inquiries to search for information that may be publicly available. 8. Training programs should develop policies for professional use of social media and educate residents on possible boundary crossings and violations of professionalism. 9. Physicians should be aware that there might be negative repercussions for content posted. (American Medical Association, 2011; Gabbard, Kassaw, & Perez-Garcia, 2011)	
Psychology	Tunick, R., Mednick,L. & Conroy, C. (2011). A snapshot of child psychologists' social media activity: Professional and ethical practice implications and recommendation s. Professional	● Clinicians must be aware of the potential dilemmas that may arise when participating in social media. ● Be savvy and diligent about privacy settings ● psychologists should carefully consider and develop a clear and consistent policy about their approach to online communication with clients and be transparent regarding their online policy ● Engage in conversation with trainees in their training about their online behavior	The authors surveyed 246 psychologists and psychologists-in-training regarding their own blogging and social networking practices, as well as their behavior around their clients' online presence. Based

DRAFT

	Psychology: Research and Practice, 42(6), 440–447.	● Consider the risks and benefits before viewing clients' online material ● Should psychologists decide that the benefits of viewing client information online outweigh the risks, we encourage our colleagues to be transparent about this practice. ● Promote safe Internet behavior with clients ● We recommend that clinicians working with youth engage in dialogue with parents about matters pertaining to their children's Internet safety	on the responses to this survey, a series of considerations and guidelines for our professional practice are proposed, and psychologists are encouraged to engage in thoughtful self-reflection as they establish their own policies regarding these matters.
Psychiatry	Peek, H., Richards, M., Muir, O., Chan, S., Caton, M., & MacMillan, C. (2015). Blogging and social media for mental health education and advocacy: A review for psychiatrists. *Current Psychiatry Reports*, 17: 88	**Blogging Guidelines** ● Use the Golden Rule of the Internet: if a psychiatrist would not say it in person, they should not say it online. ● Question intent: if publishing a story will benefit only the author, consider not publishing it. ● Keep it clean: a psychiatrist-blogger represents not only themselves in the public but also the profession and any affiliated institutions. ● Care for patients on the page: the psychiatrist-blogger is responsible for the patient's well-being even when they are not physically in their presence **Social Media and Microblogging Guidelines** The authors cite the FSMB social media guidelines to follow	"We ... review the current recommendations for ethics and professionalism as well as make recommendations to strengthen our guidance in this new [blogging and social media] and evolving field."
Psychiatry	Gabbard, G., Kassaw, K. & Perez-Garcia, G. (2011). Professional boundaries in the era of the	**TABLE 1. Recommended Guidelines for Maintaining Professional Boundaries Online** 1. Psychiatrists and other mental health professionals who use social networking sites should activate all available privacy settings (5, 19, 20).	

DRAFT

	Internet. *Academic Psychiatry*, 35:168–174.	2. Web searches should be conducted periodically to monitor false information or photographs of concern (20). If these items are discovered, the website administrator can be contacted to remove problematic information. 3. The following items should not be included in blogs or networking sites: a) Patient information and other confidential material. b) Disparaging comments about colleagues or groups of patients. c) Any comment on lawsuits, clinical cases, or administrative actions in which one is involved, because they can potentially compromise one's defense (22). d) Photographs that may be perceived as unprofessional (e.g., sexually suggestive poses or drinking/drug use). 4. Although looking up information about a patient on the Internet is not unethical because it is public, psychiatrists who choose to do so must be prepared for clinical complications that require careful and thoughtful management. Some patients may experience the psychiatrist's interest in this information as a boundary-violation or a compromise of trust (23). 5. One should avoid becoming "Facebook friends" or entering into other dual relationships on the Internet with patients (19, 21). One strategy is to have separate profiles for separate roles, that is, personal versus professional (Hsiung R, personal communication, December 14, 2009). 6. One must not assume that anything posted anonymously on the Internet will remain anonymous, because posts can be traced to their	

DRAFT

		sources (22). Psychiatrists or psychiatric residents who wish to post their availability on online dating sites are free to do so but must be fully prepared for the possibility that patients will see them and have intense reactions. 7. Training institutions should educate their trainees about professionalism and boundary issues as part of their professionalism curriculum and assist them in their mastery of technology. 8. All training institutions should develop policies for handling breaches of ethics or professionalism through Internet activity. 9. Psychotherapy training should include consideration of the clinical dilemmas presented by social networking sites, blogging, and search engines, as well as potential boundary issues.	
Physicians	Chretien, K. & Kind, T. (2013). Social media and clinical care ethical, professional, and social implications. Circulation.127, 1413-1421.	Table 3. Recommendations for Physicians Who Use Social Networking ● Avoid writing about specific patients ● Opt for highest privacy settings ● Keep in mind that all content may be discoverable ● Avoid extending “friend requests” to patients ● Respond to friend requests from patients to access physician’s personal social ● networking page by redirecting them to more secure means of communication or to a physician’s professional social networking page ● Avoid anonymity ● Accurately state credentials ● Specifically, state whether you are or not representing your employer or institution ● Avoid giving specific medical advice to non-patients	

945
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DRAFT

APPENDIX C – Statutes, Regulations or Policies Adopted in U.S. Jurisdictions

Arizona: 32-2075 – exemptions from licensure

California: California Telehealth Advancement Act of 2011, http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_0401-0450/ab_415_bill_20111007_chaptered.pdf

Colorado State Board of Psychologist Examiners: Policy 30-1 adopted 4-8-11. Teletherapy Policy: Guidance Regarding Psychotherapy Through Electronic Means within the State of Colorado. At https://www.colorado.gov/pacific/dora/Psychologist_Laws#Policies

Delaware Board of Examiners of Psychologists: Regulations in CDR 24-3500, Section 18.0 Telepsychology at http://regulations.delaware.gov/AdminCode/title24/3500.pdf define telepsychology and standards for practicing telepsychology. As of January 2016, the licensing law (Title 24, Chapter 35, Section 3502 (6) defines the "practice of psychology" to include "the use of telemedicine". At http://delcode.delaware.gov/title24/c035/sc01/index.shtml

Georgia: Georgia administrative rule 510-5-.07 (2) Practicing via Electronic Transmission rule at http://rules.sos.state.ga.us/docs/510/5/07.pdf

Hawaii: Chapter 465, Section 465-3 (8) provides a limited exemption for psychologists employed by the Department of Defense providing telepsychological services http://cca.hawaii.gov/pvl/files/2013/08/hrs_pvl_465.pdf

Idaho: Idaho Code § 54-2305-11 (2013) provides for establishing telepsychology rules http://www.scstatehouse.gov/code/t40c055.php The Idaho Board of Psychologists Examiners with the Idaho Psychological Association adopted Guidelines for Electronic Transmission and Telepsychology in the State of Idaho in 2012 that are at http://www.idahoahec.org/app/uploads/sites/2/2015/04/Idaho-Telepsychology-Guidelines.pdf

Kansas: KAR 102-1-19 requires license in state to practice psychology regardless of person's location http://www.ksbsrb.org/statutes_regs/regulationslp.html

Kentucky: Statute KRS 319.140 (2000) requires informed consent and maintaining confidentiality when using telehealth http://www.lrc.ky.gov/krs/319-00/140.PDF ; Telehealth and Telepsychology Rule 201 KAR 26: 310 (2010) at http://www.lrc.ky.gov/kar/201/026/310.htm

Maine: According to the *MaineCare Benefits Manual*, "Interactive Telehealth Services" means"[r]eal time, interactive visual and audio telecommunications whereby a Member and a Health Care Provider interact remotely through the use of technology."

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994 MaineCare Benefits Manual, *Telehealth*, ch. 1 § 4.01-9 (Apr. 16, 2016).
995
996 According to the *MaineCare Benefits Manual*, "Telehealth Services" means "[t]he use of
997 information technology by a Health Care Provider to deliver clinical services at a
998 distance for the purpose of diagnosis, disease monitoring, or treatment. Telehealth
999 Services may be either Telephonic or Interactive (combined video/audio)."
1000 MaineCare Benefits Manual, *Telehealth*, ch. 1 § 4.01-10 (Apr. 16, 2016).
1001
1002 **Mississippi:** Code Ann. § 73-31-3 (d)(ii)(7) and § 73-31-14(3) practice of psychology includes
1003 telecommunications http://www.lexisnexis.com/hottopics/mscode/
1004
1005 **Montana:** Administrative Rule 24.189.301(1) definition of a "professional relationship" includes
1006 telecommunications http://www.mtrules.org/gateway/ruleno.asp?RN=24.189.301 Admin Rule
1007 **24.189.607 (4)(d)(ii) includes teleconferencing for postdoctoral supervision**
1008 http://www.mtrules.org/gateway/ruleno.asp?RN=24.189.607
1009
1010 **New Hampshire:** Chapter 329-B, Section 329-B:16 states that the "electronic practice of
1011 psychology" is subject to standards of care adopted by the New Hampshire Board of Mental Health
1012 Practice http://www.gencourt.state.nh.us/rsa/html/XXX/329-B/329-B-16.htm
1013
1014 **New Jersey:** A "'health care provider' means an individual who provides a health care service to
1015 apatient, and includes, but is not limited to . . . a psychologist."
1016 N.J. STAT. ANN. § 45:1-61.
1017
1018 A health care provider engaging in telemedicine or telehealth shall review the
1019 medical history and any medical records provided by the patient. For an initial
1020 encounter with the patient, the provider shall review the patient's medical history
1021 and medical records prior to initiating contact with the patient, as required pursuant
1022 to paragraph (3) of subsection a. of section 3 of P.L.2017, c.117 (C.45:1-63). In the
1023 case of a subsequent telemedicine or telehealth encounter conducted pursuant to
1024 an ongoing provider-patient relationship, the provider may review the information
1025 prior to initiating contact with the patient or contemporaneously with the
1026 telemedicine or telehealth encounter.
1027 N.J. STAT. ANN. § 45:1-62(c)(4).
1028
1029 "Any health care provider providing health care services using telemedicine or telehealth
1030 shall be subject to the same standard of care or practice standards as are applicable to
1031 in-person settings. If telemedicine or telehealth services would not be consistent with this
1032 standard of care, the health care provider shall direct the patient to seek in-person care."
1033 N.J. STAT. ANN. § 45:1-62(d)(1).
1034
1035 Any health care provider who uses telemedicine or engages in telehealth while
1036 providing health care services to a patient, shall: (1) be validly licensed, certified,
1037 or registered, pursuant to Title 45 of the Revised Statutes, to provide such services

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1038 in the State of New Jersey. (2) remain subject to regulation by the appropriate New
1039 Jersey State licensing board or other New Jersey State professional regulatory
1040 entity; (3) act in compliance with existing requirements regarding the maintenance
1041 of liability insurance; and (4) remain subject to New Jersey jurisdiction if either the
1042 patient or the provider is located in New Jersey at the time services are provided.
1043 N.J. STAT. ANN. § 45:1-62(b).
1044
1045 Any health care provider who engages in telemedicine or telehealth shall ensure
1046 that a proper provider-patient relationship is established. The establishment of a
1047 proper provider-patient relationship shall include, but shall not be limited to:
1048 (1) properly identifying the patient using, at a minimum, the patient's name, date of
1049 birth, phone number, and address. When properly identifying the patient, the
1050 provider may additionally use the patient's assigned identification number, social
1051 security number, photo, health insurance policy number, or other appropriate
1052 patient identifier associated directly with the patient;
1053 (2) disclosing and validating the provider's identity and credentials, such as the
1054 provider's license, title, and, if applicable, specialty and board certifications;
1055 (3) prior to initiating contact with a patient in an initial encounter for the purpose of
1056 providing services to the patient using telemedicine or telehealth, reviewing the
1057 patient's medical history and any available medical records; and
1058 (4) prior to initiating contact with a patient for the purpose of providing services to
1059 the patient using telemedicine or telehealth, determining whether the provider will
1060 be able to provide the same standard of care using telemedicine or telehealth as
1061 would be provided if the services were provided in person. The provider shall
1062 make this determination prior to each unique patient encounter.
1063 N.J. STAT. ANN. § 45:1-63(a).
1064
1065 Telemedicine or telehealth may be practiced without a proper provider-patient
1066 relationship, as defined in subsection a. of this section, in the following
1067 circumstances:
1068 (1) during informal consultations performed by a health care provider outside the
1069 context of a contractual relationship, or on an irregular or infrequent basis, without
1070 the expectation or exchange of direct or indirect compensation;
1071 (2) during episodic consultations by a medical specialist located in another
1072 jurisdiction who provides consultation services, upon request, to a properly
1073 licensed or certified health care provider in this State;
1074 (3) when a health care provider furnishes medical assistance in response to an
1075 emergency or disaster, provided that there is no charge for the medical assistance;
1076 or
1077 (4) when a substitute health care provider, who is acting on behalf of an absent
1078 health care provider in the same specialty, provides health care services on an oncall
1079 or cross-coverage basis, provided that the absent health care provider has
1080 designated the substitute provider as an on-call provider or cross-coverage service
1081 provider.

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1082 N.J. STAT. ANN. § 45:1-63(b).
1083
1084 "'Telehealth' means the use of information and communications technologies, including
1085 telephones, remote patient monitoring devices, or other electronic means, to support
1086 clinical health care, provider consultation, patient and professional health-related
1087 education, public health, health administration, and other services in accordance with the
1088 provisions of P.L.2017."
1089 N.J. STAT. ANN. § 45:1-61.
1090
1091 "Telemedicine services shall be provided using interactive, real-time, two-way
1092 communication technologies."
1093 N.J. STAT. ANN. § 45:1-62(c)(1).
1094
1095 "'Telemedicine' does not include the use, in isolation, of audio-only telephone
1096 conversation, electronic mail, instant messaging, phone text, or facsimile transmission."
1097 N.J. STAT. ANN. § 45:1-61.
1098
1099 A health care provider engaging in telemedicine or telehealth may use
1100 asynchronous store-and-forward technology to allow for the electronic
1101 transmission of images, diagnostics, data, and medical information; except that the
1102 health care provider may use interactive, real-time, two-way audio in combination
1103 with asynchronous store-and-forward technology, without video capabilities, if,
1104 after accessing and reviewing the patient's medical records, the provider
1105 determines that the provider is able to meet the same standard of care as if the
1106 health care services were being provided in person.
1107 N.J. STAT. ANN. § 45:1-62(c)(2)
1108
1109 **New York:** "Telepractice includes the use of telecommunications and web-based applications to
1110 provide assessment, diagnosis, intervention, consultation, supervision, education and
1111 information across distance. It may include providing non-face-to-face psychological, mental
1112 health, marriage and family, creative arts, psychoanalytic, psychotherapy and social work
1113 services via technology such as telephone, e-mail, chat and videoconferencing.
1114 Telecommunications and Electronic Medical Records (EMRs) may include computer files,
1115 documents, e-mails, interactive media sessions, CD's, audiotapes, video-tapes, fax images,
1116 phone messages and text messages."
1117 New York State Education Department, Office of the Professions, Practice Alert:
1118 Telepractice (last updated Dec. 17, 2013) (applies broadly to mental health
1119 practitioners).
1120
1121 What are the acceptable modalities (e.g., telephone, video) for the practice of social work via
1122 telemedicine/telehealth that meet the standard of care for the state?
1123
1124 "Telepractice includes the use of telecommunications and web-based applications to
1125 provide assessment, diagnosis, intervention, consultation, supervision, education and

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1126 information across distance. It may include providing non-face-to-face psychological,
1127 mental health, marriage and family, creative arts, psychoanalytic, psychotherapy and
1128 social work services via technology such as telephone, e-mail, chat and
1129 videoconferencing. Telecommunications and Electronic Medical Records (EMRs) may
1130 include computer files, documents, e-mails, interactive media sessions, CD's, audiotapes,
1131 video-tapes, fax images, phone messages and text messages."
1132 New York State Education Department, Office of the Professions, Practice Alert:
1133 Telepractice (last updated Dec. 17, 2013) (applies broadly to mental health
1134 practitioners).
1135
1136 **North Dakota:** **A**dministrative rule 43-51-02 defines services provided to residents of the state,
1137 regardless of how they are provided or the physical location of the provider, to be regulated by
1138 North Dakota law and rules http://www.legis.nd.gov/cencode/t43c51.pdf . The North Dakota State
1139 Board of Psychologist Examiners has a Board Statement on Telepsychology in North Dakota dated
1140 October 17, 2014 at http://www.ndsbpe.org/uploads/2/9/2/4/2924803/faq_telepsychology_4-14-
1141 15.pdf
1142
1143 **Ohio:** Ohio Administrative Code 4732-17-01 (I) Telepsychology Rules (2011)
1144 http://codes.ohio.gov/oac/4732-17
1145
1146 **Oregon:** *Social Media Guidelines* (2018). http://oregon.gov
1147
1148 **South Carolina:** Code Section 40-55-50 (C) requires psychology license to provide services in the
1149 state including by telecommunications http://www.scstatehouse.gov/code/t40c055.php
1150
1151 **Tennessee :** Code 63-11-203(a)(2)(A)(viii) defines telepsychology
1152 http://www.lexisnexis.com/hottopics/tncode/
1153 (telepsychology rules being developed by the Tennessee Board of Examiners of Psychology
1154 were in "internal review process" as of December 15, 2015. No rules regarding telepsychology
1155 as of June 12, 2017)
1156
1157 **Texas:** "Licensees who provide psychological services through the internet or other remote or
1158 electronic means, must provide written notification of their license number and
1159 instructions on how to verify the status of a license when obtaining informed consent."
1160 22 TEX. ADMIN. CODE § 465.7.
1161
1162 **Utah:** Administrative Rule R156-61-102 (3)(b) allows "direct supervision" of a supervisee in
1163 training to receive supervision remotely "...via real time electronic methods that allow for visual
1164 and audio interactions..." http://www.dopl.utah.gov/laws/R156-61.pdf
1165
1166 **Vermont:** Statute Title 26, Chapter 055 § 3018 (1999) defines psychological services via
1167 telecommunications to be regulated by Vermont law
1168 http://legislature.vermont.gov/statutes/section/26/055/03018 Administrative Rule 6.4

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1169 Telepractice includes any interjurisdictional "telepractice services"
1170 https://www.sec.state.vt.us/media/649337/Psych-RulesAdopted-Clean-1229-2014.pdf
1171
1172 **Washington:** "'Telepsychology' is the delivery of psychological services using
1173 Telecommunications technologies."
1174 Washington Department of Health, Office of Health Professions and Facilities,
1175 Examining Board of Psychology, *Telepsychology* (Jan. 29, 2016), at 1.
1176
1177 "Psychologists utilizing telepsychology on patients-clients in Washington State must be
1178 licensed to practice psychology in Washington State or have a temporary permit to
1179 practice psychology in Washington State. Washington State licensed psychologists are
1180 encouraged to be familiar with and comply with relevant laws and regulations when
1181 providing telepsychology services to patients-clients across state and international
1182 borders."
1183 Washington Department of Health, Office of Health Professions and Facilities,
1184 Examining Board of Psychology, *Telepsychology* (Jan. 29, 2016), at 2.
1185
1186 Psychologists [must] obtain and document informed consent that specifically
1187 addresses the concerns that may be related to the telepsychology services they
1188 provide. Such informed consent should be developed so it is reasonably
1189 understandable to clients-patients. Informed consent may include, but is not limited
1190 to:
1191 (a) The manner in which the psychologist and client-patient will use particular
1192 telecommunications technologies, the boundaries that will be established and
1193 observed, and procedures for responding to electronic communications from
1194 clients-patients;
1195 (b) Issues and potential risks surrounding confidentiality and security of client patient
1196 information when particular telecommunication technologies are used (e.g.,
1197 potential for decreased expectation of confidentiality if certain technologies are
1198 used);
1199 (c) Limitations on the availability and/or appropriateness of specific telepsychology
1200 services that may be hindered as a result of the services being offered remotely.
1201 Washington Department of Health, Office of Health Professions and Facilities,
1202 Examining Board of Psychology, *Telepsychology* (Jan. 29, 2016), at 2.
1203
1204 **West Virginia:** West Virginia Board of Examiners of Psychologists, Policy
1205 Statements: Tele-Psychology.
1206
1207 Minimum equipment standards are transmission speeds of 256kbps or higher over
1208 ISDN (Integrated Services Digital Network) or proprietary network connections
1209 including VPNs (Virtual Private Networks), fractional T1, or T1 comparable cable
1210 bandwidths. Software that has been developed for the specific use of Telehealth
1211 may be used as long as the software is HIPAA Compliant and abides by a federal
1212 code pertaining to Telehealth.

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1213
1214 The audio, video, and/or computer telemedicine system used must, at a minimum,
1215 have the capability of meeting the procedural definition of the code provided
1216 through telemedicine. The telecommunication equipment must be of a quality to
1217 complete adequately all necessary components to document the level of service
1218 for the CPT codes that are available to be billed. If a peripheral diagnostic scope is
1219 required to assess the patient, it must provide adequate resolution or audio quality
1220 for decision-making.
1221
1222 **Wisconsin:** Administrative Code Psy 2.14 (2) states that "A psychologist provides psychological
1223 services in this state whenever the patient or client is located in this state, regardless of
1224 whether the psychologist is temporarily located in this state or is providing services by
1225 electronic or telephonic means from the state where the psychologist is licensed.
1226 https://docs.legis.wisconsin.gov/code/admin_code/psy/2.pdf
1227
1228 **Policy, Statments, Opinion or Position Papers**
1229
1230 **Colorado:** State Board of Psychology Examiners Administrative Policy 30-1 Teletherapy Policy-
1231 Guidance Regarding Psychotherapy Through Electronic Means in the State of Colorado
1232 http://www.colorado.gov/cs/Satellite/DORA-Reg/CBON/DORA/1251632089838
1233
1234 **Florida**: case in January 2012 board approved Florida licensed psychologist to provide
1235 telepsychology from Michigan to Florida, board opinion June 5, 2006 regarding requirement for
1236 Florida license by Ohio psychologist in Florida and telepsychology to an Ohio citizen in Ohio
1237
1238 **Louisiana:** board opinion that psychologist must be licensed in LA to provide telepsychology,
1239 that the psychologist is expected to have had a face to face relationship established previously
1240 (November 2010 Board minutes – not online) Telepsychology Guidelines adopted by board
1241 effective January 1, 2015 at http://www.lsbep.org/pdfs/2014/Final-Telepsych-Guidelines-1-
1242 15.pdf
1243
1244 **Massachusetts:** 2005 and updated October 2015 Massachusetts Board of Registration in
1245 Psychology opinion Provision of Services Via Electronic Means (same as North Carolina
1246 psychology board opinion) http://www.mass.gov/ocabr/licensee/dpl-
1247 boards/py/regulations/board-policies/provision-of-services-via-electronic-means.html
1248
1249 **New York**: Guideline updated December 17, 2013:Engaging in Telepractice (same as North
1250 Carolina psychology board statement)
1251 http://www.op.nysed.gov/prof/psych/psychtelepracticeguide.htm
1252
1253 **Nevada:** June 2013 statement in State of Nevada Board of Psychological Examiners newsletter
1254 written by board secretary/treasurer states that a Nevada psychology license is required for
1255 anyone out of state providing any psychological services in Nevada.
1256 http://psyexam.nv.gov/News-Resources/

1257
1258 **North Carolina:** 2005 psychology board opinion Provision of Services Via Electronic Means,
1259 (same as New York psychology board statement) at
1260 http://www.ncpsychologyboard.org/office/ElectronicServices.htm
1261
1262 **Texas:** Telepractice Policy Statement, Newsletter of Texas State Board of Examiners of
1263 Psychologists, Fall 1999, Vol. 12, No. 2, at
1264 http://www.tsbep.texas.gov/files/newsletters/1999Fall.pdf
1265
1266 **Virginia:** Baker (2013) states policy statement issued by Virginia Board of Counseling Guidance
1267 on Technology-Assisted Counseling and Technology-Assisted Supervision used by the Virginia
1268 Board of Psychology http://www.dhp.virginia.gov/counseling/guidelines/115-
1269 1.4%20Technology-Assisted.doc
1270
1271 **West Virginia:** Board of Examiners of Psychology policy statement Tele-Psychology-Skype lists
1272 cautions regarding the use of "skype" for providing psychological services
1273 http://www.wvpsychbd.org/policy_statements.htm
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APPENDIX D – Statutes, Regulations or Policies Adopted in Canadian Jurisdictions

Alberta: The College of Alberta Psychologists has practice guidelines for Telepsychology Services that can be accessed from the College website at www.cap.ab.ca .

British Colombia: The website for the College of Psychologists of British Colombia has, under the "Forms and Documents" section, a number of checklists that remind registrants about the requirements for certain areas of practice. The checklists for social media include – Checklist #01 for the "Use of Email and Other Electronic Media to Communicate with Clients"; Checklist #06 for "Telepsychology Services"; Checklist #07 for the "Use of Social Media"; Checklist #14 that addresses "Considerations Before Offering a Novel or Alternative Type of Service"; and Checklist #15 for "Telepsychology Assessment". These checklists can be accessed at www.collegeofpsychologists.bc.ca.

Manitoba: Telepsychology Practice Standards (2011) can be found on the website for the Psychological Association of Manitoba, the regulatory body for Manitoba. That address is www.cpmb.ca/documants/Telepsychology.Standards.4June2011.

Nova Scotia: The Model Standards for Telepsychology Service (2017) can be found on the website for the Nova Scotia Board of Examiners in Psychology at www.nsbep.org. A memorandum of understanding (MOU) between the Nova Scotia Board, the Prince Edward Island Board, the College of Psychologists of New Brunswick and the Newfoundland and Labrador Board regulates the practice of telepsychology in those provinces. This MOU among the Atlantic Provinces allows interjurisdictional telepsychology practice without requiring registration in every one of the provinces as long as the psychologist is registered in one of those provinces.

Prince Edward Island: Aside from the MOU with Nova Scotia, New Brunswick, and Newfoundland and Labrador, PEI has "Practice Guidelines: Telepsychology" that identify the jurisdictional standards and areas of the Canadian Code of Ethics for Psychologists (2017) applicable to telepsychology practice. The Practice Guidelines can be found at www.peipsychology.org.

Saskatchewan: This province has on its website, "Model Standards for Telepsychology Service Delivery" that were adopted by the Association of Canadian Psychology Regulatory Organizations (ACPRO). These brief Standards specify which sections of the Canadian Code of Ethics apply to the practice of telepsychology and identify a set of "rules" that govern this practice and can be found on the Saskatchewan website at www.skcp.ca/pdf%20files/telehealth-advisory.pdf . The College's Professional Practice

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1344 Guidelines (2019) address "Telepsychology and Social Media" and can be found at
1345 www.skcp.ca.
1346

1347 ## APPENDIX E – Codes Relevant to Social Media Use

1348

1349 **Confidentiality**

1350 • ASPPB Code – F.2, F.6, F.7, F.11
1351 • APA Code - 4.01 – 4.07
1352 • CPA Code - 1.03 – 1.05
1353

1354 **Informed Consent**

1355 • ASPPB Code – F.2, F.3, F.6
1356 • APA Code - 3.10
1357 • CPA Code - 1.16 – 1.21, 1.27, 1.30 – 1.40 and III.13 – III.15
1358

1359 **Risk Management**

1360 • ASPPB Code – Sections A, B, C, D, E and F
1361 • APA Code - Principle A, 3.06, 4.01 and 5.01
1362 • CPA Code -II.37 and II.44 – II.45
1363

1364 **Multiple Relationships**

1365 • ASPPB Code – B.1, B.2
1366 • APA Code – 3.05
1367 • CPA Code – 1.26, II.28 – II.31 and III.28 – III.31
1368

1369 **Competence**

1370 • ASPPB Code – Section A (especially A.4)
1371 • APA Code – 2.01, 2.04, and 5.04
1372 • CPA Code – II.1 – II.14, II.16, II.18, II.21 – II.23, II.56, III.35, IV.15, IV.18 and IV. 24 – IV.28
1373

1374 **Professional Conduct**

1375 • ASPPB Code – Sections A, C, D, E and F
1376 • APA Code – 2.01, 2.04, and 5.04
1377 • CPA Code – III.1 – III.8, IV.4, IV.8 and IV.10 – IV.11
1378

1379 **Security of Information**

1380 • ASPPB Code – Section F
1381 • APA Code – 4.01, 2.05 and 6.02
1382 • CPA Code – II.6, II.21, II.56 and III.37

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APPENDIX F – Example of Informed Consent Disclaimer

Confidentiality Notice: this message is intended only for the use of the individual or entity to which it is addressed and may contain information whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR, Part 2) prohibit you from making any further disclosure of it without the expressed written consent of the person to whom it pertains, or of the guardian or custodial parent of the minor to whom it pertains. This prohibition applies to any reference to
this email, either verbal or written, or to any excerpting, photocopying, or direct quotes from this email. If you are not the intended recipient, please delete this email immediately.

In requesting a response from me via email, you are hereby giving your consent for a response by email, understanding that email may not be encrypted and even if encrypted, email poses security risks that threaten confidentiality (i.e., other people reading your messages, hacking and email pirating, lost or stolen devices). If you would prefer a response in another format (telephone, voice mail, FAX, or postal service), please indicate your preference in your email message to me or contact me by any of these other methods. (Oregon Board of Psychology, 2018)**

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** It is important to stress that informed consent is a process that should be engaged in with the client and is not a form. Use of a form of any type should be seen as only part of the informed consent process and not the process itself.

APPENDIX G – Sample of Social Media Policy

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with me.

Email [and Text Message] Communications

I use email communication [and text messaging] only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges [and text messages] with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email [or text] me about clinical matters because this is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

Email [and text messaging] should not be used to communicate with me in an emergency situation. I make every effort to respond to emails[, texts] and phone calls within 24 hours, except on weekends and holidays. In case of an emergency, please call my phone line at [insert #]. If I am not immediately available by phone, please call 911, contact local crisis services [insert name of organization and phone #] or go to the nearest emergency room.

[For psychologists who do not wish to receive any text messages, delete bracketed text above referring to text messages and insert the following paragraph]

Text Messaging
Because text messaging is a very unsecure and impersonal mode of communication, I do not text message to nor do I respond to text messages from anyone in treatment with me. So, please do not text message me unless we have made other arrangements.

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1466 ***Social Media***
1467 I do not communicate with, or contact, any of my patients through social media platforms
1468 like Twitter and Facebook. In addition, if I discover that I have accidentally established an
1469 online relationship with you, I will cancel that relationship. This is because these types of
1470 casual social contacts can create significant privacy risks for you.
1471
1472 I participate on various social networks, but not in my professional capacity. If you have an
1473 online presence, there is a possibility that you may encounter me by accident. If that occurs,
1474 please discuss it with me during our time together. I believe that any communications with
1475 patients online have a high potential to compromise the professional relationship. In
1476 addition, please do not try to contact me in this way. I will not respond and will terminate
1477 any online contact no matter how accidental.
1478
1479 ***Websites***
1480 I have a website that you are free to access. I use it for professional reasons to provide
1481 information to others about me and my practice. You are welcome to access and review the
1482 information that I have on my website and, if you have questions about it, we should discuss
1483 this during your therapy sessions.
1484
1485 ***Web Searches***
1486 I will not use web searches to gather information about you without your permission. I
1487 believe that this violates your privacy rights; however, I understand that you might choose to
1488 gather information about me in this way. In this day and age, there is an incredible amount of
1489 information available about individuals on the internet, much of which may actually be
1490 known to that person and some of which may be inaccurate or unknown. If you encounter
1491 any information about me through web searches, or in any other fashion for that matter,
1492 please discuss this with me during our time together so that we can deal with it and its
1493 potential impact on your
1494 treatment.
1495
1496 Recently it has become common for patients to review their health care provider on various
1497 websites. However, mental health professionals cannot respond to such comments because
1498 of confidentiality restrictions. It is also generally preferable for patients to discuss their
1499 concerns directly with their health care provider. If you have concerns or questions about any
1500 aspect of our work together or about any previously posted online reviews of my practice,
1501 please let me know so that we can discuss them. I recommend that you do not rate my work
1502 with you on any website for several reasons. If you rate my work on a website while you are
1503 in treatment with me, it has the potential to affect our therapeutic relationship. If you choose
1504 to post an online review about me or another health care provider either while you are in
1505 treatment or afterwards, please keep in mind that you may be revealing confidential
1506 information about your treatment.
1507
1508 Thank you for keeping this policy in mind and for letting me know of any concerns.
1509 (Oregon Board of Psychology, 2018)

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APPENDIX H – Social Media Vignettes

Vignette #1

A psychologist in a moment of anger and poor judgement texts his ex-wife, telling her that she is "more bipolar" than anyone on his caseload past and present, and this includes all the inpatients at the state hospital where he did his internship. She makes a complaint to the regulatory body, and provides the text as evidence in the complaint.

Analysis: Texting creates a record of one's statements and in sending a text even if it is intended to be private / personal one needs to be prepared that it may become public. Diagnosing his ex-wife is inappropriate as she is not his client, nor should she be his client, given their past marital relationship. It is also an ethical issue as presumably he has not formally assessed his wife and direct assessment is required in establishing a diagnosis. Psychologists need to remember that all communication potentially could become public and therefore open to scrutiny.

Vignette #2

The brother-in-law of a psychologist tags him on a Facebook post. The pictures were taken at the psychologist's bachelor party and consisted of photos of the psychologist posing suggestively in various states of intoxication.

Analysis: Psychologists need to be cognizant of the fact that ultimately they may be held responsible for any representation that reflects badly upon the profession, even one that they did not post themselves or did not intend to be public. While likely this particular situation would not likely constitute an ethical infraction, it could potentially harm the psychologist's reputation among colleagues and clients who may see such posts.

Vignette #3

A psychologist complains on a professional listserv about an insurance company's reimbursement rates that they feel are low, and about the company's response time.

Analysis: Public criticism of another agency or provider while not necessarily unethical is unprofessional and may reflect badly on the profession. Further, if clients somehow get access to the post they this may negatively impact the therapeutic relationship. It is important to give consideration to whether posting to a listserv is the most appropriate way to address one's concerns.

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1557 **Vignette #4**
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1559 On a public Linked In group, a psychologist asks for help in the treatment of a client with a
1560 borderline personality disorder diagnosis, and states in the post "I just had my session with
1561 her." He provides de-identified information about the session. The client immediately
1562 responds to the post, self-identifying that she is that client, thanking him for taking care of her.
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1564 *Analysis:* We have no way of knowing whether our own clients or clients of other psychologists
1565 are in our Linked In groups. The Linked In group was public, and the psychologist should have
1566 known this. In addition, the psychologist used identifying information ("i.e., "and I just had my
1567 session with her."), which may violate confidentiality. This is a case of where a competence
1568 issue created the venue for several ethical violations to occur.
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1571 **Vignette #5**
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1573 A psychologist working in a small remote community complains on their private Facebook page
1574 that they are sick and tired of working with victims of domestic violence as in his opinion they
1575 just "whine" and then return to their relationships to experience the violence all over again.
1576 One of the psychologist's "friends" shared the post with a friend who happens to work for a
1577 local shelter and was previously the psychologist's client. A complaint was lodged with the
1578 regulatory body.
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1580 *Analysis:* The psychologist should not have assumed that his comments would be kept private.
1581 This reflects badly on the profession, is unprofessional and inappropriate, and is harmful to the
1582 ex-client.
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1585 **Vignette #6**
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1587 A Psychologist gave her distressed client her personal cell phone number and told them the
1588 client they could contact her after hours or between appointments in an emergency if they
1589 need to. The client texts the psychologist on a Friday evening at 11 p.m. indicating that they
1590 really need to talk. The psychologist does not respond as she has had a hard week and feels
1591 that she has a right to some down time. The client texts back to her that she feels abandoned
1592 by the psychologist.
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1594 *Analysis:* The psychologist has set up the unreasonable expectation that she will be available all
1595 of the time - issue of boundaries. An unintended consequence of social media is that it
1596 supports the blurring of boundaries between personal and professional. The psychologist also

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1597 is using her private phone for client contact which could potentially become a breach of
1598 confidentiality and privacy.
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1601 **Vignette #7**
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1603 A psychologist is running late to arrive at his office, so he texts his next client to let her know
1604 that he'll be late for their "meeting". The client's daughter is playing a game on her mother's
1605 phone and sees the message.
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1607 *Analysis:* Informed Consent issue: Does the Psychologist have informed consent from the
1608 client to send messages via texting? Risk Management issue: Has the Psychologist discussed
1609 with the client how to keep her confidential messages safe from prying eyes? Security of
1610 Information issue: Has the Psychologist ensured that the text message will not be accessed
1611 from his phone by unauthorized persons (his family, partner, etc.)?
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Virginia Board of Psychology

Guidance on Electronic Communication and Telepsychology

The Board's opening statement in its Standards of Practice (Regulation 18VAC125-20-150) applies regardless of whether psychological services are being provided face-to-face, by technology, or another method; it is as follows: "The protection of the public health, safety, and welfare and the best interest of the public shall be the primary guide in determining the appropriate professional conduct of all persons whose activities are regulated by the board. Psychologists respect the rights, dignity and worth of all people, and are mindful of individual differences."

Electronic communication, such as texts and emails related to client/patient care, are included in the Board's interpretation of telepsychology. Telepsychology has become a burgeoning means of delivering both professional assessment and intervention services. Telepsychology services have been implemented in a number of diverse settings to a broad range of clients, and may even be a preferred modality in some instances. With the advent of these tools in the digital age come risks to privacy and possible disruption to client / patient care.

Not all domains and issues related to electronic transmission and telepsychology can be anticipated, but this document provides guidance to psychologists providing telepsychological services to clients in the Commonwealth of Virginia for compliance with the Standards of Practice in Regulation 18VAC125-20-150. These guidelines pertain to professional exchanges between licensed psychologists and their clients/patients/supervisees. Psychologists who choose to use social media are faced with a variety of additional challenges that are not addressed in this document.

<u>Definition of Telepsychology</u>

For the purposes of this guidance document, the Board has adopted the definition of telepsychology developed by the American Psychological Association (APA)/ Association of State and Provincial Psychology Boards/ APA Insurance Trust and reported in their *Guidelines for the Practice of Telepsychology* (2013, p. 792):

> *Telepsychology is defined, for the purpose of these guidelines, as the provision of psychological services using telecommunication technologies. Telecommunications is the preparation, transmission, communication, or related processing of information by electrical, electromagnetic, electromechanical, electro-optical, or electronic means (Committee on National Security Systems, 2010). Telecommunication technologies include but are not limited to telephone, mobile devices, interactive videoconferencing, e-mail, chat, text, and Internet (e.g., self-help websites, blogs, and social media). The information that is transmitted may be in writing or include images, sounds, or other data. These communications may be synchronous, with multiple parties communicating*

in real time (e.g., interactive videoconferencing, telephone), or asynchronous (e.g., e-mail, online bulletin boards, storing and forwarding of information). Technologies may augment traditional in-person services (e.g., psychoeducational materials posted online after an in-person therapy session) or be used as stand-alone services (e.g., therapy or leadership development provided over videoconferencing). Different technologies may be used in various combinations and for different purposes during the provision of telepsychology services. For example, videoconferencing and telephone may also be utilized for direct service, while e-mail and text are used for nondirect services (e.g., scheduling). Regardless of the purpose, psychologists strive to be aware of the potential benefits and limitations in their choices of technologies for particular clients in particular situations.

Specific Guidance on Electronic Communication

Psychologists should be cognizant of particular risks for disclosure of confidential patient personal health information (PHI) through electronic (i.e., text and email) communications between mental health professionals and their patients. Although these communication methods share with telephone communications some significant security problems, electronic communications (i.e., phone text and email correspondence) carry particular risk as they can leave a written record of detailed information that is more easily retrieved, printed, and shared with others by any person who has or gains access to either computer device used in these two-way communications. Psychologists are advised to avoid using these tools for communicating any information that discloses a patient's personal health information or treatment details. Electronic communications are considered part of the patient's/client's health record.[1] Even for routine patient scheduling arrangements, psychologists should be aware of and advise patient/clients of associated security risks in the use of these tools. Psychologists should be cognizant of whether they are using a secure communication system. Electronic communications should be succinct and minimal in their number.

Specific Guidance on Treatment / Assessment / Supervision

(1) All provision of telepsychology services - therapeutic, assessment, or supervisory – is expected to be in real time, or synchronous.

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[1] See Code of Virginia Section 32.1-127.1:03 definition: *"Health record" means any written, printed or electronically recorded material maintained by a health care entity in the course of providing health services to an individual concerning the individual and the services provided. "Health record" also includes the substance of any communication made by an individual to a health care entity in confidence during or in connection with the provision of health services or information otherwise acquired by the health care entity about an individual in confidence and in connection with the provision of health services to the individual.*

(2) Practitioners of telepsychology in the Commonwealth of Virginia must hold a current, valid license issued by the Virginia Board of Psychology or shall be a supervisee of a licensee.

(3) License holders understand that this guidance document does not provide licensees with authority to practice telepsychology in service to clients/ supervisees domiciled in any jurisdiction other than Virginia, and licensees engaged in out-of-state professional activities bear responsibility for complying with laws, rules, and/or policies for the practice of telepsychology set forth by other jurisdictional boards of psychology.

(4) Psychologists should make every effort to verify the client's/patient's/supervisee's geographic location at the start of each session. If the client/ patient/ supervisee is located outside of Virginia and any other jurisdictions where the psychologist holds a license, the psychologist should contact the psychology licensing board in that jurisdiction to determine whether practice would be permitted or reschedule the appointment to a time when the client/ patient/ supervisee is located in Virginia or another jurisdiction where the psychologist holds a current license.

(5) Psychologists who are licensed in Virginia but are not in Virginia at the time they want to provide telepsychology services to a patient/client/supervisee in Virginia should check with the jurisdiction where they are located to determine whether practice would be permitted.

(6) License holders practicing telepsychology shall comply with all of the regulations in 18 VAC 125-20-10 et seq., including the Standards of Practice specified in 18VAC125-20-150 and 18VAC125-20-160, and with requirements incurred in state and federal statutes relevant to the practice of clinical, school, or applied psychology.

(7) License holders practicing telepsychology should establish and maintain current competence in the professional practice of telepsychology through continuing education, consultation, or other procedures, in conformance with prevailing standards of scientific and professional knowledge, and should limit their practice to those areas of competence. License holders should establish and maintain competence in the appropriate use of the information technologies utilized in the practice of telepsychology.

(8) License holders recognize that telepsychology is not appropriate for all psychological problems and clients/ supervisees, and decisions regarding the appropriate use of telepsychology are made on a case-by-case basis. License holders practicing telepsychology are aware of additional risks incurred when practicing clinical, school, or applied psychology through the use of distance communication technologies and should take special care to conduct their professional practice in a manner that protects and makes paramount the welfare of the client/ patient/ supervisee.

(9) Psychologists who provide telepsychology services should make reasonable efforts to protect and maintain the confidentiality of the data and information relating to their clients and

inform them of any possible increased risks of compromised confidentiality that may be inherent in the use of the telecommunication technologies.

(10) License holders practicing telepsychology should:

(a) Conduct a risk-benefit analysis and document findings specific to:

(i) The chronological and developmental age of the client/ patient, and the presence of any physical or mental conditions that may affect the utility of telepsychology. Section 508 of the Rehabilitation Act, 29 U.S.C 794(d) is pertinent to making technology available to a client/patient with disabilities.

(ii) Whether the client's/ patient's presenting problems and apparent condition are consistent with the use of telepsychology to the client's/ patient's benefit; and

(iiI) Whether the client/ patient/supervisee has sufficient knowledge and skills in the use of the technology involved in rendering the service or can use a personal aid or assistive device to benefit from the service.

(b) Not provide telepsychology services to any person or persons when the outcome of the analysis required in paragraphs (10)(a)(i) and (10)(a)(ii) and (10)(a)(iii) is inconsistent with the delivery of telepsychology services, whether related to clinical or technological issues.

(c) Consider the potential impact of multicultural issues when delivering telepsychological services to diverse clients.

(d) Upon initial and subsequent contacts with the client/ patient/ supervisee, make reasonable efforts to verify the identity of the client/ patient/supervisee;

(e) Obtain alternative means of contacting the client/ patient/supervisee (e.g., landline and/or cell phone);

(f) Provide to the client/ patient/supervisee alternative means of contacting the licensee;

(g) Establish a written agreement relative to the client's/ patient's access to face-to-face emergency services in the client's/ patient's geographical area, in instances such as, but not necessarily limited to, the client/ patient experiencing a suicidal or homicidal crisis that is consistent with the jurisdiction's duty to protect and civil commitment statutes;

(h) Whenever feasible, use secure communications with clients/supervisees, such as encrypted text messages via email or secure websites and obtain and document consent for the use of non-secure communications.

(i) Discuss privacy in both the psychologist's room and the client/patient/supervisee's room and how to handle the possible presence of other people in or near the room where the participant is located.

(j) Prior to providing telepsychology services, obtain the written informed consent of the client/ patient/supervisee, in language that is likely to be understood and consistent with accepted professional and legal requirements, relative to:

(i) The limitations of using distance technology in the provision of clinical, school, or applied psychological services / supervision;

(ii) Potential risks to confidentiality of information because of the use of distance technology;

(iii) Potential risks of sudden and unpredictable disruption of telepsychology services and how an alternative means of re-establishing electronic or other connection will be used under such circumstances;

(iv) When and how the licensee will respond to routine electronic messages;

(v) Under what circumstances the licensee and service recipient will use alternative means of communications under emergency circumstances;

(vi) Who else may have access to communications between the client/ patient and the licensee;

(vii) Specific methods for ensuring that a client's/ patient's electronic communications are directed only to the licensee or supervisee;

(viii) How the licensee stores electronic communications exchanged with the client/ patient/supervisee;

(k) Ensure that confidential communications stored electronically cannot be recovered and/or accessed by unauthorized persons while the record is being maintained or when the licensee disposes of electronic equipment and data;

(l) Discuss payment considerations with clients to minimize the potential for misunderstandings regarding insurance coverage and reimbursement.

(11) Documentation should clearly indicate when services are provided through telepsychology and appropriate billing codes should be used.

(12) Psychologists who offer assessment services via telepsychology are expected to have considered and addressed the following broad concerns for any and all tests used with technology:

(a) Preservation of the acceptable psychometric properties (e.g., reliability, validity, normative reference group comparisons);

(b) Maintenance of any expected standardization guidelines in test administration to allow prior psychometric research to remain applicable;

(c) Adherence to scientifically accepted interpretation guidelines;

(d) Acceptability of the evaluation environment;

(e) Full disclosure of the unique risks to clients within a consent to evaluation process;

(f) Anticipation and satisfactory management of technical problems that may arise;

(g) Assurance that the examinee characteristics are adequately matched to normative reference populations;

(h) assurance that examinee identity and associated text results are secure with respect to confidentiality.

(13) In the context of a face-to-face professional relationship, this document does not apply to:

(a) Electronic communication used specific to appointment scheduling, billing, and/or the establishment of benefits and eligibility for services; and,

(b) Telephone or other electronic communications made for the purpose of ensuring client/ patient welfare in accord with reasonable professional judgment.

Recommended References

The Board recommends any psychologist considering the use of telepsychology read and become familiar with the *Guidelines for the Practice of Telepsychology* and the "Practice Guidelines for Video-Based Online Mental Health Services" developed by the American Telemedicine Association (2013). Further, given the complexity associated with telepsychology, psychologists who want to offer such services will want to review other resources. The American Psychological Association (APA) has published several books (e.g., Luxton, Nelson, & Maheu, 2016), including an ethics casebook that is a companion to the APA's *Guidelines for the*

Practice of Telepsychology (Campbell, Millan, & Martin, 2018). In addition, the Ohio Psychological Association has developed a variety of resources, including a model informed consent document and a list of areas of competence for telepsychology (see https://ohpsych.site-ym.com/page/CommunicationandTech).

Other References

American Telemedicine Association. (2013). *Practice guidelines for video-based online mental health services.* Arlington, VA: Author. Available at https://www.integration.samhsa.gov/operations-administration/practice-guidelines-for-video-based-online-mental-health-services_ATA_5_29_13.pdf

Campbell, L. F., Millan, F., & Martin, J. N. (2018). *A telepsychology casebook: Using technology ethically and effectively in your professional practice.* Washington, DC: American Psychological Association.

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Luxton, D. D., Nelson, E.-L., & Maheu, M. M. (2016). *A practitioner's guide to telemental health: How to conduct legal, ethical, and evidence-based telepractice.* Washington, DC: American Psychological Association.