President's Message

Fellow RIPA Members:

I am pleased to address you as your new RIPA president. I enjoyed meeting some of you at our recent get-together on a lovely summer evening and look forward to another get-together we are planning for the fall. Those of us who have been involved with RIPA, serving on committees and the board, have found our work to be of benefit to the community of psychologists in Rhode Island, along with providing us personally with networking opportunities and camaraderie. I ask those of you who have not been active members to join a committee, come to an event, or contact a board member to express your views about our common concerns. At this point in time we need members to help out on our communications, membership, legislative, and insurance committees. I urge you to become involved.

Leslie A. Feil, Ph.D.
RIPA President

Upcoming Continuing Professional Education

Friday, September 24, 2010
Mindfulness and Acceptance-Based Behavioral Therapies for Generalized Anxiety and Related Disorders
Susan M. Orsillo, Ph.D.
Lizabeth Roemer, Ph.D.
[6 CE Credits]
Location
The Crowne Plaza
801 Greenwich Avenue
Warwick, RI 401-732-6000
Register at www.ripsych.org

Friday, October 22, 2010
Integration of Psychological Services in Medical Settings: Barriers and Opportunities
Paul Block, Ph.D.
William A. Hancur, Ph.D.
Christine Low, Ph. D.
Wendy Plante, PhD.
Ronald Seifer, Ph. D.
[5 CE Credits]
Location
The Radisson Airport Hotel
2081 Post Road
Warwick, RI 401-739-3000

Legislative Committee Update

This legislative session was marked by the legislature’s focus on the budget at the detriment of passing legislation, including legislation of concern to psychologists. Our Legislative Committee submitted three bills to the General Assembly this year and submitted testimony for each bill. Many thanks to Past-President James Campbell for testifying at two of the hearings.

The first bill, S2430, sought to amend our licensing statute to enable the Board of Psychology to recognize and refer psychologists to a colleague assistance program. Colleague assistance programs assist impaired professionals to get assistance programs to a colleague assistance program. Colleague assistance programs assist impaired professionals to get assistance programs to a colleague assistance program. Colleague assistance programs assist impaired professionals to get assistance programs to a colleague assistance program.

The most heated issue at the session was the proposed Model Council since my first term in 1996. This issue has been a major focus on my work at the context APA strategic planning process. So we are stuck at this point. This issue has been a major focus on my work at the Council, but before a final vote which would technically require the membership to vote to postpone resolving this issue until it could be considered in the next APA strategic planning process. So we are stuck at this point. This issue has been a major focus on my work at the Council since my first term in 1996.

For decades the Council has tried to come to terms with its composition. The Council is comprised of representatives of Division, and State Provincial and Territorial Associations. Over the past few years through a very complex apportionment system we have been functionally assured we would have a vote, but the votes of the smallest associations are not fully guaranteed. Last year a compromise was worked out by a task force, and then that compromise was amended by the Council, but before a final vote which would technically require the membership to vote to amend the bylaws, the leadership decided they wanted to postpone resolving this issue until it could be considered in the context APA strategic planning process. So we are stuck at this point. This issue has been a major focus on my work at the Council since my first term in 1996.

For many years members of some divisions and specialty associations have been offered discounts on their APA dues. After several years of debate the Council voted to give members state associations the same discount they will provide to members of these divisions and specialty associations. The discount will be less than what has been offered in the past, but it will be the same for all in the future. All who qualify will receive a $25 discount.

The Council voted to adapt the ethics code to prohibit psychologists from being involved in torture.

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The Council of Representatives Report

Here are the highlights of the February 2010 Council of Representatives meeting held in Washington, DC:

The American Psychological Association commits to its vision through a mission based upon the following values: Continual Pursuit of Excellence; Knowledge and Its Application Based Upon Methods of Science; Outstanding Service to Its Members and to Society; Social Justice, Diversity, and Inclusion; Ethical Action in All That We Do.

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The Council voted to adapt the ethics code to prohibit psychologists from being involved in torture.
The Coalition of Mental Health Professionals of Rhode Island, led by RIPA members James Curran, Peter Erickson and myself have met with executives at the Medical Laboratory Association (MLA) to discuss the potential changes to the title of “psychologist” to people with non-doctoral degrees. Non-doctoral school psychologists protested that this would devalue their training and potentially undermine their role in schools. Supporters of the Act expressed concern that for psychologists to become recognized as physicians by CMS, it is essential that only doctoral level psychologists be authorized as “psychologists.” Through much heated debate in the backrooms and in the Council session, The Division of School Psychology (16) offered a compromise that recognizes that public school staff is regulated by Departments of Education not Departments of Health. The compromise allows non-doctoral level personnel who are working in the schools to retain their title if it is granted by their regulating state Department of Education. The Act stipulates that the title must include the word “school.” Thus, those with a master degree or a certificate of advanced graduate studies who work in schools can continue to be called “school psychologists.” It is my understanding that NASP and RISPA approved of this compromise.

Submitted by Peter Oppenheimer, Ph.D.
APA Council Representative

"Social Psychology"

RIPA member Nina Finnock says the conversation at the joint "Meet and Greet" at Twenty Water Street, East Greenwich shows that social gain gets together are planned each year - look for the next gathering this fall!

The MLA creates a distinction between psychologists who are "health service providers" versus "general applied psychologists.

The most conflicted issue was the recommendation to fully restrict the title of "psychologist" to people with doctoral degrees. Non-doctoral school psychologists protested that this would devalue their training and potentially undermine their roles in schools. Supporters of the Act expressed concern that for psychologists to become recognized as physicians by CMS, it is essential that only doctoral level psychologists be authorized as “psychologists.” Through much heated debate in the backrooms and in the Council session, The Division of School Psychology (16) offered a compromise that recognizes that public school staff is regulated by Departments of Education not Departments of Health. The Act stipulates that the title must include the word “school.” Thus, those with a master degree or a certificate of advanced graduate studies who work in schools can continue to be called “school psychologists.” It is my understanding that NASP and RISPA approved of this compromise.

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Insurers and Managed Care Update

COMPRI and UBH

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APA Council Representative

Q: What rights to confidentiality do minors have when they are receiving psychological treatment?

A. This issue frequently arises in the midst of treatment when adolescents especially, request that the psychologist not disclose information about their treatment to their parents. Last year, in a matter involving psychotherapy with minors, Iowa Supreme Court ruled that parents do not have the absolute right to their children’s medical record if it is not in their child’s best interests. While this ruling currently only applies to courts in Iowa, the ruling may affect court rulings in the future. Similarly, RI state law does not address minors receiving mental health treatment. In RI, parents have the right to constrain their child’s accessing treatment with a different provider, and minor patients who continue in treatment will lose the right to authorize disclosures to third parties. Whereas, parental consent for treatment, the parent does not control protected health information. Guidance from this law is limited because of the reference to physicians and because it relates only to disclosures of communication to third parties, not to disclosures of health information to third parties, not to parents accessing the child’s health record for themselves. Similarly, RI state law does not address minors receiving mental health treatment. In RI, parents have the right to constrain their child’s accessing treatment with a different provider, and minor patients who continue in treatment will lose the right to authorize disclosures to third parties. Whereas, parental consent for treatment, the parent does not control protected health information. Guidance from this law is limited because of the reference to physicians and because it relates only to disclosures of communication to third parties, not to disclosures of health information to third parties, not to parents accessing the child’s health record for themselves.

To address both therapeutic and risk management concerns, it is best to have a frank discussion about the importance and limits of confidentiality with adolescents and their parents together at the outset of treatment. Research has found that adolescents often do not know how to integrate valued statements about “risk of harm” to themselves or others. However, the psychologist tells me that my treatment discussions with substance use, sexuality, and suicidal and homicidal ideation, statements, and behaviors will best convey to parents and teens which information psychologists would choose to keep confidential from parents, which information they would feel compelled to share, and which information communication between teens and parents and providers to discuss together but would not share with parents against teens’ wishes. It is advisable to ask parents in front of the adolescent whether they wish for the adolescent and psychologist maintaining a confidential relationship as long as content does not fall into a high-risk category. Of course, parent agreement, if it is provided, should be clearly documented in the medical record. Anecdotally, parents are often reassured to hear that the psychologist encourages communication between teens and past and will help with that goal. Conversely, teens are often reassured when told that if confidentiality must be broken, they will be informed. It will be done with the teenager present and not behind their back, and the therapist will help the teen to ideally be the one to inform parents of the information.

As always, when faced with a complex case involving confidentiality and a minor patient, it is best to seek advice from a Ethics Committee, a mental health lawyer, or a mental health attorney, as needed.

Wendy A. Plante, Ph.D.
Bradley Hasbro Children’s Research Center/ Clinical Psychologist
Newport, RI

References/Recommended Readings:

Submitted by Peter Oppenheimer, Ph.D.
APA Council Representative

The newsletter of the Rhode Island Psychological Association Summer 2010

www.ripsych.org

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