
Legislative Update

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U.S. FEDERAL MENTAL HEALTH RELATED LEGISLATION

Mental Health Parity

A mental health parity bill, the Paul Wellstone Mental Health Equitable Treatment Act (H.R.1402), has been introduced this congressional year. The issue of mental health parity, as you probably know, is not a new issue. In fact, mental health parity has been on the congressional agenda since the Mental Health Parity Act of 1996 expired on September 30, 2001. Since then, several bills to enact a new parity law have been introduced, but have failed to pass. In order to keep the current law in force, at the end of each congressional year, Congress has passed laws to simply extend the 1996 act. The Senator Paul Wellstone Mental Health Equitable Treatment Act was introduced in the House and Senate in 2004. Like the previous bills, this bill prohibits discriminatory mental health coverage. As the bill stalled and failed to pass at the end of the year, the 1996 Act was once again extended.

The 2005 parity bill seeks to reduce discrimination by private insurers by requiring health insurance companies to provide the same coverage for mental health and medical services with respect to outpatient sessions, inpatient days, co-payments, deductibles and maximum out-of-pocket expenses within their plans. The previous bills have covered businesses of 50 or more employees. The bills do not mandate that employers provide mental health coverage, but order that if the employer does provide medical care coverage, the employer is required to provide the same level of benefits for mental health, as it does for medical care.

State Mental Health Parity

Mental health parity bills have been much more successful at the state level. A majority of the U.S. states have enacted their own mental health parity laws. However, a universal and standard law is missing, as the state laws vary as to what level and types of mental illnesses are included. Some states mandate parity for serious mental illnesses while other state laws include all mental illnesses. Additionally, a federal parity law is needed to cover all private insurers, some of whom are not now subject to state parity laws because of the national Employee

Retirement Income Security Act.

A parity bill was unsuccessful last year in the state of Washington. However, that bill was reintroduced this year in the state senate and state house. As the Governor supported parity in her recent campaign, parity advocates expect the Governor to sign the bill if it passes out of the state house and senate this year.

Iowa Governor Tom Vilsack signed a limited mental health parity bill into law that directs employer-paid health insurance policies to cover "biologically-based" mental health treatment as any other disease. The Iowa legislation covers, among other mental health ailments, schizophrenia, bipolar disorders, major depressive disorders, obsessive-compulsive disorders and autism conditions that are usually not covered under most group insurance plans offered by employers. The parity legislation does, however, provide various exemptions, such as exemptions for small businesses.

A mental health parity bill passed through both houses last legislative year in New York. The bill was entitled Timothy's Law named after Timothy O'Clair, a 12-year child who committed suicide after his parents were unable to obtain adequate ongoing mental health services for him due to the restrictions for mental health services in their insurance policy. Although the Assembly's bill included broad coverage, the state Senate's bill limited coverage to a few diagnostic categories.

Missouri has a new parity law which is termed as a comprehensive mental health parity law. Under the new law, group policies must include coverage for all mental illnesses equal to the coverage provided for physical illnesses. Substance abuse, however, is not included. APA's research indicates that thirty-eight states have parity laws and half of those laws are comprehensive.

Association Health Plans

This bill shows the need for a federal mental health parity law. Although a majority of states have state mental health parity laws, under the congressional bill regarding Association Health Plans, AHPs would be exempt from state regulations, including mental health parity laws. AHPs allow small businesses to join together collectively to purchase and establish health benefit programs. The House of Representatives passed H.R. 525 263-165, a strong bipartisan vote for affordable healthcare for small businesses and working families. This vote marks the eighth time that the House has passed AHPs, though, at this time, the bill has yet to gain Senate approval.

Children's Mental Health Bills

The Keeping Families Together Act failed to pass in last year's Congress. However, bills (S. 380, H.R. 823) have been reintroduced this year. The Keeping Families Together Act seeks to amend the Public Health Service Act to establish a state family support grant program to end the custody-relinquishment problem, in which parents give legal custody of their emotionally disturbed children to the state agencies for the purpose of obtaining mental health services for those children. The bill's goal is to improve collaboration among agencies that serve children with mental health needs, including education, child welfare and juvenile justice. The Government Accountability Office's 2003 report provides that in 2001, there were 12,700 documented cases of children being placed in child welfare and juvenile justice systems in order for the children to have access to needed mental health services.

The Parental Consent Act

The Parental Consent Act seeks to place a ban on federal funding for mental health screening. During this Congressional year, the House of Representatives rejected an effort to ban any federal funding for "universal mental health screening." Not to say this was a victory for mental health screening advocates. As it was expressed that it was defeated simply because it would not have had a substantive effect, since there has not been a successful movement to provide a mandatory or universal mental health screening program. A similar amendment was also defeated last year.

Child Health Care Crisis Relief Act of 2005

The goal of this bill is to increase the number of well trained mental health service professionals providing clinical mental health care to children and adolescents. (H.R. 1106).

Elementary & Secondary Education Act

This bill calls for an amendment to the Elementary and Secondary Education Act of 1965 to direct the Secretary of Education to make grants to states for assistance in hiring additional school-based mental health and student service providers. (H.R.559). It was referred to a House subcommittee on March 24th of this year.

Positive Aging Act of 2005

This bill seeks to amend the Older Americans Act of 1965 to provide for mental health screening and treatment services, and to amend the Public Health Service Act to provide for integration of mental health services and mental health treatment outreach teams. The bill addresses the mental health needs of older adults by creating models of care that include mental

health services and

improve access to mental health services in community-based settings. Last year, the Positive Aging Act of 2004 was introduced, but failed to pass.

Mental Health Legislation for Veterans

The Veterans Mental Health Care Capacity Enhancement Act of 2005 (S.1177) is a bill to improve mental health services at all facilities of the Department of Veterans Affairs. The Military Health Services Improvement Act of 2005 (H.R. 1639), addresses the mental health care needs of returning war veterans. This legislation seeks to provide mental health services for returning war veterans by providing early intervention to address their mental health needs. It provides for pre- and post-deployment mental health screening for members of the Armed Forces.

New Mental Health Service Laws

The Mentally Ill Offender Treatment and Crime Reduction Act of 2004, was signed into law by President Bush on October 30th of last year. The new law authorizes an increase in federal funds for programs providing mental health services to adult and juvenile nonviolent offenders. It also provides additional resources for pretrial jail diversion programs and mental health courts and provides for cross-training for police and mental health personnel working with offenders who have mental health disorders. In response to the U.S. Justice Department's research that showed that 20 percent of youth in the juvenile justice system have serious mental health problems, this new law seeks to ensure that youthful nonviolent offenders with mental disorders are given the mental health care they need.

This congressional year, the issue is whether there will be funding to support the new law. Supporters of the new law are asking that funding be included in the FY 2006 budget for the Justice Department to support the newly authorized programs to help local communities cope with the disturbing trend of "criminalization" of mental illness. The authorization of a program into law is only the first step. The actual appropriation of funds is a must for the program to become a reality.

Funding is also being sought for the Garrett Lee Smith Memorial, which was signed into law at the end of last year. The new law is a suicide prevention and campus-counseling law that will develop youth suicide early intervention and prevention programs and expand campus mental health services. The law also provides federal funds for education, screening, prevention and intervention programs. The new law is in memorial to Senator Gordon Smith's (R-Ore.) son, a

college student who committed suicide.

Medicare Mental Health Modernization Act of 2005

This bill was referred to a Senate committee in April of 2005. The bill calls for an amendment to the Social Security Act, Medicare provision, to expand and improve coverage of mental health services under the medicare program.

U.S. FEDERAL LEGISLATION RELATED TO PSYCHOLOGISTS

Health Professionals Substance Abuse Education Act (S.538)

The goal of this act is to educate health professionals concerning substance use disorders and addiction. Psychologists are listed within the definition of health professionals under the act, making the act applicable to psychologists.

Public Health Service Act of 2005

The Public Health Service Act of 2005 (S. 92) seeks to amend title VII of the Public Health Service Act to establish a psychology post-doctoral fellowship program. It calls for the established post-doctoral fellowship program to make grants and to encourage the provision of psychological training and services in underserved treatment areas. Another bill to strengthen the Public Health Service Act (S. 89) proposes to amend title VII of the Public Health Service Act to make certain graduate programs in professional psychology eligible to participate in various health professions loan programs.

Scope of Practice

A federal bill calls for the amendment of title XVIII of the Social Security Act to remove the restriction that a clinical psychologist or a clinical social worker provide services in a comprehensive outpatient rehabilitation facility to a patient only under the care of a physician. The amendment adds that a patient may receive qualified psychological services under the care of a clinical psychologist with respect to such services to the extent permitted under the applicable state law. (S. 70).

Defense Graduate Psychology Education Program

There are currently four million dollars in the 2006 House Defense Appropriations bill to establish a Defense Graduate Psychology Education Program. The funds are to be used to train psychologists in the area of military psychology. The program's goal is to train psychologists to help war veterans upon their return from service with the various mental health issues veterans

face after returning from service.

U.S. FEDERAL PRIVACY ISSUES

HIPAA- Health Insurance Portability and Accountability Act The Health Insurance Portability and Accountability Act (HIPAA) continues to be a hot topic for healthcare practitioners. HIPAA, as we know it today, regulates privacy and security issues of protected health information. However, HIPAA's ultimate goal was to provide continual health insurance coverage for employees and their families when they change or lose their jobs. When it was signed into law in 1996 as Public Law 104-191, additional regulations were included as it was determined that this new protection would create additional administrative burdens on health care providers, payers, and clearinghouses. Thus, HIPAA includes the Administrative Simplification section, which is made up of the Transactions & Code Set Standards, the Privacy Rules, the Security Rules and the Unique Identifiers. The goal is that these four sections will work together to increase the efficiency and cost-effectiveness of the health care system and to reduce administrative burdens associated with the electronic transfer of health information between organizations and to provide protections for health information.

Transactions and Code Sets

The Transactions and Code Sets Rule provides transaction and code sets standards for use by health plans, health care clearinghouses and certain health care providers. This rule had a compliance deadline of October 16, 2003, after a one-year extension was afforded to health plans, clearinghouses or providers who applied. The Electronic Transactions Standards require health plans, health care providers, and health care clearinghouses which transmit health information to adopt standards for financial and administrative electronic transactions, as well as to utilize uniform code sets in connection with the standard transactions. By providing national standards for electronic claims and other administrative transactions, health care providers will be able to submit the same transaction to any health plan or clearinghouse in the country, thereby simplifying and improving health care transaction efficiency.

Unique Employer Identifiers

The Unique Employer Identifiers are standards to provide for the adoption of Unique Health Identifiers for all individuals, employers, health plans and health care providers. The ultimate purpose of creating these standards was the idea that unique identifiers would ensure continuity of care, accurate record keeping, and assist in the detection of fraud, waste and abuse.

The Privacy Rule

The Privacy Rule is the rule that has concerned and affected practitioners the most. The Privacy Rules establish the first ever across-the-board standards for protecting the privacy of personal health information in the United States. It is expected that these rules will have an impact upon virtually every health care provider in the country by requiring health care providers, plans and clearinghouses to establish appropriate administrative, technical and physical safeguards to protect the privacy of personal health information. As all states have laws to protect the use and disclosure of personal health information, practitioners and other entities falling under the HIPAA rules have been attempting to determine if their state laws will be pre-empted by HIPAA, and thereafter, curtailing their policies to be in-line with the current law.

The Security Rule

The Security Rule, for electronic health information, was published in the Federal Register on February 20, 2003, with a compliance date of April 21, 2005 (or April 21, 2006 for small health plans). Thus, at the beginning of this year, practitioners were focused on this section of the HIPAA rules. Basically, these are the standards that set out policies health care entities and providers must take in order to protect personal health information within their possession from internal and external threats. The policies mandate physical safeguards for the storage, maintenance and transmission of individual health information. All health plans, health care providers and health care clearinghouses must comply with the Security Standards if they maintain or transmit individually identifiable health information, regardless of form. The Security Standards require that organizations conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information held by the covered entity. This risk assessment is a must in order for a covered entity to decide how it will deal with various issues related to securing confidentiality.

The deadline for compliance with the Security Rule passed with much less debate and panic as compared to the deadline for the Privacy Rule. As the deadlines for both rules have passed, practitioners and those who fall under the HIPAA regulations, should be in compliance with both rules. Studies on the issue of compliance, suggest that the number of healthcare systems and practitioners in full compliance with the HIPAA regulations has doubled in the last year. Although the studies suggest that compliance is on the rise, the following reported incidents show that outrageous violations are still occurring. The following cases were reported by a HIPAA advisory, www.hipaadvisory.com:

July 26, 2005, Hospital Reports Stolen Records

A Missouri medical center notified 27,000 patients that two computers that contained some of the patients' personal information were stolen. The computers were stolen from a company that converts the hospital's patient records to microfilm.

July 15, 2005, Medical Firm's Files Stolen

The personal information of 57,000 Blue Cross Blue Shield of Arizona customers was stolen from a managed care company. The theft included personal, medical and financial records of policyholders.

April 26, 2005 Computer Stolen

After a computer was stolen from a Houston hospital, the hospital notified 16,000 people that the computer may have contained some of their medical records and Social Security numbers. The computer was stolen from the premises of a company that the hospital had given the computer to for the records to be converted to digital files.

April 12, 2005 Burglary Takes Computers & Patient Data

185,000 patients have been informed that two computers containing their personal information were stolen from a locked office during a burglary.

Flea Market Purchase Creates a HIPAA Violation

A Cottonwood, AL, man bought more than just a computer from a flea market. After the man purchased the computer for ten dollars, he discovered that it contained personal medical information on 3,000 people, one of whom was his late grandfather. Discarding information, or the failure to properly discard information, could violate not only the HIPAA Privacy Rule, but also the Security Rule.

HIPAA Enforcement Rules

The U.S. Department of Health & Human Services has been busy drafting the new HIPAA Enforcement Rules. The new draft calls for an amendment relating to investigations of noncompliance to make them apply to all of the HIPAA Administrative Simplification rules, not just the Privacy rule. Under the law, the penalties cannot exceed \$100 per violation or \$25,000 per calendar year. The Department has a complaint-driven procedure, in which persons or entities that discover a security violation may file a complaint with the Office of Civil Rights for the agency to investigate. Complaints may also be forwarded to the U.S. Justice Department for possible criminal prosecution.

Information from the Department provides that since the privacy regulations went into effect, the Office for Civil Rights has received 10,785 complaints. In most of these cases, the complaint has been dismissed because the incident occurred prior to the compliance date or because no violation actually occurred, or the matters have been resolved through voluntary compliance.

New Concerns Regarding Risks

As some companies are beginning to offer the service of storing one's health information on-line, there is concern rising regarding individuals' privacy and the security of the on-line records. These personal health record services may not be covered by HIPAA. Thus, personal health information given to these companies could be sold commercially without the individual's consent.

New Privacy Legislation to Revise HIPAA

The Safeguarding Americans from Exporting Identification Data (SAFE-ID) Act seeks to revise HIPAA to establish prohibitions on healthcare organizations that send medical information overseas for processing and creates a civil right of action for a violation. (SB S810 and HR1653).

Health Information Technology

While practitioners have been focused on HIPAA implementation and most have made substantial efforts in recognizing privacy and security issues, most, if not all, longed for the day that the last regulations would be implemented and HIPAA concerns would be over. Unfortunately, new challenges in the area of technology and privacy are on the horizon. With the advent of regional and national health information exchanges, new issues of privacy and security must be considered and addressed.

To make matters even more confusing, a bill introduced in August 2005, seeks to allow the federal HIPAA privacy and security regulations to supersede any state privacy and security law, so that the state privacy laws do not negatively impact health information technology systems. Several other bills in Congress reflect Congress's support for the use of technology in healthcare, such as, the National Health Information Incentive Act of 2005 (HR 747), the Affordable Health Care Act (S. 16), the Information Technology for Health Care Quality Act (S. 1223), the Health Information Technology Act of 2005 (S. 1227), the Health Technology to Enhance Quality Act of 2005 (S. 1262), and the Health Information Technology Quality and Improvement Act (S. 1355). These acts provide for health information systems and funding to hospitals and practitioners to create such collaborative systems of sharing health information.

E-Therapy & Related Federal Legislation

Unlicensed Practice

A few years ago, E-Therapy was what everyone was talking about. On-line therapy centered websites popped up and grew in number. However, the new craze came to a crushing halt when the issue of legality was raised. Ethical questions, issues of confidentiality and debates over the effects of this non-face-to-face relationship could be addressed and dealt with. However, the simple question of: Is it Legal? could not be simply answered.

The legal implications center around state licensure. As health care professionals, such as psychologists, are licensed by their respective state licensing boards and licensed to practice only within that state where they hold a license, national or worldwide practicing via the Internet brings forth the issue of unlicensed/ unlawful practicing a profession. Numerous issues arise from the practice of telehealth, such as, where does the therapy actually “occur?” Is it in the state where the practitioner is located or is it the state where the patient resides? State boards of various professions have come to differing conclusions. Some state boards have addressed the area, whereas others have not. Some professions have been very active in addressing the issue, whereas others have not. Nurses, for example, are on the forefront with the Interstate Compact for Licensed Nursing.

The Nurse Licensure Compact

The Nurse Licensure Compact has been viewed as a means to create reciprocity for nursing licensure across state lines and a way to facilitate telenursing. The compact allows a nurse who is licensed in one state to practice in other states, including by electronic means. The original compact included RN and LPN/VN nurses. A new compact for APRNs is now available. To review the nursing compact, go to www.ncsbn.org

It is hoped that this compact will serve as a model for other professions. However, currently, for those other professions, including psychologists, those legal issues still remain unanswered. Although questions regarding legal implications remain, a google search for “e-therapy” reveals that there are a lot of adventurers who are uneducated or unconcerned about the legal implications. Studies have indicated that there are presently more than 200 e-therapy websites.

Recent US Supreme Court Case

Will a recent US Supreme Court decision solve the interstate professional licensing problem? The case does not address professional licensing, but the sale of wine. The issue in the

case was whether a state could restrict wine merchants in other states from selling their wine on-line to residents in the first state. The court held that this interstate discrimination to be unconstitutional and that non-residency should not foreclose a producer in one state from access to markets in other states. Certainly the sale of wine and the regulation of mental health professionals for the protection of the public are completely different. Whether this case is the beginning of the end of interstate regulatory barriers remains to be seen.

On-line Therapy Confined to Particular State

In order to avoid the licensure problems and the uncertainty of the question where "online therapy" takes place, some psychologists and other mental health care providers are providing services on-line, but only to patients/clients within the state they are licensed. This eliminates the problematic question of who has jurisdiction over the practitioner. See www.etherapy.com and www.counselcenter.com, a Canadian based site, for examples.

The Potential of On-line Therapy

Most studies show that the delivery of health services via the Internet has the potential to expand services to medically underserved populations. In the report by the President's New Freedom Commission on Mental Health it is specifically recommended that Congress encourage the use of health technology and telehealth to improve access and coordination of mental health care, particularly for Americans in remote areas or in underserved populations, and the development and implementation of integrated electronic health records.

Various states have set up task forces and committees to study the need for telehealth and propose methods to develop and operate a telehealth system. All studies, federal and state, show that the practice of telehealth could serve as a method to deliver necessary services to rural areas, shut-ins, and others in need of treatment and services.

The Federal Government's Response

Since most state professional licensing boards have been slow to address the problem or create any solutions, the problem eventually became recognized at the federal level. With the passage of the Health Care Safety Net Amendments of 2002, Congress provided: "It is the sense of Congress that... States should develop reciprocity agreements so that a provider of services... who is a licensed or otherwise authorized health care provider under the law of one or more States, and who, through telehealth technology, consults with a licensed or otherwise authorized health care provider in another State, is exempt, with respect to such consultation, from any State law of the other State that prohibits such consultation on the basis that the first health care provider is not

a licensed or authorized health care provider under the law of that State." The Department of Health & Human Services received the authority to: "make grants to State professional licensing boards to carry out programs under which such licensing boards of various States cooperate to develop and implement State policies that will reduce statutory and regulatory barriers to telemedicine."

In the 108th Congress, the Telehealth Improvement Act of 2004, although it did not pass, sought to amend the Public Health Service Act to require the Secretary of Health and Human Services to convene a conference of state licensing boards, local telehealth projects, health care practitioners, and patient advocates to promote interstate licensure for telehealth projects. Additionally, within an appropriation bill, Congress provided: "Physician licensure is frequently identified as one of the most critical barriers to the increased use of telemedicine. There is a need to stimulate cooperation and communication among licensing authorities to address these issues and to facilitate multi-State practice, ensure public safety and create an environment for advancing telehealth services. The Committee has provided \$1,000,000 above the fiscal year 2004 level to support incentive grants that would be used as authorized in the Health Care Safety Net Act of 2002 to develop and implement policies to reduce barriers to telehealth services."

This year, the Medicare Telehealth Enhancement Act of 2005 (HR 2807) was introduced. It seeks to amend title XVIII of the Social Security Act (Medicare) regarding telehealth services to remove current geographic restrictions on the provision of such services, and to direct the Secretary of the Department of Health & Human Services to encourage and facilitate multistate practitioner licensure across state lines. The goal of the act is to improve the provision of telehealth services under the Medicare Program by providing grants for the development of telehealth networks. It provides: "For purposes of expediting the provision of telehealth services, for which payment is made under the medicare program, across State lines, the Secretary of Health and Human Services shall, in consultation with representatives of States, physicians, health care practitioners, and patient advocates, encourage and facilitate the adoption of provisions allowing for multistate practitioner licensure across State lines."

State Actions regarding Telehealth

Although state professional licensing boards have been slow to address telehealth, there are a few states or state boards that have addressed the issue. The following are a few examples of such state action. California has a telemedicine law, which is applicable to psychologists and this year was amended to include teledermatology and teleophthalmology to the definition of telemedicine, and limits the practice of those services to board certified dermatologists and ophthalmologists, respectively. The New Mexico Medical Board has a telemedicine license. Arizona regulates telemedicine consultation. New York has an act entitled, Telemedicine Access Act. The North Carolina Board of Psychology has adopted a policy statement regarding distance and internet therapy. The Vermont Board of Psychology has a notice on its website regarding telepractice called, A Word on Telepractice. It states that Professionals who provide services via the Internet or other electronic means should provide as much information as possible to

individuals who access their services. At a minimum, the psychologist should prominently disclose: Name and location of the psychologist, type of license and jurisdiction where licensed, what the psychologist is licensed and trained to do, to whom the client may make a complaint and how, and the limits and limitations of Internet practice/service delivery. Additionally, it provides that this disclosure is not unlike the disclosure we require of psychologists and other mental health providers in face to face settings.

<http://vtprofessionals.org/opr1/psychologists/telepractice.html>

For up-to-date information regarding etherapy related federal, provincial or state legislation, go to:

<http://tie.telemed.org/legal/legislation>

STATE LEGISLATION

Licensure Issues

Pursuant to amendments to the Minnesota licensing act, licensure as a licensed psychological practitioner, master's level practitioner, will be phased out and all such licenses will terminate December 31, 2011 and the licensure as a licensed psychological practitioner will be eliminated. The act provides the steps for a licensed psychological practitioner to convert his or her license to a psychologist license. One step includes completion of two full years of supervised post-licensure employment.

A new act in Arkansas will create licensure for licensed psychological practitioners and uncredentialed neuropsychological assessment technicians.

An amendment to the Minnesota Licensing Professional Counselors Act provides that licensed psychologists can automatically be licensed as a licensed professional counselor in that state.

Licensing for school mental health specialists is added to the state psychology board in a Rhode Island bill. (RI 2005 HB 5953).

A new law North Dakota will afford licensure by the North Dakota Board of Psychology to I/O Psychologists. The bill was signed into by the North Dakota Governor this year. The original bill, introduced at the request of a graduate student, sought to exempt graduates of a doctoral level "research psychology" or I/O psychology program from the psychology licensure law. The only qualification was receipt of a doctoral degree from a regionally accredited institution. The language of the bill allowed the exempted practitioner to use the title "industrial psychologist" or "organizational psychologist, or similar title." The psychology board testified in opposition to the bill, claiming that the public was not adequately protected in that the qualifications for these psychologists were insufficient, that being exempt from the law they would not be accountable to anyone in the event of unethical practice, that they would not have any requirement for continuing education, and that the public would easily confuse this type of psychologist with a licensed psychologist, making assumptions about qualifications and accountability that would not be true.

In compromise, an amendment was created which brought the I/O psychologists under the state psychology law, as opposed to being exempt. The new law defines I/O psychologists and does not include "counseling" in their scope of practice, provides what doctoral programs are acceptable for I/O psychologists, states what written or oral or both exams are necessary for licensure as an I/O psychologist, and provides the supervised experience requirements, which includes distance-supervision by a qualified I/O psychologist, as well as the CE requirements.

Effective January 1, 2005, the California Board has new supervised experience regulations. Under the new regulations, supervisors are required to take a course in supervision every two years. The new regulations also change the previous requirement that supervisors be on-site. Now the supervisors are only required to be "available" to the supervisee while the supervisee is working. Availability can be via cell phone, beeper, or other appropriate technology. Additionally, prior to the start of the supervised experience, the supervisor and the supervisee must sign a supervision agreement that concludes goals, objectives, start and completion date, and duties involved. Specific forms can be viewed via:

www.psychboard.ca.gov/laws_regs/supervised_approved.htm

A bill in the New York Assembly provides for the licensure of school psychologists; authorizes the use of the title "school psychologist" to licensed or exempt individuals; defines practice as a school psychologist; sets forth requirements for professional licensure (including educational attainment, experience, exam, fee and continuing education requirements); establishes a five member state committee for school psychologists to assist the state board for psychology; provides for issuance of limited permits under specified circumstances; and identifies exempt persons. (NY 2005 AB 4151).

UNLICENSED PRACTICE

A bill in New Jersey will make it a crime of the third degree to practice psychology, marriage and family therapy, chiropractics or State-certified psychoanalysis without the appropriate license or certification. The state already has such a law for physicians and other healthcare providers. This law includes psychologists and provides that a person is guilty of a crime of the third degree if he knowingly does not possess a license to practice psychology, or knowingly has had such license suspended, revoked or otherwise limited by an order entered by the State Board of Psychological Examiners, and he engages in the practice of psychology; exceeds the scope of practice permitted by the board order; holds himself out to the public or any person as being eligible to engage in that practice; engages in any activity for which such license is a necessary prerequisite; or practices psychology under a false or assumed name or falsely impersonates another person licensed by the board. (NJ 2004-2005 AB 2740).

A new law in Massachusetts gives the state licensing boards more disciplinary authority. The new law grants the state boards the ability to investigate and prosecute individuals who

practice a profession without the necessary license, those who practice while their license is expired and those who continue to practice after their license is suspended or revoked. The new law also increases the current penalties for practicing without a license. Additionally, all boards will have authority to assess fines for professional misconduct by licensees.

A bill in Idaho amends its unlawful practice provision to add the use of any title or description incorporating the words "psychological," "psychologist" or "psychology" or to offer to render or to render psychological services, forbidding the use of these titles or terms to anyone except those licensed to practice psychology in the state. (ID 2005 HB 44).

Prescription Privileges

Both New Mexico and Louisiana have issued certificates granting prescriptive authority to qualified psychologists in their states. After much work, New Mexico's prescription privileges regulations became effective this year on January 7th. New Mexico was the first state to enact a prescribing law for psychologists in March 2002. Louisiana passed similar prescription privilege legislation in May 2004.

New Mexico's regulations were created by a joint committee of physicians and psychologists. The regulations allow properly trained psychologists to prescribe psychotropic drugs. In order to be properly trained and receive a prescribing certificate, a psychologist must complete at least 450 hours of coursework; an 80-hour practicum in clinical assessment and pathophysiology; a 400 hour/100 patient practicum under physician supervision; and pass a national certification examination. The regulations contain collaboration provisions which include not only having the psychologist initiate contact with the patient's physician when medication is warranted, but also having the physician initiate contact with the patient's psychologist when any changes in the patient's medical condition might affect the treatment being provided by the psychologist. New Mexico's final rules can be found at:

<http://www.rld.state.nm.us/b&c/psychology/RxP%20Rules/Rules.htm>

In May 2004, Louisiana became the second state in the country to gain a law authorizing properly trained psychologists to prescribe certain medications for the treatment of mental health disorders. To be implemented, the Louisiana law also went through the rule-making process similar to New Mexico, with the Louisiana State Board of Examiners in Psychology overseeing the process. In February of this year, the Louisiana Board issued its first Certificates of Prescriptive Authority to two Louisiana Medical Psychologists.

Each year, more and more states address the issue of prescription privileges. Within the last legislative sessions, the following states had a prescribing bill: New Hampshire, Florida, Arizona, Wyoming, Connecticut, Tennessee, Texas, Georgia, Missouri, Hawaii & Illinois.

Currently, there are pending bills in Hawaii, Illinois, Missouri, Tennessee, & Wyoming. For up-to-date information go to:

<http://www.prescribingpsychologist.com/Legislation.htm>

Scope of Practice

Last year, the Indiana Board of Psychology created a rule, Restricted Psychology Tests and Instruments Rule, to require that social workers who use certain tests and assessment tools do so only under the direct supervision of a psychologist and restricted the use of certain psychological tests. However, the Governor found that there was a need for more guidance on the use of psychological tests and rejected the board's rule. This year, a different approach was taken in an effort to limit the use of tests. The state senate bill 591 sought to amend the current rules regarding psychological testing.

This restricted test rule legislation, which was signed into law on May 11, 2005, by Governor Daniels, requires the psychology board and the social worker, marriage & family therapist, and mental health counselor board to meet and draft recommendations to the legislative council no later than October 1, 2005, regarding definitions and criteria related to assessment, diagnosis, psychological testing, and appraisal instruments. The law also states that the state psychology board may adopt new rules regarding restricted tests after December 31, 2005. Under state rule IC 4-22-2, the psychology board is to establish, maintain, and update a list of restricted psychology tests and instruments containing those psychology tests and instruments that, because of their design or complexity, create a danger to the public by being improperly administered and interpreted by an individual other than:(1) a psychologist licensed under IC 25-33-1-5.1;(2) an appropriately trained mental health provider under the direct supervision of a health service provider endorsed under IC 25-33-1-5.1; (3) a qualified physician licensed under IC 25-22.5;(4) a school psychologist who holds a valid:(A) license issued by the professional standards board under IC 20-1-1.4-2; or(B) endorsement under IC 20-1-1.9;practicing within the scope of the school psychologist's license or endorsement; or(5) a minister, priest, rabbi, or other member of the clergy providing pastoral counseling or other assistance.

A new California regulation affords the right to psychologists to treat their patients in acute care hospitals as attending practitioners with full hospital privileges. Under the new regulation, psychologists may make decisions, including admits, transfers, and discharge, as a member of the hospital staff. More and more states are enacting such laws to grant hospital privileges to psychologists. Currently, eighteen states afford hospital privileges to psychologists.

In Hawaii, two proposed bills that would have prevented a psychologist from serving as an "attending physician" in a workers' compensation case failed to pass.

A bill in Iowa that would have excluded psychologists from evaluating persons thought to be incompetent to stand trial failed to pass in the state legislature. Under the current law, a physician or a psychologist can make that determination.

Child Custody Evaluation Issues

A bill in Pennsylvania seeks to follow in the footsteps of West Virginia and Florida, in placing limitations on disciplinary complaints involving child custody evaluations to the state board of psychologists. Like the other states' laws, the bill would not forbid a parent or aggrieved party from filing a complaint with the state psychology board, but would require that prior to the disposition of the child custody case, complaints may only be filed with the board upon being approved by the judge in the child custody case.

West Virginia, following in the footsteps of a 2003 Florida law, passed legislation to afford psychologists who conduct custody evaluations limited immunity from liability. Under the law, psychologists who provide "good-faith" custody evaluations consistent with APA's guidelines, are immune from liability. Additionally, the law provides that administrative complaints against a psychologist regarding a custody evaluation cannot be filed anonymously.

The New York State Psychology Board has created a Practice Alert on Custody Evaluations. The alert is not a regulation, but a way to educate its licensees. The text of the Practice Alert can be viewed at: www.op.nysed.gov/psycheval.htm

Mental Health Screening for Children

A number of states have addressed the issue of mental health screening for children this year. These state bills seek to prohibit mental health screening for children in schools and additionally, restrict school personnel from making recommendations regarding a child's mental health. Legislation was presented this year in Alaska, Florida, Georgia, New Mexico, New Hampshire, New York, Pennsylvania, Tennessee, Utah, and Vermont that would limit or completely prohibit mental health screening for children. The Alaska bill even included a provision that forbid school personnel from recommending a particular physician or psychologist to a child's parent or guardian. A Utah bill which sought to forbid certain school personnel from making health care recommendations, including the use of psychotropic drugs, was ultimately vetoed by the Governor. Critics of these types of legislation point to the report by the President's New Freedom Commission on Mental Health, which recommends screening and early intervention for children.

Criminal Record Checks

There were many changes to the Texas Psychologists Licensing Act as a result of the Psychology Board's sunset review last year. The board was successful in many avenues, one being its continuation of being an independent board for twelve more years. The board was also given authority for several acts. One interesting grant of authority is that the board was given authority to conduct a Texas Department of Public Safety criminal record check on all licensees every quarter.

Criminalization of Sexual Misconduct

Sexual Misconduct by healthcare practitioners is grounds for disciplinary action in almost, if not, all states and all licensing boards, however, more and more states have begun enacting laws that make that behavior a crime. A study reports that in 1983, legislators in several states undertook an examination of sexual abuse by psychotherapists and other professionals to determine whether criminal sanctions were warranted. From that, Wisconsin became the first state, in a line of many, to enact a law criminalizing psychotherapist-patient sexual exploitation. Thereafter, Minnesota enacted a law defining such behavior to be a felony. Arizona, California, Colorado, Connecticut, Florida, Georgia, Iowa, Maine, New Hampshire, New Mexico, North Dakota, South Dakota, Texas, and Wisconsin thereafter, passed comparable laws making sexual misconduct between a psychologist and a patient a felony. Some states have blanket laws that cover various licensed professions. Laws also vary as to what "sexual misconduct" is, and what penalty is proscribed for the misconduct. Additionally, the laws are different as to whether a former patient is covered under the law and whether the misconduct has to take place during the existence of the professional relationship.

Some states require a licensing board to report to the proper authorities disciplinary misconduct that could be punishable criminally. Florida licensing boards are under such a law. This year that particular law is subject to much debate as it was discovered that approximately 24,000 disciplinary cases investigated by the state health department since 1992 had not been sent to prosecutors for a determination of whether any criminal acts should be pursued. The state Department of Health's inspector general found that the department apparently failed to formally refer to the authorities cases in which healthcare practitioners may have committed criminal acts. Under state law at issue, when an agency is notified of misconduct by one of its licensees, it is required to determine whether there is probable cause to proceed with discipline. Then, if there is reason to believe a crime may have been committed, notification shall be sent to the proper law enforcement authorities.

The 24,000 disciplinary cases referred to the authorities are cases in which officials had found probable cause of misconduct since 1992. The cases are now to be reviewed for a

determination of whether the misconduct was also a criminal act and whether the statute of limitations is applicable in the case. It was reported that the investigation into the non-referral of cases began when a member of the public, a researcher for the Citizens Committee on Human Rights, requested information about psychologists who were accused of sexual misconduct and asked for documentation that the cases had been referred for criminal prosecution. The researcher explained that the committee's primary mission is to monitor misconduct by psychotherapists. Other organizations with such a mission exist and monitor misconduct by mental health professionals, such as www.psychsearch.net, which post pictures of mental health professionals who are criminally prosecuted for sexual misconduct.

Release of Confidential Information

A proposed law in Minnesota will allow a psychologist who is a victim of crime perpetrated by his or her patient or former patient, to release confidential information regarding that patient. Under the law, the psychologist may release information such as the patient's name and identifying information and may acknowledge that a professional relationship exists or existed to the proper law enforcement authorities.

Continuing Education

Effective March of this year, Kentucky psychologists must complete a minimum of three hours of continuing education in ethical practice or risk management within each three-year renewal period.

California has a new amendment to its continuing education requirements, which went into effect January 9, 2005. The amendment amends the exemption provision of the continuing education rules to afford an exemption to those engaged in active military service. The exemption, prior to the amendment, provided for an exemption to a psychologist who had been absent from California for at least one year because of military service. The amendment changes the rule to allow an exemption for a psychologist engaged in active military service. Additionally, at the end of last year, changes were made to the continuing education regulations to increase the number of hours allowed for distant learning continuing education. Prior to the amendment psychologists were allowed to accrue up to eight hours of the required thirty-six hours of continuing education via distant learning. Effective January of this year, psychologists in California can earn up to eighteen hours of distant learning continuing education.

Medicare & Medicaid Issues

It may surprise some to hear that a majority of mental health care is paid for by Medicaid.

Unfortunately, Medicaid has been termed as Congress's favorite political pinata. The current House approved budget calls for a \$20 billion cut in Medicaid funding. The budget resolutions regarding Medicare from the House and the Senate differ greatly. Although each includes huge budget cuts for Medicare, the Senate version seeks to spread the cuts out over a five-year period.

Securing funds for Medicaid payments to psychologists will be an issue put before the Alaska legislature this year.

The Centers for Medicare and Medicaid Services (CMS) published its final rule changes that now allow clinical psychologists to supervise technicians and other staff members who conduct psychological or neuropsychological testing. Before these rule changes were made, only physicians could supervise such individuals. Now psychologists are afforded the same level of supervision privileges as physicians in regard to testing. Medicare defines a clinical psychologist as a doctoral-level practitioner recognized by Medicare as qualified to provide both therapeutic and diagnostic services.

Board Consolidation & Creation

In an effort to cut costs and save money, state governments have been attempting to consolidate and/ or restructure state agencies across the country. For example, Ohio has pending legislation that would consolidate the psychology board with 15 other healthcare regulatory boards. The consolidation is being proposed as a way to increase efficiency and accountability.

On the other hand, New Hampshire has a bill to establish a committee to study forming an independent board of psychology. Under the bill, the committee may solicit information and testimony from members of the board of mental health practice, pastoral psychotherapists, clinical social workers, marriage and family therapists, clinical mental health counselors, psychiatrists, and other service providers and mental health practitioners, and any other source the committee deems relevant to its study. The committee is directed to also review psychology board formations and structures of other states including, but not limited to: definitions; appointments; membership, terms and vacancies; powers and duties; meetings; licenses; rules and regulations; continuing education requirements; and other pertinent governance components. (NH 2005 SB 50).

CANADIAN LEGISLATION

Federal Privacy Legislation

The issue of privacy and privacy legislation is not confined to the U.S. In fact, the Canadian provinces have been struggling with federal and provincial privacy issues for the last few years. The practitioners in Canada have had to, not only become familiar with new privacy rules, but to determine which privacy legislation was, in fact, applicable to them. Initially, Canada had two federal privacy laws, the Privacy Act and the Personal Information Protection and

Electronic Documents Act.

The Privacy Act, which is applicable to federal governmental departments and agencies has been in effect since July 1, 1983. The Privacy Act limits the collection, use and disclosure of personal information, and gives individuals the right to access and request correction of personal information about themselves held by federal governmental organizations.

The Personal Information Protection and Electronic Documents Act (PIPEDA) was created to apply to private sector organizations that collect, use or disclose personal information in the course of commercial activities. Initially, PIPEDA applied only to personal information that was collected, used or disclosed in the course of commercial activities by the federally regulated private sector. However, in 2004, the act became applicable to personal information collected, used or disclosed by the retail sector, publishing companies, the service industry, manufacturers and other provincially regulated organizations.

Organizations and activities can be exempt from compliance of PIPEDA by obtaining a federal governmental exemption, in which the government determines that the organization or activity is within a province that has its own privacy law that is substantially similar to the federal law. However, PIPEDA continues to apply to the federally regulated private sector and to commercial activities in inter-provincial and international transactions.

Provincial Privacy Legislation

Every province and territory has its own privacy legislation governing the collection, use and disclosure of personal information held by governmental agencies. However, as for the private sector, PIPEDA applies unless there is an exemption. For example, the privacy laws in British Columbia, Alberta and Quebec have been declared substantially similar to PIPEDA. Thus, the laws in these provinces will regulate the collection, use and disclosure of personal information by businesses and organizations within those provinces.

A new issue that has arisen under the application of PIPEDA is its effect on administrative investigations. To combat this problem, there is new federal legislation to exempt regulatory bodies from this federal privacy legislation.

Personal Health Information

In response to arguments that PIPEDA is problematic for organizations that collect, use or disclose personal health information, jurisdictions have enacted or intend to enact legislation to deal specifically with the collection, use and disclosure of personal health information by provincial health care organizations and other approved individuals and agencies. In provinces with such privacy acts, those affected by the acts will need to determine which act to follow. Ontario, Alberta, Saskatchewan and Manitoba enacted legislation to deal specifically with the collection, use and disclosure of personal health information by provincial health care organizations and other approved individuals and agencies.

On November 1, 2004, Ontario's new provincial privacy law, the Personal Health

Information Protection Act went into effect. This legislation was created specifically to address the handling of health information. It is expected to bring some clarity about consent and other matters that were uncertain in light of the federal privacy act, PIPEDA. The new legislation will keep personal health information of patients private and confidential. The Act consists of two parts: the Personal Health Information Protection Act, and the Quality of Care Information Protection Act. Its goal is to provide consistent rules for individuals and organizations that collect, use and disclose personal health information. The new rules are applicable to all health information custodians (health care providers) in Ontario and to individuals and organizations that receive personal health information from health information custodians. In contrast to PIPEDA, which applies to personal information, including health information, collected or disclosed within commercial activities, the PHIPA applies to all personal health information. An overview of the act can be viewed at:

www.health.gov.on.ca/english/providers/project/priv_legislation/info_custodians.html

Although Alberta had four privacy acts in force, there was not an act that governed personal information held by private practice psychologists. Therefore, Alberta created the Personal Information Protection Act, which went into force in January of this year. It regulates the method private sector organizations use to handle personal information in a manner that recognizes both the right of an individual to have his or her personal information protected and the need of organizations to collect, use or disclose personal information for purposes that are reasonable. Personal regulatory associations are listed as an example of the type of organization to which Alberta's PIPA applies. Alberta already had a Health Information Act. However, that act applied only to health care practitioners working in the publicly funded health care system. It did not apply to providers who work outside the publicly funded system. Thus, Alberta enacted the PIPA which applies to those practitioners. A guide to Alberta's privacy laws can be found at www.psp.gov.ab.ca.

Handling of Complaints

The Privacy Commissioner of Canada has been asked to explain how complaints will be handled in relation to PIPEDA and provincial privacy acts. The Commissioner has explained that a determination of which act applies will determine if the federal privacy commissioner's office or the provincial privacy office will investigate and resolve the complaint. The federal privacy commissioner has provided that the federal office will apply PIPEDA and will take and investigate complaints relating to private sector organizations that collect, use or disclose personal health information in the course of commercial activity until there is a declaration that the particular provincial act is substantially similar. Once there is a substantially similar declaration, the federal

office will transfer the complaint to the pertinent provincial privacy office. Inter-provincial complaints and issues involving provincial and federal jurisdictions will be handled by the federal office.

The guidelines that provide what laws are substantially similar provide that privacy protection that is consistent with and equivalent to that in the federal Act; incorporate the ten principles in the CSA Model Code for the Protection of Personal Information, CAN/CSA-Q830-96, found in Schedule 1 of the PIPEDA; provide for an independent and effective oversight and redress mechanisms with powers to investigate; and restrict the collection, use and disclosure of personal information to purposes that are appropriate or legitimate shall be substantially similar. A declaration of substantially similar determines what act applies, as well as, who has enforcement jurisdiction. For example, as Alberta's Personal Information Protection Act has been declared substantially similar, organizations in Alberta will not be subject to the federal private sector privacy law and compliance with privacy rules and enforcement of the Alberta privacy law will be dealt with by the province's privacy office. However, the federal privacy commissioner's office will remain responsible for oversight in relation to the activities of federal businesses within Alberta and issues regarding the collection, use and disclosure of personal information that crosses provincial boundaries in the course of commercial activity.

Self Assessments

In compliance with the Regulated Health Professions Act, the College of Psychologists of Ontario is requiring each member psychologist to undertake a self-review every other year, by completing a Quality Assurance Self Assessment Guide & Professional Development Plan. Members who have Certificates Authorizing Supervision must complete the plan each year. Inactive members are also required to complete the plan. Members may obtain all needed forms from the College's website, www.cpo.on.ca. After completing all the self review and creating a plan, a member psychologists must complete a declaration form stating that they have completed the self review and created a plan and file this declaration with the College, their actual plans are not required to be returned to the College, but are to be retained. The Self Assessment Guide was created to allow members to review and evaluate their current level of knowledge and skill. Sections in the Guide include: Legislation, Codes, Service to Clients, Teaching/Training and Research Activities, Supervisory Activities, Current Areas of Practice and/or Services Provided, Anticipated Areas of Future Practice, Professional Development Plan, Reflection on Professional Development Plan and Reference List of Areas of Practice and Service Provided. After completing the self assessment, members are to create a Professional Development Plan to address items identified in the self-review.

As required under the Health Professions Act, a new omnibus legislation, the Alberta College has created a Mandatory Continuing Competence Program. The program will provide the rules and guidelines for psychologists to employ in obtaining their required continuing

competency and in submitting proof of their completion to the College. The program is based on self-evaluation.

Mutual Recognition Agreement

The Mutual Recognition Agreement was signed in June 2001. It functions as an agreement between regulatory bodies in Canada to ensure national standards for licensure and practice in professions to enable professional mobility. Since its enactment, the provincial colleges have been drafting necessary changes to their training, education, and examination requirements to comply with the agreement. Under the agreement, although a master's level practitioner must be allowed to practice in a doctoral level province, that province can regulate what title the practitioner may employ. Thus, a psychologist in Alberta (requires a master's degree for entry level licensure as a psychologist) could move to Manitoba (requires a doctoral degree for entry level licensure as a psychologist) and practice in that province as he or she practiced in Alberta. However, he or she would not be allowed to use the title psychologist, but would use the title psychological associate, or whatever title Manitoba dictated.

The Mutual Recognition Act was amended as to psychologists last year. The Regulatory Bodies for Professional Psychologists in Canada entered into an amended act after various issues regarding its application arose. To combat one issue, members, seeking licensure through the MRA, are required to remain members in good standing with their provincial college before and until such time as they become a member of a new jurisdiction.

Prescription Privileges in Canada

For up-to-date information on prescription privileges in Canada, visit the Pharmacology & Psychology section's page of the Canadian Psychological Association's website at: www.cpa.ca/PharmPsych. That section is encouraging debate in Canada regarding prescription privileges for psychologists. The new section has presented information to Canadian psychologists this year by sponsoring a speaker at the Canadian Psychological Association's annual meeting. Although there has not been any prescription privilege legislation created in Canada, the issue is becoming a hot topic and subject of debate.

New Accessibility Law The Accessibility For Ontarians With Disabilities Act, 2005, went into effect June 14, 2005. This legislation seeks to address accessibility issues for disabled individuals by requiring the government to work with the disability community and the private and public sectors to jointly develop standards to be achieved in stages of five years or less, leading to an accessible Ontario in 20 years. Standards will include both the public and private sectors and will include a full range of disabilities – including physical, sensory, mental health, developmental and learning. The legislation provides time lines for compliance and sets tough penalties for

violators.

New Mental Health Act

Nova Scotia is in the process of reviewing and creating a new Mental Health Act. Bill 109, Mental Health Act, failed to become a new law this year. However, efforts will continue to enact legislation that will protect the individual rights and freedoms of mental health patients. The Department of Health, Mental Health Division, stated: “Our vision of the mental health of Nova Scotians is one in which consumers and communities can attain their optimal level of mental health. Programs and services will run the gamut from mental health promotion to acute care. They will be unified, coordinated, flexible, offered on a district basis and geared to the needs and desires of the consumer.” It is argued that the need for separate mental health legislation is crucial, as mental disorders accounted for more hospital days in Canada than any other illness. The Mental Health Legislation Development Group has been meeting since October 2004 in order to assist the government in developing and adopting mental health legislation that promotes mental health and community participation as well as protects and promotes the rights of Nova Scotians.

Competent to Stand Trial Assessments

An Act to amend the Criminal Code regarding Mental Disorders (BILL C-10) sets out who will do assessments. Due to a shortage of psychiatrists, amendments were proposed to afford psychologists the right to due independent assessments of whether an accused is fit to stand trial. After much debate regarding allowing psychologists such a right, the amendment to grant assessments to psychologists was unsuccessful. However, the bill now contains a provision allowing provincial governments to designate persons, other than psychiatrists, as being qualified to conduct an assessment.

Oral Examinations

The Saskatchewan College of Psychologists recently adopted a new policy to address the issue of oral examination failures and incomplete passes. The policy addresses both applicants seeking initial registration and applicants who are being registered under the Mutual Recognition Act. The College provides that “A recommendation of a failure by an oral examination panel leads to the immediate independent review of any failures of the competency-based portion of the examination. If, on review, failure is confirmed, applicants can sit for one reexamination of the competency portion and two reexaminations of the APE portion of the examination, before a re-application process becomes necessary. An applicant may also request an appeal of unfavorable

results to the Council of the College following the independent review.” Additionally, the college has created a service advisory for candidates seeking Authorized Practice Endorsement (APE), which allows the psychologist to make a diagnosis. The college provides that the practice of diagnosis is a protected practice and competency must be found before an applicant is given APE. The College has determined that the requirements for APE in Saskatchewan are consistent with, and are assumed under the Mutual Recognition Act. The College now requires, with few exceptions (MRA compliant applicants from other jurisdictions and “grandparented” members of Saskatchewan College of Psychologists) all members of the College to sit for an oral examination in order to be awarded the APE. Without APE, psychologists are required to have a qualified consignor for any diagnosis. The College has created a policy regarding the number times a candidate may retake the examination and also has created an avenue for an appeal.

Membership verse Licensure

The Saskatchewan College of Psychologists has also developed a new policy regarding college membership. The College did this in regards to the problem that a registered psychologist, being investigated for alleged misconduct, could simply not renew their registration in an effort to avoid being disciplined. The College determined that once the individual failed to renew membership, the College would lose jurisdiction to discipline the individual if misconduct was found. To combat this foreseen problem, the College’s policy differentiates between membership and an annual license. The policy states that membership in the College is ongoing and that once a person is registered they become a member and remain a member, until his or her resignation is accepted or until there is a discharge of membership for disciplinary action. On the other hand, the annual license affords the member the right to use the title psychologist and practice psychology. When a member simply does not pay the annual fees for a license, the member will remain a member of the College, but will not be in good standing and cannot use the title. The College, however, has jurisdiction over members not in good standing.

Services for Members of Canadian Forces and Veterans

Bill C-45, is an Act that seeks to provide services, assistance and compensation to or in respect of Canadian Forces members and veterans. Much like bills in the U.S. Congress, recognition is being made to the particular needs of members of the military.

Referrals to Psychiatrists

Effective October 1, 2004, Alberta psychologists are allowed to refer patients to psychiatrists when they request an opinion of a consultant psychiatrist in the form of a verbal or

written communication (fax, email, letter). The psychiatrist must then do a history, an examination and review of diagnostic data and provide a written opinion with recommendations as to treatment, to the referring psychologist. Psychologists are not allowed to receive payment for referring a patient. However, the psychiatrist is afforded the right to payment under this new act.

Emergency Services

Nova Scotia has been working on meeting the mandate of the Post-Trauma Services Committee by coordinating a provincial network of psychologists who would respond in a timely manner following a major disaster and provide pro bono psychological services and assistance, such as group debriefing sessions, to affected individuals. Additionally, the Psychosocial Emergency Response Group is attempting to coordinate emergency services in coordination with organizations such as the Red Cross, Capital Health, United Council of Churches, and the CISM network in case of a major emergency.

Child Custody Evaluations

Issues with child custody evaluations do not exist only in the United States. The issue of child custody evaluations is also a discussion in the provinces. A few years ago, the Ontario Psychological Association published a set of guidelines called “Ethical Guidelines for Psychological Practice Related to Child Custody and Access.” The Guidelines were developed to provide a guide of consistent ethical practice for practitioners. In drafting the guidelines, the association looked to the nature of complaints filed against psychological practitioners. The guidelines provide guidance regarding practitioners’ roles, ethical boundaries and balancing the limits of confidentiality.

Auto Insurance Claims

Another set of guidelines for practitioners in Ontario is the Guidelines for Assessment and Treatment in Auto Insurance Claims. These 2005 guidelines, are recommended for practitioners to employ when planning and reviewing assessment and treatment proposals in auto cases. The guidelines are accompanied by a companion document, which includes excerpts from the Statutory Accident Benefits Schedule. Included is a list of indicators for when clinical/ health/ rehabilitation psychological assessment is reasonably required and information regarding treatment plans. The Ontario Psychological Association provides these documents to its members via its website.

Limitations Act

The Saskatchewan Limitations Act went into effect this year.

The act is applicable to all professions in the province, including psychologists. The Act establishes time limits for when an individual may bring a claim against a professional. The Act defines an action or claim as “a claim to remedy an injury, loss or damage that occurred as a result of an act or omission.” Under the Limitations of Actions Act of 2001, a claim could be brought against a psychologist within six years after the cause of action arose. Section 3(1)(j) of the Limitations of Actions Act states: “Periods of Limitation, 3(1) The following actions shall be commenced within and not after the times respectively hereinafter mentioned: (j) any other action not in this Act or any other Act specifically provided for, within six years after the cause of action arose.” The new act, however, decreases the time limit for bringing a claim from six years to two years “from discovery of the cause of action,” with an outside limit of 15 years in some situations. Thus an individual has two years from the day that he or she knew or ought to have known that damage/injury occurred. There are exceptions, such as minors and mentally ill patients, as the time limitation periods do not apply for the time during which the claimant is either a minor or is incapacitated by mental disability.