MARYLAND BOARD OF EXAMINERS OF PSYCHOLOGISTS

WINTER 2013

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Chair's Column

Steven A. Sobelman, Ph.D.

Whew…..it has been cold out there!!!

As a quick note, please remember that March 31st is the deadline for license renewal for psychologists with an "even" license number.

The 2014 Legislative Session has already begun. The Board continues to monitor legislation that is pertinent to the practice of psychology.

As of this writing and was mentioned in the last Board newsletter, during the 2014 Legislative Session, the Board introduced legislation associated with registering Psychology Associates. The Board worked with the leadership of the Maryland Psychological Association (MPA) to improve upon the previously submitted legislation. In part, the bill that will be introduced for the 2014 Legislative Session will:

- Still require psychology associates to be supervised by licensed psychologists;
- Help clarify the roles of psychology associates and psychologists to the public;
- Enable the Board to monitor and regulate the practice of psychology associates; and
- Allow the Board to discipline psychology associates when applicable.

During continued dialogue with MPA's leadership, the Board also agreed to drop the National Examination (EPPP) requirement for Psychology Associates while retaining the requirement to successfully pass the state jurisprudence examination. Also, during the current legislation session, the Board and MPA have maintained an open dialogue on a number of other legislative bills that impact the profession. In this regard, the Board has invited the MPA leadership to participate in reviewing regulations that still need to be promulgated for the new Psychology Associates statute. Many of you may not know that in the summer, 2013, the Board began an experimental project that allows applicants to take the jurisprudence examination online. As you may remember, the jurisprudence examination tested your knowledge of Maryland law as it pertained to the practice of psychology. Quite frankly, many us may not remember all of the exemptions to licensure or the maximum number of CEs you can use for being an editor of a journal during a 2-year period, but we always have COMAR (online or the "lime" green book) as a reference point. With that in mind, the Board entered into discussions during an Open meeting as to whether it is necessary to have applicants memorize all of the information as opposed to knowing where to look for the information and what resources are available. Thus, the Board began looking at available technology in order to provide for an online, open book, type of examination. It is important to mention, that all licensed psychologists are personally and professionally responsible for knowing the laws and regulations that apply to the practice of psychology in Maryland. The major issue at this point in time involves the unavailability of 24/7 coverage if the website has a glitch. If for some reason, there is a glitch, the applicant is encouraged to contact the Board office during normal business hours. However, the feedback so far is that the experiment is going well and the Board will continue offering this option to some applicants.

Changing topics -- probably the most frequent question I receive involves practicing psychology without a license. Whether at a workshop or through email inquiries to the Board, psychologists ask about issues related to telepsychology. *Continued on page 2*

Continued from page 1. ***Chair's Column, Steven A. Sobelman, Ph.D.***

A question might go like this, "my patient moved to another State and I'd like to continue psychotherapy with the patient. Can I do this?" The answer is "yes" if you are licensed in the State in which the patient is now living. Otherwise, the answer is "you cannot practice in the State in which you don't hold a license." I suspect this will change down the road, as many states and professional organizations are examining this issue (and topic), but current laws prohibit the practice.

Each year the Board has a retreat in December. A portion of the retreat is usually open to the public and the Board has developed themes or topics for the Retreat, which recently has included topics like Psychology Associate Licensing, License Mobility, and Telepsychology. Most of the public who attend the Board's retreat include the Maryland Psychological Association leadership as the retreats also serve as a gathering place for the Board and MPA to share and discuss ideas in a collegial setting. However, this year the Board decided that instead of a retreat, an in-house training for Board members would be helpful. During the day we covered many general topics to include: the role of a Board member, the regulatory process, ethics, to include Board member conflicts of interest , and the recusal process on complaints. Additionally, we discussed administrative processes, licensing process, complaint process, legislations and regulations, and committees responsibilities in greater detail.

Board members, Board staff, and the Board attorneys gave presentations on each of the discussed topics. The feedback was very positive. Being a Board member is so much more than attending monthly meetings. On a personal note, it has been a privilege to work with and beside the dedicated Board members, DHMH Board staff, and DHMH Board attorneys while serving to protect the public.

I started the column with a comment about the weather and figured that ending on this note might be suitable. So, if you like Proust, "A change in the weather is sufficient to recreate the world and ourselves." Or, how about what Mark Twain said? "Climate is what we expect, weather is what we get." But IMHO, Oscar Wilde said it best, "Conversation about the weather is the last refuge of the unimaginative." *Enjoy today and spring is right around the corner! —End—*

2014 BOARD MEETING DATES

March 7, April 11, May 9, June 6, July 11, Sept. 12, Oct. 10, Nov. 7.

Open meetings begin at 9:00 am

JURISPRUDENCE EXAM DATES MARCH – JUNE 2014

March 28, April 25, May 16, June 20, .

For examination information contact Dorothy Kutcherman, Licensing Coordinator 410-764-4703.

Is Informed Consent Really Necessary? "Yes!" (*By Jeffrey E. Barnett, Psy.D., ABPP*

Informed consent is an absolutely essential component of every successful professional relationship for psychologists (and for all those who provide clinical services under our supervision such as psychology associates, trainees, and students). Informed consent is not a one-time event or a singular action that is taken; rather, it is an ongoing process that begins when the professional relationship is initiated (and perhaps even before) and that continues through the conclusion of this relationship.

Historical Perspective on Informed Consent

The doctrine of informed consent in health care has evolved over the years, with its foundations in medical practice. Initially, physicians often took on the role of benevolent authoritarians, or what Welfel (2006) describes as the "doctor-knows-best" approach. With their patients' best interests at heart, but as knowledgeable experts, physicians typically conducted their assessment and then provided needed (in their opinion) treatment. At times, when outcomes were not as patients had anticipated or when they believed they were harmed, there were malpractice lawsuits, many of which were won by the former patients who filed these suits. Rulings in their favor helped to create a new standard of care that required physicians to share information with their patients about the services to be provided prior to providing these treatments. But, the information to be shared with patients was what the physician decided the patient needed to know to make an informed decision about participation. Additional malpractice lawsuits with rulings in the suing patients' favor led to additional standards of care. At present, informed consent standards dictate that each patient or client must be provided in advance with the information that a typical or reasonable individual would want or need to know to assist him or her to make an informed decision. One can reasonably ask "What information would clients in general want or need to know prior to the professional service being provided that would enable them to make an informed decision about participation?"

Benefits of Informed Consent

Potential benefits of informed consent include: "promoting client autonomy and self-determination, minimizing the risk of exploitation and harm, fostering rational decision-making, and enhancing the therapeutic alliance" (Snyder & Barnett, 2006, p. 37). It also can help set the tone from the outset for a collaborative working relationship. Fisher and Oransky (2008) further emphasize that when carried out effectively, the informed consent process can "demonstrate psychotherapists' respect for clients' right to self-determination and can initiate meaningful contributions to treatment through enhancing mutual trust, building rapport, and facilitating a sense of ownership" (p. 576).

Informed Consent Requirements

As is hopefully evident, the informed consent process should be much more than having a client sign a form that provides basic information about the services to be provided. While the informed consent process should be documented, and thus provided both in writing and verbally (COMAR, 10.36.05), there are several requirements that must be met for informed consent to be considered valid. These include: (1) consent must be given voluntarily, (2) the client must have the capacity and right to consent, (3) we must actively ensure the client's understanding of what they are agreeing to, and (4) the consent must be documented (Barnett, Wise, Johnson-Greene, & Bucky, 2007). The Code of Ethics and Professional Conduct (COMAR, 10.36.05) addresses these points in the minimum standards shared in Section .05, Representation of Fees and Services, which states in part that psychologists in general must:

(a) Obtain informed consent using appropriate language understandable to the client;
(b) Vary appropriate informed consent forms and procedures to ensure that the client:
  (i) Has the capacity to consent;
  (ii) Has been provided with information concerning participation in the activity that reasonably might affect the willingness to participate, including limits of confidentiality and monetary costs or reimbursements;
  (iii) Is aware of the voluntary nature of participation and has freely and without undue influence expressed consent; and
  (iv) Is given the opportunity to ask questions and receive answers regarding the activity.

Section .05, Representation of Fees and Services of the Code of Ethics and Professional Conduct (COMAR, 10.36.05) also provides psychologists with the minimum requirements that must be met with regard to informed consent. First, this standard makes it clear that informed consent is required for all professional services psychologists offer, regardless of the medium used for providing these services. *Continue on page 4*

Continued from page 3. ***Is Informed Consent Really Necessary? "Yes!", Jeffrey E. Barnett, Psy.D., ABPP***

It states that this requirement applies to "conducting research or providing assessment, psychotherapy, counseling, or consulting with an individual or organization in person or by electronic transmission or other forms of communication" (COMAR, 10.36.05 B). This section goes on to state that for psychotherapy and counseling relationships, at a minimum, the following must be addressed through the informed consent process:

(a) The clarification of reasonable expectations;
(b) The nature and purpose of testing, reports, and consultations;
(c) The limits of confidentiality;
(d) Specific information concerning fees, billing, and electronic services available in the payment of fees;
(e) Psychotherapeutic schedules; and
(f) The process and conditions of termination of therapy.

Of course, there may be additional issues and pieces of information of relevance to the services to be provided and to the client's needs that should also be shared during the informed consent process. For example, some clients will want to know your credentials, training, and past experience relevant to working with clients with similar difficulties. Not included in the minimum requirements above, but very relevant to achieving the goals of informed consent and consistent with prevailing professional standards described in the professional literature (e.g., Packman, Cabot, & Bongar, 1994) is the need to inform clients of reasonably available options and alternatives to the treatment being offered (to include no treatment at all) and the potential risks and benefits of each along with clients' responsibilities in the professional relationship and expectations regarding their role in the services to be provided (Younggren, Fisher, Foote, & Hjelt, 2011). Further, Fisher and Oransky (2008) emphasize the need to take special care in the informed consent process when offering "new and untested treatments" (p. 576).

While we should actively ensure that clients understand what they are agreeing to in this shared decision-making process, it is vital that all written documents that share relevant information with clients be written at a level that can reasonably be understood by the average client (and modified if needed for particular clients). Authors (e.g., Paasche-Orlow, Taylor, & Brancati, 2003) have found that many informed consent documents utilized by health professionals are written at a grade-level that significantly exceeds many clients' actual reading level. These authors recommend that we avoid professional jargon and write at a sixth to eighth grade reading level. And, of course, we should review this written information with clients verbally and ensure their understanding of it before providing professional services.

Informed Consent as an Ongoing Process

As has been mentioned, informed consent should be viewed as an ongoing process. This process can begin before the professional relationship is even established. For example, information shared on your website about your credentials and training, the type of services you offer, your approach to treatment, if you participate in insurance plans or not, and other relevant information that will likely be of importance to potential clients can all be considered as a part of the informed consent process. Of course, merely listing information on one's website or in written forms that potential clients can read does not meet the requirements for valid informed consent, but they can be seen as initial step or stages in the informed consent process. Similarly, information shared during an initial telephone consultation can serve as the beginning of the informed consent process, but should not be considered to be sufficient to meet the requirements of a valid informed consent. Even after the client agrees to the initial treatment plan that has been provided in writing and reviewed verbally to ensure his or her understanding of it, the informed consent process should not be considered completed. It is recommended that the informed consent agreement be reviewed on an ongoing basis when it appears that points previously agreed to are relevant to ongoing services, that may impact the client and decisions to be made, and when it is possible that a review of this agreement will be in the client's best interest. Additionally, it is recommended that the informed consent agreement be updated whenever significant changes in the services to be provided are likely to occur since what was previously agreed to is now being changed (Barnett, Wise, Johnson-Greene, & Bucky, 2007). We should keep in mind our ultimate obligations to our clients' best interests and the reasonable person standard described earlier when considering if the informed consent agreement needs to be updated at any point in time. *Continued on page 5*

Continued from page 4 . ***Is Informed Consent Really Necessary? "Yes!"***
Jeffrey E. Barnett, Psy.D., ABPP

Diversity and Individual Differences

When considering clients' best interests with regard to how the informed consent process is implemented, diversity factors and other individual differences should always be considered. Diversity factors that may necessitate how the informed consent process is conducted include age, culture, race, ethnicity, gender, disability, and others. Additional individual difference issues that may impact how informed consent is addressed include if the "client" is an individual, couple, family, or group; if the client is an organization; in situations of third-party requests for services, divorce/custody situations, and if the client has impaired cognitive capacities, among others. The prudent psychologist should consider all diversity issues and individual differences and how they may impact the informed consent process to include client needs and expectations, rather than use a "one size fits all" approach to informed consent. When considering these issues, consultation with experienced colleagues is recommended, especially when less familiar with the differences in question. It is also vital that psychologists be familiar with laws and regulations relevant to the informed consent process to include who has the legal right to give their own consent to treatment and under what circumstances, mandatory reporting requirements, and who may have access to information shared in the professional relationship, among others.

Conclusions

This brief article provides a review of the basics of informed consent and the informed consent process. There is an extensive literature written on clinical, ethical, and legal issues of relevance to informed consent. We should each familiarize ourselves with this literature and ensure that our knowledge about informed consent issues and that our informed consent practices with clients remain consistent with required standards of practice. Additionally, as with all professional services provided by psychologists, while we must always meet the minimum expectations set in regulations and laws, it is hoped that we each will aspire to exceed these standards, being motivated by a desire to provide the best possible services to clients clinically, ethically, and legally. *—End—*

Congratulations Dr. Leigh and Dr. Barnett!

During APA's summer 2013 convention, two (2) Board members received praiseworthy recognition for achievement and accomplishment within their area of expertise.

Dr. Irene W. Leigh was given the American Deafness and Rehabilitation 2013 Boyce R. Williams Award, its highest honor, and

Dr. Jeffrey E. Barnett was given the American Psychological Foundation's Rosalee G. Weiss Award for Outstanding Leaders in Psychology, and he received the Division 42 (Psychologists in Independent Practice) Mentoring Award.

Congratulations to you both!

Newly Licensed Psychologists

July 2013
Heather Anne Adams, Psy.D
Ann Aspnes, Ph.D.
Elgiz Bal, Ph.D.
Elizabeth Day Ballard, Ph.D.
R. Justin Boyd, Ph.D.
Gina Luff Bruns, Ph.D.
Ximena Celedon, Psy.D
Brian J. Hall, Ph.D.
Chelsea Jillian Howe, Psy.D
Catherine A. McGill, Psy.D
Keri Rosch, Ph.D.
Gregory P. Ryan, Psy.D
Jeanmarie Likar Sandford, Psy.D
Aaron M. Sawyer, Ph.D.
Kasey Lyn Serdar, Ph.D.
Sarah van Cleve Spencer, Ph.D.
Tessa Taylor, Ph.D.

August 2013
Xi Besha, Ph.D.
Sarah E. Dew-Reeves, Ph.D.
Kirk A. Duncan, Psy.D.
Dena M. Dunn, Psy.D.
Susan C. Han, Ph.D.
Rosha Dushianthi Hebsur, Psy.D.
Vidyulata Kamath, Ph.D.
Samantha L. Marks, Psy.D.
Amanda J. Murray, Ph.D.
Robert J. Sawyer, II
Jonathan R. Schettino, Ph.D.
Rebecca L. Wald, Ph.D.
Kathryn M. Wiens, Psy.D.

September 2013
Ana Arenivas, Ph.D.
Caron M. Casciato, Psy.D
Courtney N. Compagnone, Psy.D
Marie C. Deyro, Psy.D
Susan A. Etkind, Ph.D.
Radha V. Gholkar, Ph.D.
Allison C. Houle, Ph.D.
Cleopatra Lightfoot-Booker, Psy.D
Noah M. Meyers, Ph.D.
Jason D. Mathison, Psy.D
Melissa V. Morris, Ph.D.
Anastasia Raisa Pytal, Psy.D
Danielle M. Raines, Psy.D
Karen E. Seymour, Ph.D.
Emilie Stuber, Psy.D
Tameka M. Tucker, Ph.D.
Michael Christopher Wagner, Psy.D
Kerstin Youman, Ph.D.

October 2013
Erin Elizabeth Burns, Ph.D.
Jillian M. Egan, Psy.D
Michael Leonard Green, Ph.D.

October 2013 cont.
Harper B. Johnston, Ph.D.
Michael Keaveny, Psy.D
Amberlyn Celeste Kelleher, Psy.D
Krista Lesinski, Psy.D
Erica Shawn Merson, Ph.D.
Leena Mohapatra, Ph.D.
Eboka E. Mullins, Ph.D.
Shawneen R. Pazienza, Ph.D.
Laura E. Solomon, Psy.D
Dahlia R. Topolosky, Psy.D
Karena Wilson-Plater, Psy.D

November 2013
Kendra Brook Battaglia, Psy.D
Joseph E. Cleary, III, Psy.D
Randi A. Dublin, Ph.D.
Jenita Griffin, Psy.D
Julie D. Lapides, Psy.D
Edward K. Maher, Ph.D.
Yael N. Mansoor, Ph.D.
Sarah M. Matthews, Psy.D
Kelly Sheperd Riolo, Ph.D.
Samantha L. Scott, Ph.D.

December 2013
Samantha Mae Daniel, Ph.D.
Kathryn Lynn Farley, Psy.D
Carol J. Fitzpatrick, Ph.D.
Brenda Hanna-Pladdy, Ph.D.
Ann M. Hummel, Ph.D.
Johari Makeba Massey, Ph.D.
Betsy Mencher, Ph.D.
Magda E. Rodriguez Gonzalez, Psy.D
Katherine Bruckman Shanahan, Ph.D.
Mary K. vonWitzleben, Ph.D.

January 2014
Douglas N. Craig, II, Psy.D.
Krista Beth Highland, Ph.D.
Mary E. Long, Ph.D.
Vanessa I. Pikler, Ph.D.
Katherine S. Salamon, Ph.D.

February 2014
Sarah R. Brager, Psy.D.
Catherine L. Dempsey, Ph.D.
Helen A. Ehlers, Psy.D.
Makon Fardis, Ph.D.
Clare Marks Gibson, Ph.D.
Jonathan P. Gorman, Psy.D.
Winnifred Hunter, Ph.D.
Brynn Huyssen, Psy.D.

What Do the CLAS Standards Mean for Individual Providers?

Monica McCann, MA, MPH
DHMH— Office of Minority Health and Health Disparities

In April 2013, the U.S. Department of Health and Human Services, Office of Minority Health released the much anticipated "National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care". The National CLAS Standards were originally released in 2000. The relaunched CLAS Standards signify progress in the state-of-the-art in theory and practice of cultural competency guidelines for health organizations to address health care disparities and enhance health equity. The overarching theme of the National CLAS Standards is to present a blueprint for health care organizations to "provide, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs". However, the National CLAS Standards hold significance not only for health care organizations, but also for individual licensed health care professionals in Maryland and around the country.

How Can I Translate the National CLAS Standards to Address My Own Care and Service Delivery Practices?
A clear role for individual health care professionals in implementing the National CLAS Standards is to serve as an advocate for patients and clients within the health care organizations where you work. Both individual and collective advocacy for the health equity and cultural competency principles promoted by the CLAS Standards are necessary in order to adequately address disparities in health care. Outlined below are several adapted CLAS Standards which provide suggestions for individual practitioners as they champion implementation of the Standards within their organizations.

Governance, Leadership, and Workforce:
- Using formal channels of communication within your organization, provide recommendations to your organization's decision-makers about the following:
  - Implementation of organizational policies, practices, and resources to promote health equity and delivery of culturally and linguistically appropriate services to patients/clients; and,
  - Recruitment, promotion and support of a culturally and linguistically diverse workforce that reflects and is responsive to the communities being served by the organization.
- Be an active participant in cultural competency training opportunities offered within your organization, and actively seek out additional training opportunities sponsored by other organizations.

Communication and Language Assistance:
- Always use the assistance of trained medical interpreters (in-person or via a telephonic language assistance service) during encounters with patients/clients who have limited English proficiency or other communication needs. (Refrain from using minors and untrained individuals as interpreters.)
- Inform patients/clients that language assistance is provided to them at no cost. Ensure that signage and frequently used health education materials in your office, or station where you provide services, are easy to understand and available in the primary languages used in the surrounding community.

Continue on page 7

Continue from page 6. ***What Do the CLAS Standards Mean for Individual Providers?,*** **Monica McCann, MA, MPH**

Engagement, Continuous Improvement, and Accountability:

- Stay informed about your organization's CLAS-related goals and policies, offer suggestions for improving them, and be mindful of how to implement them during individual patient/client encounters.
- Be accountable for quality improvement efforts and recommend ways to incorporate CLAS-related measures into your organization's continuous quality improvement activities.
- Inform all patients/clients about opportunities for them to contribute to your organization's continuous quality improvement process through participation in community needs assessments, focus groups, and similar activities.
- Inquire and stay informed about community resources (formal and informal) that may be helpful as supports to patients/clients self-managing their care.

Other General Suggestions to Keep In Mind …

- Regularly engage in personal reflection regarding one's own biases, cultural values, beliefs and philosophies (both personal and professional) and how they may influence interactions with patients/clients and ultimately affect their response to the care management plan.
- Seek opportunities, both within your organization and in the community, to learn about the diverse cultural experiences of members of the community being served.
- Be cognizant of the provider-patient power imbalance and actively develop strategies to listen and communicate with patients/clients in a respectful manner that is non-shaming and non-judgmental.
- Consider patients/clients and their families as full partners in the decision-making process.
- As best as possible, tailor services and care delivery to the unique needs of your individual patients/clients.
- Offer assistance with completing forms, and assume that all patients/clients will have difficulty understanding health information—this is the universal precautions approach to health literacy.

Further information about the National CLAS Standards is available at the following Website: https://www.thinkculturalhealth.hhs.gov/Content/clas.asp. The Website also hosts several online continuing education modules on cultural competency.

Additional training modules and resources also can be found in the Cultural Competency and Health Literacy Primer published in March 2013 by the Maryland Office of Minority Health and Health Disparities (MHHD) and the University of Maryland School of Public Health. The Primer and other resources can be accessed on the MHHD Website: http://dhmh.maryland.gov/mhhd/SitePages/Home.aspx *References furnished upon request.* ***—End—***

February 2014

Terri Friedland Julian, Ph.D.
Brooke T. Kahn, Psy.D.
Katharine I. Lacefield, Ph.D.
John Lawrence, Psy.D.
Leslie Carol Leathers, Ph.D.
Lauren Lestremau, Ph.D.
Heather I. Major, Psy.D.
Jeffrey C. Mann, Psy.D.
Sanjay C. Mehta, Psy.D.
Julie Polinger, Psy.D.
Autumn Porubsky, Psy.D.
Deborah Potvin, Ph.D.
Sangeeta Prasad, Psy.D.
Aimee Catherine Ruscio, Ph.D.
Joshua N. Semiatin, Ph.D.
Sepideh S. Soheilian, Ph.D.
Anna Campbell Sullivan, Psy.D.
David M. Tirpak, Ph.D.
Marlin C. Wolf, Ph.D.
—End—

The Maryland Responds Program Wants YOU!

The MD Responds Program is the Medical Reserve Corps (MRC) for the State of Maryland. The MRC is a Nation-wide network of volunteer programs, who respond to local emergencies and ongoing public health efforts. MD Responds, previously known as the Maryland Professional Volunteer Corps, is administered by the Maryland Department of Health and Mental Hygiene (DHMH), Office of Preparedness and Response (OPR).

To become a MD Responds volunteer, visit https://mdresponds.dhmh.maryland.gov/, and click the **"Register Now"** button.

Parenting Coordination: A New Frontier
Neal R. Morris, Ed.D., M.S.

Parenting Coordination has gained increased attention as parents and the courts utilize this intervention model to deal with high-conflict custody/visitation disputes. The term "frontier" highlights that few professionals are providing this service because in addition to being complex work, the licensed psychologist must follow two sets of practice standards (psychological and legal) each with its own unique ethical boundaries. And few psychologists appear to have the requisite training, skills, wisdom, and interest necessary to do a good job, even though the need is great and the potential benefit to the individuals involved is significant. Based on this interest and in response to member states' request for guidance on how to approach issues regarding Parenting Coordination, Matt Sullivan, Ph.D., a leading expert in the field practicing in Northern California and a 1985 graduate of the University of Maryland, was invited to speak at a recent meeting of the Association of State and Provincial Psychology Boards. Dr. Sullivan's presentation and recommendations are summarized below and may be helpful to psychologists who act in this capacity or interact with parent coordinators.

The 2012 Guidelines for the Practice of Parenting Coordination issued by the American Psychological Association ("APA") define Parenting Coordination as "a nonadversarial dispute resolution process that is court-ordered or agreed to by divorced or separated parents who have ongoing patterns of high conflict and/or litigation about their children" (APA, 2012, p. 2). Parents experiencing significant ongoing conflict – trying to prove that the other is unfit, not responsible, or violating some agreement – often seem to forget the needs of their children. The defining principle of Parenting Coordination is a "…continuous focus on the children's best interests…" (APA, 2012, p. 2)). In addition to APA Guidelines, the Association of Family and Conciliation Courts ("AFCC") issued guidelines for the practice of Parenting Coordination in 2005. Maryland has standards for custody evaluations (COMAR 10.36.09) and legal guidelines were issued in 2011 by the Court of Appeals of Maryland regarding Parenting Coordination (Maryland Rule 9-205.2). The APA and AFCC Guidelines and Maryland's legal guidelines offer direction to the Board of Examiners when issues of standards of practice arise.

According to Sullivan, the average psychologist serving as a Parenting Coordinator ("PC") has been in practice for more than 17 years. The role of a PC is intensive case management. The goal is to teach the conflicting parents how to effectively co-parent their children, i.e., how to place the needs of their children ahead of their own respective needs. The PC's objectives include education, negotiation, and sometimes mediation around the various issues on an ongoing basis until the parents can manage on their own or until there are agreed upon rules for virtually every concern and the parents demonstrate a consistent capability to apply and follow these rules of engagement on behalf of their children's best interests.

A psychologist performing Parenting Coordination must be skilled at sizing-up situations presented by conflicting parents. A PC must know child development norms, family dynamics, and the likely effects of divorce on children of all ages. A PC must be a good communicator. TA PC must be able to impart a great amount of knowledge to the parents, and often to grandparents and other important adults in the child's life. A PC must be adept at negotiating disputes to a win-win outcome. A PC must decide disputes in favor of the children's best interests based on the PC's knowledge of legal standards and mental health standards. A competent and effective PC will be efficient and prompt in deciding disputes, which means that the PC must be readily accessible to the parents via telephone, video conferencing, and/or email/text. Sullivan's experience suggests that in nearly all cases, even hard-boiled, highly conflicted parents eventually take the chance to work outside the courtroom, without expensive lawyers, if given reasonable access to a PC whose goal is to help the parents do best by their children.

PCs typically begin work with a family after the family has been to court, when the parents still have unresolved conflicts about their children. Sometimes there is a court order appointing the PC, or the court may suggest a particular PC, or the parents may select a PC recommended to them by their lawyers or friends. Most Maryland Circuit Courts maintain a list of qualified professionals available to act as a PC. The PC also could become involved with parents before they go to court, such as in the Collaborative Law approach.

Continue of page 9

Continue from page 8 ***Parenting Coordination: A New Frontier, Neal R. Morris, Ed.D., M.S.***

The first step a PC must take after being selected and agreeing to provide Parenting Coordination services is to develop a contract that spells out procedures, roles and responsibilities, the services to be offered, access, expectations, fees, payment methods, and any other concerns. The next task may be helping the parents craft a parenting plan that fits their circumstances. These preliminary agreements are usually reviewed by the parents' respective attorneys; in some jurisdictions, the court may review the PC contract or even place it into a court order. It is understood that there is open access to information by the parents. The Parenting Coordination contract may stipulate that the PC may keep some material confidential, such as communications from other professionals working with the parents or the children. The contract may also make clear that the PC does not provide psychotherapy or other professional service to any members of the family. A PC may, however, recommend that psychotherapy be sought by the parents or children. A PC is not a custody evaluator either! Serial roles (e.g. psychotherapist, then PC, then custody evaluator) are a certain way to risk violating an ethical boundary. As Sullivan stated, "… wear one professional hat, only one hat and no logo!"

The stakes are high for family members and the necessary skill level great because Parenting Coordination is complex and may be emotionally taxing. This kind of professional service exposes a licensed psychologist to multiple demands and practice standards, but the potential benefits in helping families to do the best for their children are large. With appropriate training, knowledge, and expertise, and with thoughtful attention to legal and ethical issues, a licensed psychologist may provide valuable services to families in the role of Parenting Coordinator. *References furnished upon request. —End—*

Rewards and Challenges of a Consumer Member
By Lydia McCargo-Redd

My appointment by the Governor of Maryland to the Maryland Board of Examiners of Psychologists has been a rewarding and challenging experience; an awesome responsibility to the citizens of the state. It has been rewarding to see members of the board working together, respecting each member's opinion and the nine (9) members understanding that we are one – one collective voice for protecting the citizens of Maryland. I have witnessed valid advice from our legal counsel and excellent investigative reporting that allows board members to read, digest, process and then present relevant facts on cases/complaints to the board for a decision. There is generally a robust discussion among board members before decisions are rendered. I also observed board members being careful to recuse themselves from cases to avoid any conflict of interest. This appointment has been challenging, requiring me to learn the subject matter as quickly as possible to be able to give a fair opinion to the board after listening to cases and reading and presenting cases (with the assistance of a board psychologist). It is important for me to understand the laws that protect the public and to make sure that everyone is treated fairly and equitable. Overall, the experience has made me proud of the board's task at hand which is to protect the citizens of Maryland!

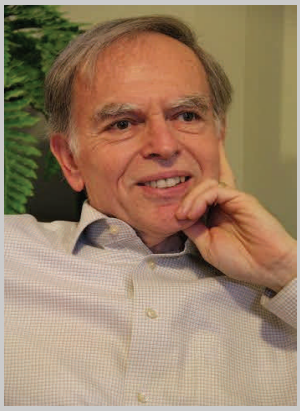
A Consumer Member's Reflections
By Harriet Rakes

I was appointed as a consumer member to the Maryland Board of Examiners of Psychologists (the Board) approximately four years ago. As a consumer member I have been given the opportunity to participate in carrying out the Board's mission to protect the citizens of Maryland and to promote quality health care in the field of psychology. I have had the opportunity to share my views on all matters before the board and I have always felt that my views were considered in the final decisions that resulted. I have observed that whether you are a consumer member or a professional member on the Board, each of us is made to feel like an integral member of the Board. In fact, I have found that the psychologists actively seek out, and greatly value, the consumer members' perspective. For a number of years I have been involved in both state and local politics, therefore, upon being asked to serve on a State Board, I felt it would be a service to the state as well as a challenge. I have enjoyed serving on the psychology Board. I have been very impressed that all Board members are concerned about the services psychologists provide to the State's residents. Further, our meetings are handled in a very professional and orderly manner. My hat goes off to the leaders and members of the Board!

Meet the New Board Member
Christopher Bishop, Psy.D.

Dr. Bishop is an Assistant Professor at Trinity Washington University in the Psychology and Human Relations Department. He is a licensed psychologist and clinical social worker. Dr. Bishop's research interest includes juvenile and adult forensics and cultural issues. His practice work includes juvenile competency, parental capacity evaluations, educational assessments, and forensic evaluations. Dr. Bishop is a native of Maryland and married to Dr. Charla McKinzie-Bishop and feels privileged to serve on the Board.

Meet the New Board Member
James F. Gormally, Ph.D.,ABPP



Jim Gormally was born in Baltimore, received his Ph.D. from Southern Illinois University at Carbondale. He is a Maryland licensed psychologist and was board certified in Counseling Psychology by the American Board of Professional Psychology (ABPP) in 1996. He has worked at several hospitals using testing to help with diagnostic questions, and most recently at the Walter Reed National Military Medical Center. He recently launched a website (DrGormally.com) focused on resilience, trying to reach out to couples who have been affected by military deployments. He likes biking and recently partnered with another Maryland psychologist to complete a "metric century". He is married, has two children, and is greatly enjoying being a grandpa for the first time.

2013 Annual Complaint Report

Total # of Complaints received involving licensed and unlicensed activities	41
Complaints resolved	28
Disciplinary actions taken against licensees, or other actions taken against non-licensees	5
Licenses suspended or revoked	3
Pending complaints	13

Public Orders

Love, Barbara. Psych LN:02672 Date of Order - 10/8/2013

ADDRESS, EMAIL & NAME CHANGE

Please notify the Board of any changes to your contact information. On-line at www.dhmh.maryland.gov/psych or by contacting Sally at sally.mitchell@maryland.gov

MEET THE BOARD

Steven A. Sobelman, Ph.D. — Chair

Jeffrey E. Barnett, Psy.D., ABPP — Vice Chair

Christopher L. Bishop, Psy.D.

James F. Gormally, Ph.D., ABPP

Irene W. Leigh, Ph.D.

Lydia McCargo-Redd, Consumer Member

Neal Morris, Ed.D., MS, CBSM, ABPP

Myra A. Waters, Ph.D.

Harriet Rakes—Consumer Member

MEET THE STAFF

Lorraine Smith, M.A., MPH, Executive Director

Sally Mitchell, Administrative Assistant

Dorothy Kutcherman, Licensing Coordinator

P. Morris English, M.S., Investigator

Sangeeta Sarkar, Data Base Analyst

Linda Bethman, JD, Board Counsel

Brett Felter, JD, Staff Attorney