



STATE OF WISCONSIN
Department of Safety and Professional Services
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Governor Scott Walker Secretary Dave Ross

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PSYCHOLOGY EXAMINING BOARD MEETING
Room 121A, 1400 E. Washington Avenue, Madison WI
Contact: Dan Williams (608) 266-2112
FEBRUARY 6, 2013

Notice: The following agenda describes the issues that the Board plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a description of the actions and deliberations of the Board.

9:00 A.M.

OPEN SESSION – CALL TO ORDER – ROLL CALL

- A. **Adoption of Agenda (1-4)**
- B. **Approval of Meeting Minutes of December 5, 2012 (5-10)**
- C. **9:00 A.M. - Public Hearing on Administrative Rule PSY 2 Relating to Applicant Appearance (11-16)**
 - 1) Review and Respond to Clearinghouse Report and Public Hearing Comments
- D. **9:10 A.M. APPEARANCE by Shel Gross from Mental Health America of WI as to the Topic of Suicide Prevention Education (17-30)**
- E. Secretary Matters
- F. **Administrative Matters – Discussion and Consideration (31-32)**
 - 1) Board Election
 - 2) Chair Appointments **(33-34)**
 - 3) Liaison Authority and Signature Process
 - i. Credentialing
 - ii. DLSC **(35-36)**
 - 4) Paperless Initiative **(37-40)**
 - 5) Staff Update
- G. Discussion and Consideration Regarding Streamlining of Licensure Process
- H. **Licensing Status for Credentials Renewed with Continuing Education Waiver due to Retirement (41-42)**
- I. **Legislation/Administrative Rule Matters – Discussion and Consideration (43-46)**
 - 1) Revisions to Administrative Rule PSY 4 Relating to Continuing Education

- J. Items Received After Printing of the Agenda:
 - 1) Introductions, Announcements and Recognition
 - 2) Presentations of Petition(s) for Summary Suspension
 - 3) Presentation of Proposed Stipulation(s), Final Decision(s) and Order(s)
 - 4) Presentation of Proposed Final Decision and Order(s)
 - 5) Informational Item(s)
 - 6) Division of Legal Services and Compliance Matters
 - 7) Education and Examination Matters
 - 8) Credentialing Matters
 - 9) Practice Questions/Issues
 - 10) Legislation/Administrative Rule Matters
 - 11) Liaison Report(s)
 - 12) Speaking Engagement(s), Travel, or Public Relation Request(s)

K. Informational Item(s)

L. Other Board Business

M. Public Comments

CONVENE TO CLOSED SESSION to deliberate on cases following hearing (s. 19.85(1)(a), Stats.; consider closing disciplinary investigation with administrative warning s.19.85(1)(b), Stats. and 440.205, Stats., to consider individual histories or disciplinary data (s. 19.85(1)(f), Stats.; and, to confer with legal counsel (s. 19.85(1)(g), Stats.)

N. **Deliberation of Proposed Stipulation(s), Final Decision(s) and Order(s)**

- 1) David Prasse, Ph.D (12 PSY 011) **(47-52)**

O. **Deliberation of Proposed Final Decision and Order in the Matter of the Disciplinary Proceedings Against Randi Erickson, Psy.D., Respondent (DHA Case#SPS-12-0029)(DLSC Case #11PSY033) (53-90)**

- 1) Respondent's Objections to Proposed Decision
- 2) DLSC's Response to Respondent's Objections

P. Deliberation of Administrative Warning(s)

Q. **Division of Legal Services and Compliance**

- 1) Case Status Report
- 2) Case Closings

R. Consulting with Legal Counsel

S. **Reinstatement Review for Cheryl Rose Buechner, Ph.D (91-118)**

T. Review of Applications for Licensure

- 1) Sharon Gray, Ed.D **(119-162)**
- 2) Elizabeth Hansen, Psy.D **(163-192)**
- 3) Julie Janecek, Ph.D **(193-230)**
- 4) Sarah Kohlstedt, Ph.D **(231-266)**
- 5) Sujatha Ramesh, Ph.D **(267-290)**
- 6) Jamie Roberts, Psy.D **(291-320)**
- 7) Keyona Walker, Ph.D **(321-364)**
- 8) Shanda Wells, Psy.D **(365-400)**
- 9) Erin Williams, Psy.D **(401-446)**

U. Review of Additional Information Requested of Applicants for Licensure

- 1) Rosemary Doyle, Psy.D **(447-494)**
- 2) India Gray-Schmiedlin, Ph.D (Information not yet Received as of Printing of Agenda) **(495-496)**
- 3) Allison Jahn, Ph.D **(497-502)**
- 4) Shaneen Meskew, Ph.D **(503-510)**
- 5) Julia Myers, Psy.D **(511-518)**
- 6) M. Christine Foskett, Psy.D (Information not yet Received as of Printing of Agenda)
- 7) Maggie Kozmin, Psy.D (Information not yet Received as of Printing of Agenda)

V. Oral Interview of Applicants for Licensure – Final Approval for Licensure

- 1) Carla Davey, Ph.D
- 2) M. Christine Foskett, Psy.D
- 3) Allison Jahn, Ph.D
- 4) Maggie Kozmin Psy.D
- 5) Shaneen Maskew, Ph.D
- 6) Michael Mihajlovic, Psy.D
- 7) Julia Myers, Psy.D

W. Deliberation of Items Received After Printing of the Agenda:

- 1) Application Issues and/or Reviews
- 2) Professional Assistance Procedure (PAP)
- 3) Monitoring Matters
- 4) Proposed Stipulations, Final Decisions and Orders
- 5) Administrative Warnings
- 6) Orders Fixing Costs/Matters Related to Costs
- 7) Proposed Final Decisions and Orders
- 8) Petitions for Summary Suspension
- 9) Petitions for Re-hearings
- 10) Case Closings
- 11) Education or Examination Matters
- 12) Review Additional Information Requested of Applicants for Licensure
- 13) Oral Interviews of Applicants for Licensure – Final Approval for Licensure
- 14) Review of Applications for Licensure
- 15) Supervision Reviews
- 16) Credential Issues
- 17) Appearances from Requests Received or Renewed
- 18) Motions

RECONVENE INTO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION

Vote on Items Considered or Deliberated on in Closed Session, If Voting is Appropriate

DLSC – Signatures for Orders

X. Other Board Business

ADJOURNMENT

**PSYCHOLOGY EXAMINING BOARD
MEETING MINUTES
DECEMBER 5, 2012**

PRESENT: Rebecca Anderson, Ph.D.; Bruce Erdmann, Ph.D.; Daniel Schroeder, Ph.D.;
Melissa Westendorf, J.D., Ph.D.

STAFF: Dan Williams, Executive Director; Pamela Stach, Legal Counsel; Matt Niehaus, Bureau
Assistant; and other Department Staff

CALL TO ORDER

Bruce Erdmann, Ph.D., Chair, called the meeting to order at 9:05 a.m. A quorum of four (4) members was present.

ADOPTION OF AGENDA

Amendments to the Agenda:

- Item “S-9” (closed session) Under the item titled “**REVIEW OF APPLICATIONS FOR LICENSURE**” **REMOVE:**
 - Emily Stebner, Psy.D.
- Item “P-1” (closed session) Under the item titled “**DELIBERATION OF ADMINISTRATIVE WARNING**” **REPLACE** “12 PSY 068” with:
 - “12 PSY 008”
- Item “R-9” (closed session) Under the item titled “**ORAL INTERVIEW OF APPLICANTS FOR LICENSURE – FINAL APPROVAL FOR LICENSURE**” **REPLACE** “Alexandara Marks, Psy.D” with:
 - “Alexandra Marks, Psy.D”

MOTION: Rebecca Anderson moved, seconded by Daniel Schroeder, to adopt the agenda as amended. Motion carried unanimously.

APPROVAL OF MEETING MINUTES OF OCTOBER 10, 2012

Amendments to the Minutes:

- Page 1 of the Minutes: **CHANGE** the header of approval of meeting minutes as follows:
 - “Approval of Meeting Minutes of June 2010~~2012~~”
- Page 2 of the Minutes: **REPLACE** “making” with “examining possible” in the motion on **DISCUSSION OF PROVISIONAL LICENSURE**
- Page 2 of the Minutes: **REPLACE** “nominate” with “name” and insert “a delegate of the Board after Bruce Erdman, Ph.D. in the motion on **SPEAKING ENGAGEMENT(S), TRAVEL, OR PUBLIC RELATION REQUEST(S)**
- Page 6 of the Minutes: **REMOVE** “unanimously” from the motion on **12 PSY 013.**

MOTION: Daniel Schroeder moved, seconded by Rebecca Anderson, to approve the minutes of October 10, 2012 as amended. Motion carried unanimously.

**DISCUSSION AND CONSIDERATION OF EMERGING ISSUES RELATED TO
TELEPSYCHOLOGY**

9:10 APPEARANCE - SECRETARY DAVE ROSS AND JEFF WEIGAND

MOTION: Daniel Schroeder moved, seconded by Rebecca Anderson, to thank Secretary Ross for attending the meeting. The Board thanks Secretary Ross for considering creation of a multi-disciplinary (e.g. Pharmacy, Medicine, Psychology, Nursing, MPSW Jt. Board, Dentistry) task force to develop statutory authority for regulating the area of Telehealth. Motion carried unanimously.

MOTION: Melissa Westendorf moved, seconded by Daniel Schroeder, to designate Rebecca Anderson and/or Daniel Schroeder as the Board's representative(s) in the multi-disciplinary task force on Telehealth. Motion carried unanimously.

LEGISLATIVE/ADMINISTRATIVE RULE MATTERS

Discussion and Consideration of Proposed Rule Revision to PSY 2.09 and 2.12

MOTION: Melissa Westendorf moved, seconded by Rebecca Anderson, to approve the amended proposed order amending PSY 2. Motion carried unanimously.

**DISCUSSION AND CONSIDERATION AS TO THE REQUEST BY ASPPB FOR BOARD
REVIEW OF A POSITION PAPER**

MOTION: Melissa Westendorf moved, seconded by Daniel Schroeder, to designate Bruce Erdmann as the Board's representative to respond to the ASPPB survey on behavior analysis. Motion carried unanimously.

CLOSED SESSION

MOTION: Rebecca Anderson moved, seconded by Daniel Schroeder, to convene to closed session pursuant to Wisconsin State statutes 19.85(1)(a)(b)(f) and (g), for the purpose of conducting oral interviews, reviewing monitoring requests, requests to extend practice, application reviews, consulting with Legal Counsel and Division of Enforcement case status reports. Roll Call Vote: Rebecca Anderson, Ph.D.-yes; Bruce Erdmann, Ph.D.-yes; Daniel Schroeder, Ph.D.-yes; and Melissa Westendorf, J.D., Ph.D. Motion carried unanimously.

The Board convened into Closed Session at 10:28 a.m.

RECONVENE INTO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION

MOTION: Rebecca Anderson moved, seconded by Daniel Schroeder, to reconvene into open session. Motion carried unanimously.

The Board reconvened into Open Session at 3:21 p.m.

VOTE ON ITEMS CONSIDERED OR DELIBERATED ON IN CLOSED SESSION, IF VOTING IS APPROPRIATE

MOTION: Melissa Westendorf moved, seconded by Daniel Schroeder, to affirm all motions made in closed session. Motion carried unanimously.

REVIEW OF ADMINISTRATIVE WARNING

1:50 P.M. APPEARANCE – DR. MICHAEL OSTROWSKI

MOTION: Daniel Schroeder moved, seconded by Melissa Westendorf, to affirm the administrative warning against Dr. Michael Ostrowski (12 PSY 012). The Board recognizes Dr. Ostrowski's good faith effort to meet the 40 continuing education requirements and his diligence in responding when the problem was identified. Motion carried unanimously.

DELIBERATION OF PROPOSED STIPULATION(S), FINAL DECISION(S) AND ORDER(S)

Paul M Smerz, Ph.D. (11 PSY 029)

MOTION: Rebecca Anderson moved, seconded by Daniel Schroeder, to adopt the Findings of Fact, Conclusions of Law, Stipulation and Order in the matter of disciplinary proceedings against Paul M. Smerz, Ph.D. (11 PSY 029). Motion carried unanimously.

DELIBERATION OF ADMINISTRATIVE WARNING(S)

12 PSY 008

MOTION: Daniel Schroeder moved, seconded by Rebecca Anderson, to issue an Administrative Warning in case number 12 PSY 008. Motion carried unanimously.

REVIEW OF ADDITIONAL INFORMATION REQUESTED OF APPLICANTS FOR LICENSURE

MOTION: Melissa Westendorf moved, seconded by Daniel Schroeder, to accept the additional information submitted by:

- Kristin Hoff, Psy.D
- Lisa Howell, Ph.D
- Reid Kehoe, Psy.D
- Jonathan Marin, Ph.D
- Kristen Marin, Ph.D
- Stephen Melka, Ph.D
- Kathleen Murphy-Ende, Ph.D, Psy.D
- Renata Okonkwo, Ph.D
- Darlene Piekarek, Ph.D
- Emily Schweigert, Ph.D
- Jason Siewert, Ph.D
- Jennifer Wilson, Ph.D

Motion carried unanimously.

MOTION: Rebecca Anderson moved, seconded by Daniel Schroeder, to accept the additional information submitted by Angela Fleck, Ph.D and Gary Plato, Psy.D. Motion carried. Recused: Bruce Erdmann

(Melissa Westendorf, Vice Chair, assumed the role of Chair as Bruce Erdmann recused himself from deliberation and voting on the matters concerning Angela Fleck, Ph.D. and Gary Plato, Psy.D.)

**ORAL INTERVIEW OF APPLICANTS FOR LICENSURE
FINAL APPROVAL FOR LICENSURE**

MOTION: Rebecca Anderson moved, seconded by Daniel Schroeder, to grant licensure to practice psychology to:

- Noah Adrians, Ph.D
- Sally Frutiger, Ph.D
- Kristin Hoff, Psy.D
- Lisa Howell, Ph.D
- Reid Kehoe, Psy.D
- Jonathan Marin, Ph.D
- Kristen Marin, Ph.D
- Jaya Matthew, Ph.D
- Stephen Melka, Ph.D
- Kathleen Murphy-Ende, Ph.D, Psy.D
- Renata Okonkwo, Ph.D
- Darlene Piekarek, Ph.D
- DuMont Schmidt, Ph.D
- Emily Schweigert, Ph.D
- Jason Siewert, Ph.D
- Jennifer Wilson, Ph.D

Motion carried unanimously.

MOTION: Rebecca Anderson moved, seconded by Daniel Schroeder, to grant licensure to practice psychology to Angela Fleck, Ph.D, Alexandra Marks, Psy.D, and Gary Plato, Psy.D. Motion carried. Recused: Bruce Erdmann

(Melissa Westendorf, Vice Chair, assumed the role of Chair as Bruce Erdmann recused himself from deliberation and voting on the matters concerning Angela Fleck, Ph.D., Alexandra Marks, Psy.D, and Gary Plato, Psy.D.)

REVIEW OF APPLICATIONS FOR LICENSURE

MOTION: Rebecca Anderson moved, seconded by Daniel Schroeder, to act upon the review of applications conducted on December 5, 2012 as noted in the application files.

- John Bayless, Ph.D
- Carla Davey, Ph.D
- M. Christine Foskett, Psy.D
- Allison Jahn, Ph.D
- Shaneen Meskew, Ph.D
- Michael Mihajlovic, Psy.D
- Julia Myers, Psy.D

Motion carried unanimously.

MOTION: Rebecca Anderson moved, seconded by Daniel Schroeder, to act upon the review of applications conducted on December 5, 2012 as noted in the application file of Maggie Kozmin, Psy. D. Motion carried. Recused: Bruce Erdmann

(Melissa Westendorf, Vice Chair, assumed the role of Chair as Bruce Erdmann recused himself from deliberation and voting on the matters concerning Maggie Kozmin, Psy.D.)

DIVISION OF LEGAL SERVICES AND COMPLIANCE

Case Closings

Bruce Erdmann left the room at 3:09 p.m.

12 PSY 005

MOTION: Daniel Schroeder moved, seconded by Rebecca Anderson, to close case #12 PSY 005, for Compliance Gained (P2). Motion carried. Recused: Bruce Erdmann

(Melissa Westendorf, Vice Chair, assumed the role of Chair as Bruce Erdmann recused himself from deliberation and voting on the matters concerning 12 PSY 005.)

Bruce Erdmann returned to the room at 3:16 p.m.

Rebecca Anderson left the room at 3:16 p.m.

11 PSY 042

MOTION: Daniel Schroeder moved, seconded by Melissa Westendorf, to close case #11 PSY 042, for Insufficient Evidence (IE). Motion carried unanimously. Recused: Rebecca Anderson

Rebecca Anderson returned to the room at 3:20 p.m.

ADJOURNMENT

MOTION: Rebecca Anderson moved, seconded by Melissa Westendorf, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 3:41 p.m.

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**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

| | | | |
|--|---|---|--|
| 1) Name and Title of Person Submitting the Request: Sharon Henes Paralegal | | 2) Date When Request Submitted: <i>22 January 2013</i> | |
| | | Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others | |
| 3) Name of Board, Committee, Council, Sections: Psychology Examining Board | | | |
| 4) Meeting Date: 6 Feb 2013 | 5) Attachments: <input type="checkbox"/> Yes <input type="checkbox"/> No | 6) How should the item be titled on the agenda page? Public Hearing on Administrative Rule Psy 2 relating to applicant appearance. Review and respond to Clearinghouse Report and Public Hearing comments. | |
| 7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both | 8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input type="checkbox"/> No | 9) Name of Case Advisor(s), if required: | |
| 10) Describe the issue and action that should be addressed: Hold Public Hearing at 9:00 a.m. Discuss any public hearing comments. Review, discuss and respond to any Clearinghouse comments (red folder) Decide whether to forward rule for Governor's approval and to legislature. | | | |
| 11) Authorization | | | |
| <i>Sharon Henes</i> | | <i>22 January 2013</i> | |
| Signature of person making this request | | Date | |
| Supervisor (if required) | | Date | |
| Bureau Director signature (indicates approval to add post agenda deadline item to agenda) | | Date | |
| Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Board Services Bureau Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting. | | | |

STATE OF WISCONSIN
PSYCHOLOGY EXAMINING BOARD

IN THE MATTER OF RULE-MAKING :
PROCEEDINGS BEFORE THE :
PSYCHOLOGY EXAMINING BOARD : NOTICE OF PUBLIC HEARING
:

NOTICE IS HEREBY GIVEN that pursuant to authority vested in the Psychology Examining Board in §§ 15.08(5)(b) and 455.08, Wis. Stats., and interpreting §455.04(5), Wis. Stats., the Psychology Examining Board will hold a public hearing at the time and place indicated below to consider an order to repeal Psy 2.12(2); renumber Psy 2.12(3) and (4); and amend Psy 2.09(4) relating to applicant appearances.

Hearing Date, Time and Location

Date: February 6, 2013
Time: 9:00 a.m.
Location: 1400 East Washington Avenue
Room 121A
Madison, Wisconsin

APPEARANCES AT THE HEARING:

Interested persons are invited to present information at the hearing. Persons appearing may make an oral presentation but are urged to submit facts, opinions and argument in writing as well. Facts, opinions and argument may also be submitted in writing without a personal appearance by mail addressed to the Department of Safety and Professional Services, Division of Policy Development, P.O. Box 8935, Madison, Wisconsin 53708. Written comments must be received at or before the public hearing to be included in the record of rule-making proceedings.

Analysis prepared by the Department of Safety and Professional Services.

ANALYSIS

Statutes interpreted: § 455.04(5), Wis. Stats.

Statutory authority: §§ 15.08(5)(b) and 455.08, Wis. Stats.

Explanation of agency authority: Each examining board shall promulgate rules for its own guidance and for the guidance of the trade or profession to which it pertains, and

define and enforce professional conduct and unethical practices not inconsistent with the law relating to the particular trade or profession. The Psychology Examining Board shall adopt such rules as are necessary under chapter 455.

Related statute or rule: § 455.04(5), Wis. Stats.

Plain language analysis:

Section 1 amends Psy 2.09(4) to reflect the statute provision which has a discretionary provision regarding appearances. Currently the rule requires every applicant to appear before the Board in person prior to licensure as a psychologist. The change will reduce the administrative burden of the resources of the Psychology Examining Board and the Department of Safety and Professional Services. It would also significantly reduce the time it takes an applicant to become licensed because they would no longer have to wait until a scheduled meeting to make an appearance.

Section 2 repeals the provision for licensure by reciprocity for applicants who are licensed in another state which is a signatory to the agreement of reciprocity of the Association of State Provincial Psychology Boards. The reciprocity agreement requires an appearance before the Board as part of the licensing process. Currently there are only seven other signatory states (Arkansas, Kentucky, Missouri, Nebraska, Nevada, Oklahoma and Texas). None of these states are neighboring states, therefore the change would not have a significant impact on applicants.

Section 3 renumbers Psy 2.12(3) and (4) to Psy 2.12 (2) and (3).

Summary of, and comparison with, existing or proposed federal regulation:

None

Comparison with rules in adjacent states:

Illinois: Illinois does not require a personal appearance.

Iowa: Iowa does not require a personal appearance.

Michigan: Michigan does not require a personal appearance.

Minnesota: Minnesota does not require a personal appearance

Summary of factual data and analytical methodologies:

The Psychology Examining Board conformed the rule to the statute. No additional factual data or analytical methodologies were used.

Analysis and supporting documents used to determine effect on small business or in preparation of economic impact analysis:

This rule creates a change which matches the statutory languages. The rule has a positive effect on applicants and does not have an effect on small business.

This rule was posted for public comment on the economic impact of the proposed rule, including how this proposed rule may affect businesses, local government units and individuals, for a period of 14 days. No comments were received relating to the economic impact of the rule.

Fiscal Estimate and Economic Impact Analysis:

The Fiscal Estimate and Economic Impact Analysis is attached.

Initial Regulatory Flexibility Analysis or Summary:

The proposed rules do not have an economic impact on small businesses.

Agency contact person:

Sharon Henes, Paralegal, Department of Safety and Professional Services, Division of Policy Development, 1400 East Washington Avenue, Room 151, P.O. Box 8935, Madison, Wisconsin 53708; telephone 608-261-2377; email at Sharon.Henes@wisconsin.gov.

Place where comments are to be submitted and deadline for submission:

Comments may be submitted to Sharon Henes, Paralegal, Department of Safety and Professional Services, Division of Policy Development, 1400 East Washington Avenue, Room 151, P.O. Box 8935, Madison, WI 53708-8935, or by email to Sharon.Henes@wisconsin.gov. Comments must be received at or before the public hearing to be held at 9:00 a.m. on February 6, 2013 to be included in the record of rule-making proceedings.

TEXT OF RULE

Section 1. Psy 2.09(4) is amended to read:

Psy 2.09(4) APPEARANCE BEFORE THE BOARD. The applicant ~~shall~~ may be required to appear before the board in person prior to licensure to allow the board to make such inquiry of them as to qualifications and other matters as it considers proper.

Section 2. Psy 2.12(2) is repealed.

Section 3. Psy 2.12(3) and (4) are renumbered to Psy 2.12(2) and (3).

(END OF TEXT OF RULE)

COPIES OF RULE

Copies of this proposed rule are available upon request to Sharon Henes, Paralegal, Department of Safety and Professional Services, Division of Policy Development, 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708, or by email at Sharon.Henes@wisconsin.gov.

ADMINISTRATIVE RULES FISCAL ESTIMATE AND ECONOMIC IMPACT ANALYSIS

Type of Estimate and Analysis

Original Updated Corrected

Administrative Rule Chapter, Title and Number

Psy 2

Subject

Applicant Appearances

Fund Sources Affected

Chapter 20 , Stats. Appropriations Affected

GPR FED PRO PRS SEG SEG-S

Fiscal Effect of Implementing the Rule

No Fiscal Effect
 Indeterminate

Increase Existing Revenues
 Decrease Existing Revenues

Increase Costs
 Could Absorb Within Agency's Budget
 Decrease Costs

The Rule Will Impact the Following (Check All That Apply)

State's Economy
 Local Government Units

Specific Businesses/Sectors
 Public Utility Rate Payers

Would Implementation and Compliance Costs Be Greater Than \$20 million?

Yes No

Policy Problem Addressed by the Rule

This amendment will bring the rule in line with the statutes which has a discretionary provision regarding applicant appearances rather than the current rule which is mandatory. The rule also repeals the reciprocity provision because the Agreement of Reciprocity of the Association of State and Provincial Psychology Boards requires a personal appearance before the Board.

Summary of Rule's Economic and Fiscal Impact on Specific Businesses, Business Sectors, Public Utility Rate Payers, Local Governmental Units and the State's Economy as a Whole (Include Implementation and Compliance Costs Expected to be Incurred)

There is no economic or fiscal impact on specific businesses, business sectors, public utility rate payers, local governmental units or the state's economy as a whole.

Benefits of Implementing the Rule and Alternative(s) to Implementing the Rule

The benefit to rule will reduce the administrative burden of the resources of the Psychology Examining Board and the Department of Safety and Professional Services. It would also significantly reduce the time it takes an applicant to become licensed because they would no longer have to wait until a scheduled meeting. The repeal of the provision regarding the Agreement of Reciprocity of the Association of State and Provincial Psychology Boards would have minimal impact due to there only being seven other signatory states and none are neighboring states.
 The alternative to rule change would be to continue requiring every applicant to appear before the Board prior to obtaining a license.

Long Range Implications of Implementing the Rule

The long range implication would be streamlined application process.

Compare With Approaches Being Used by Federal Government

None

Compare With Approaches Being Used by Neighboring States (Illinois, Iowa, Michigan and Minnesota)

None of our neighboring states require a personal appearance before the Board prior to issuance of a license.

Name and Phone Number of Contact Person

Sharon Henes (608) 261-2377

**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

| | | | |
|---|---|--|--|
| 1) Name and Title of Person Submitting the Request: Dan Williams | | 2) Date When Request Submitted: 1/17/13 Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others | |
| 3) Name of Board, Committee, Council, Sections: WI Psychology Examining Board | | | |
| 4) Meeting Date: 2/6/13 | 5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | 6) How should the item be titled on the agenda page? Appearance by Shel Gross from Mental Health America of WI as to the topic of: Suicide Prevention Education | |
| 7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both | 8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | 9) Name of Case Advisor(s), if required: N/A | |
| 10) Describe the issue and action that should be addressed: <p>Dan: I was given your name and contact information by Sarah Bowen at the WI Psychological Assn. Myself and other members of the Prevent Suicide Wisconsin Steering Committee had a discussion with Sarah about the attached article on the need to enhance competencies of mental health professionals to assess and manage suicide. While we are potentially looking at a variety of strategies, one such strategy is to designate specific continuing education requirements as part of relicensure. I understand that there are likely many requests for requirements of different types. However, we would appreciate the opportunity to meet with the Psychology Examining Board to discuss this idea. Perhaps additional ideas and suggestions would be forthcoming.</p> <p>Prevent Suicide Wisconsin is Wisconsin's statewide suicide prevention coalition. Our participants include state staff from a variety of agencies, local coalition representatives from around Wisconsin and other professionals and advocates interested in reducing suicide. You can find out more about what we do at: www.preventsuicidewi.org</p> <p>My role includes managing both a federal and state suicide prevention grant. Wisconsin continues to have suicide rates above the national average and a major emphasis for our grants is professional education. Thanks for any assistance you can provide.</p> <p>Shel Gross</p>  <p>133 S. Butler St., Rm. 330 Madison, WI 53703 Ph: 608-250-4368</p> | | | |

Preventing Suicide through Improved Training in Suicide Risk Assessment and Care: An American Association of Suicidology Task Force Report Addressing Serious Gaps in U.S. Mental Health Training

WILLIAM M. SCHMITZ JR., PsyD, MICHAEL H. ALLEN, MD, BARRY N. FELDMAN, PhD, NINA J. GUTIN, PhD, DANIELLE R. JAHN, MA, PHILLIP M. KLEESPIES, PhD, PAUL QUINNETT, PhD, AND SKIP SIMPSON, JD

There are twice as many suicides as homicides in the United States, and the suicide rate is rising. Suicides increased 12% between 1999 and 2009. Mental health professionals often treat suicidal patients, and suicide occurs even among patients who are seeking treatment or are currently in treatment. Despite these facts, training of most mental health professionals in the assessment and management of suicidal patients is surprisingly limited. The extant literature regarding the frequency with which mental health professionals encounter suicidal patients is reviewed, as is the prevalence of training in suicide risk assessment and management. Most importantly, six recommendations are made to address the longstanding insufficient training within the mental health professions regarding the assessment and management of suicidal patients.

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BACKGROUND

In 2009, suicide was the tenth leading cause of death overall and the third leading cause of death for youth aged between 15 and 24 (Centers for Disease Control and Prevention [CDC], 2012); the number of suicides in the nation (36,909) was more than double the number of homicides (16,799; CDC, 2012). Approximately one third of people who die by suicide have had contact with mental health services within a year of their death, and 20% have had mental health contact within the last month of their life (Luoma, Martin, & Pearson, 2002).

When a mental health professional sees a patient who is at risk for suicide, he or she is faced with the need to make decisions about patient care that can have serious life-or-death consequences. If a patient dies by suicide, there is a significant emotional

impact on the patient's family, his or her social network, and the clinician or clinician-in-training treating the patient (Calhoun, Selby, & Faulstich, 1980; Cerel, Roberts, & Nilsen, 2005; Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988b; Kleespies, Penk, & Forsyth, 1993; Veilleux, 2011). When a patient of a mental health professional dies by suicide, clinical, ethical, and legal questions may arise about the adequacy of the clinician's evaluation and about the sufficiency of his or her training to perform such evaluations.

In this article, we establish that mental health professionals regularly encounter patients who are suicidal, that patient suicide occurs with some frequency even among patients who are seeking treatment or are currently in treatment, and that, despite the serious nature of these patient encounters, the typical training of mental health professionals in the assessment and management of suicidal patients has been, and remains, woefully inadequate. We follow this with a review of the current state of training and competence among mental health professionals regarding suicide assessment and interventions. We conclude with recommendations to address the longstanding insufficient response of the mental health disciplines to the issue of appropriate training in the assessment and management of suicidal patients.

THE INCIDENCE OF PATIENT SUICIDAL BEHAVIOR IN CLINICAL PRACTICE

Almost all mental health professionals encounter patients who are suicidal. Psychiatrists and other clinical staff who work on inpatient psychiatry units see patients at risk for suicide daily. Multiple agencies (e.g., the Joint Commission) have made it clear that suicides in inpatient settings should not happen, and yet they occur with some frequency. In fact, suicide has regularly been among the five most frequently reported sentinel events in recent years (i.e., an unexpected event in a

hospital that caused serious injury or death; Joint Commission, 2010b); insufficient or absent patient assessment is reported as the root cause in over 80% of suicide deaths in these reported sentinel events (Joint Commission, 2011).

Mental health professionals in outpatient settings also encounter suicidal patients with great regularity. A survey of psychologists-in-training found that 97% of respondents had provided care to at least one patient (and often several) with some form of suicidal behavior or suicidal ideation during their training (Kleespies et al., 1993). In addition, social workers encounter suicidal patients on a regular basis, with 87% of social workers in a random nationwide sample reporting that they had worked with a suicidal patient within the past year (Feldman & Freedenthal, 2006). Other research has found that 55% of clinical social workers reported that at least one of their patients had attempted suicide during their professional careers (Sanders, Jacobson, & Ting, 2008).

Mental health professionals not only treat suicidal patients, but also sometimes lose patients to suicide, leading some authors to refer to suicide as an "occupational hazard" (Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989, p. 294). Ruskin, Sakinofsky, Bagby, Dickens, and Sousa (2004) found that 50% of psychiatrists and psychiatry residents in their sample had experienced at least one patient suicide. This finding was consistent with the 51% rate noted in an earlier national survey, which also indicated that a majority of psychiatrists who reported having a patient die by suicide had more than one patient die by suicide (Chemtob, Hamada, Bauer, Kinney, & Torigoe, 1988). Research has found that psychologists, social workers, and counselors experience somewhat lower rates of patient suicide. Between 22% and 30% of psychologists report experiencing a patient suicide (Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988; Pope & Tabachnick, 1993), and investigations of patient suicides among social workers and counselors reveal numbers similar to those of psychologists (Jacobson, Ting,

Sanders, & Harrington, 2004; McAdams & Foster, 2000).

CURRENT STATUS OF THE FIELD

There have been numerous calls from national and international public, private, and governmental organizations to improve training in the assessment and management of suicide risk (e.g., Institute of Medicine [IOM], 2002; Joint Commission, 2010a; U.S. Department of Health and Human Services [USDHHS], 2001); World Health Organization 1996). In 1999, Dr. David Satcher, then Surgeon General of the United States, issued *The Surgeon General's Call to Action to Prevent Suicide*. In this document, Satcher provided a vision that would lead to a cohesive and comprehensive national suicide prevention strategy (U.S. Public Health Service [USPHS], 1999). The strategy included having mental health professionals achieve competence in suicide risk assessment and management.

Competence has been defined by various authors in a number of different ways. When discussing competence in suicide risk assessment and management, we refer to Quinnett's (2010) definition, in which *competence* is defined as the capacity to conduct:

[A] one-to-one assessment/intervention interview between a suicidal respondent in a telephonic or face-to-face setting in which the distressed person is thoroughly interviewed regarding current suicidal desire/ideation, capability, intent, reasons for dying, reasons for living, and especially suicide attempt plans, past attempts and protective factors. The interview leads to a risk stratification decision, risk mitigation intervention and a collaborative risk management/safety plan, inclusive of documentation of the assessment and interventions made and/or recommended.

Competence in the assessment of suicidality is an essential clinical skill that has consistently been overlooked and dismissed

by the colleges, universities, clinical training sites, and licensing bodies that prepare mental health professionals.

THE PREVALENCE OF TRAINING IN SUICIDE RISK ASSESSMENT AND MANAGEMENT

The lack of training available in the institutions that prepare mental health professionals has been documented for decades. Multiple studies have found that only approximately half of psychological trainees had received didactic training on suicide during their graduate education, and the training provided was often very limited (Dexter-Mazza & Freeman, 2003; Kleespies et al., 1993). It is critical to note that didactic training is not necessarily synonymous with effectively building the skills needed to conduct adequate suicide risk assessments and treat suicidal patients. Providing information to trainees is necessary but not sufficient as trainees must also be given opportunities to translate this information into competent practice by assessing and treating suicidal patients with proper supervision. Nearly 76% of responding directors of graduate programs in psychology indicated that they wanted to include more suicide-specific training in their programs, but encountered a variety of barriers to doing so (Jahn et al., 2012).

Training has been similarly sporadic among social work training programs. Less than 25% of a national sample of social workers reported receiving any training in suicide prevention, with a majority of the respondents reporting that their training had been inadequate (Feldman & Freedenthal, 2006). Faculty and deans-directors of graduate social work programs reported that most students receive 4 hours or fewer of suicide-related education (Ruth et al., 2009). The lack of training is even more pronounced among professional counseling and marriage and family therapy training programs. Wozny (2005) found that suicide-specific courses were present in 6% of accredited marriage and family therapy programs and in

2% of accredited counselor education programs.

Only the field of psychiatry seems to be attempting to ensure that their trainees are, at a minimum, exposed to the skills required to properly conduct a suicide risk assessment and address suicidality in treatment. Ellis, Dickey, and Jones (1998), in a national survey of directors of training in psychiatry, found that 94% of the responding directors reported some form of training in suicide risk assessment and intervention in their residency programs. However, the majority of directors reported that most of the training occurred in passive formats (e.g., therapy supervision, general seminar), and only 27.5% reported training via skill development workshops.

A more recent national survey of chief psychiatry residents by Melton and Coverdale (2009) found that, despite 91% of the residency programs offering some teaching on the care of suicidal patients, the average number of seminar sessions or lectures was only 3.6 and the specific content that was covered by the different programs was often vague and nondescript. Many of the respondents were of the opinion that the focus on suicide intervention was insufficient (Melton & Coverdale, 2009).

The lack of training requirements stands in stark contrast to the ongoing calls for improvement in this area. The original *National Strategy for Suicide Prevention (NSSP; USDHHS, 2001)* outlined critical objectives that would address the oft-cited, and previously discussed, deficiency in training regarding suicidality. Objective 6.3 of the NSSP specifically stated that the goal was to, “[b]y 2005, increase the proportion of clinical social work, counseling, and psychology graduate programs that include training in the assessment and management of suicide risk, and the identification and promotion of protective factors” (p. 82). There was a similarly stated objective (6.2) directing that the same goals be addressed in medical residency and physician assistant educational programs. Furthermore, objective 6.9 called for an “increase [in the] number of recertification or licensing programs in relevant professions that require

or promote competencies in depression assessment and management and suicide prevention” by 2005 (USDHHS, 2001, p. 86).

In late 2010, two organizations (the Suicide Prevention Resource Center [SPRC] and the Suicide Prevention Action Network [SPAN]) collaborated on the publication of *2010 Progress Review of the National Strategy*. This document provided a detailed analysis of how, and to what degree, the original NSSP (USDHHS, 2001) had been implemented. The *2010 Progress Review of the National Strategy* (SPRC & SPAN, 2010) findings regarding the current standards for clinical training were disheartening. After reviewing the standards for 11 different mental health professional groups, “[o]nly the Council for the Accreditation of Counseling and Related Educational Programs ... had increased attention on suicide in its 2009 standards compared to the previous version” (SPRC & SPAN, 2010, p. 23).

Moreover, state licensing boards for clinical social workers and psychologists, whose mission is to protect the public’s health and safety from untrained and unqualified providers, do not require exam items on the assessment and management of suicidal patients. Again, only psychiatry has made some efforts in this regard. The American College of Psychiatrists Psychiatry Resident-in-Training Examination, which is completed by nearly everyone who will be board eligible during their residence, includes suicide-specific questions within the emergency psychiatry domain (American College of Psychiatrists, 2011). In addition to the lack of items on licensure examinations, not a single state or mental health licensing body requires continuing education addressing suicide, suicide risk, or other behavioral emergencies.¹

¹Our review of state continuing education (CE) requirements found eight states having no CE requirements for psychologists, three states having no requirements for social workers, and six states having no requirements for physicians, including psychiatrists. Among states that maintain CE requirements for licensure, our review indicated that none require any suicide-specific CE credits.

However, continuing education on other topics is mandated in a majority of states for licensure renewal. In fact, 27 states require continuing education in ethics for licensure renewal for psychologists, 27 states require continuing education in ethics for licensure renewal for social workers, and 21 states require continuing education in ethics for licensure renewal for addictions counselors. This mandatory education ensures that mental health professionals are informed about the current issues in ethics, yet there is no similar requirement to ensure that mental health professionals are using current information to assess and treat suicidal patients.

The evidence clearly suggests that there has been negligible progress in improving the competence of mental health professionals in evaluating, managing, and treating suicidal patients. However, it is not a lack of effective training materials that has hampered such progress.

Training is Available and Accessible

There have been concerns raised in the past regarding the effectiveness of continuing education programs in impacting providers' behaviors or changing patient-related outcomes (Davis et al., 1999). Recent research has suggested that interactive continuing medical education training programs, especially those that included supervised skill demonstration and rehearsal, significantly affected health care providers' behavior (Bloom, 2005). However, a recent review has raised questions about the efficacy of training in workshop formats for improving the clinical care of the suicidal patient (Pisani, Cross, & Gould, 2011). Despite this review, studies have shown improvements in knowledge and skills because of continuing education programs.

Sockalingam, Flett, and Bergmans (2010), for example, found that training in suicide intervention for psychiatry residents increased comfort in treating suicidal patients and improved self-reported clinical practice. McNiel et al. (2008) reported that a workshop on evidence-based assessment of

suicide risk significantly improved the ability of psychiatry residents and psychology interns to identify risk factors for suicide and also improved their specificity about the significance of risk and protective factors when developing plans for intervention. Allgaier, Kramer, Mergl, and Hegerl (2009) found that training improved attitudes regarding the treatability of older adult suicide risk and increased knowledge about pharmacotherapy for depression and suicide risk among geriatric nursing staff. Moreover, Slovak and Brewer (2010) found that licensed social workers had more positive attitudes toward using firearm assessment and safety counseling when they had received training on the use of firearm counseling for suicide prevention. While Pisani et al. (2011) had some reservations about the efficacy of continuing education programs in changing clinical practices, they noted that there is strong support for the effectiveness of evidence-based training workshops in transferring knowledge and shifting attitudes.

The scientific literature is beginning to demonstrate that empirically based skills taught in a brief continuing education format can change clinic policy, confidence in risk assessment, and confidence in management of suicidal patients, with changes sustained at a 6-month follow-up (McNiel et al., 2008; Oordt, Jobs, Fonseca, & Schmidt, 2009). Findings such as these, in conjunction with the known elements that facilitate the translation of continuing education training into clinical practice (Bloom, 2005), suggest that suicide-specific continuing education can "meaningfully impact professional practices, clinic policy, clinician confidence, and beliefs" (Oordt et al., 2009, p. 21).

At the present time, there are several training programs that have been recognized for disseminating content that is consistent with the core competencies that have been referenced earlier and have been demonstrated to be effective in increasing suicide-specific knowledge and skills. The depth and breadth of these evidence-based training programs vary in length from 6 hours (i.e., *Assessing and Managing Suicide Risk: Core*

Competencies for Mental Health Professionals; SPRC, 2011) to 16 hours (i.e., Recognizing and Responding to Suicide Risk; AAS, 2011). Outcome data regarding behavior change in response to these trainings is emerging, with changes documented up to 4 months after training (Jacobson & Berman, 2010).

Systems-Level Problems Affecting Training

Despite the numerous “calls to action” and sternly worded “recommendations” to increase training and ensure the competence of practitioners in the area of suicide assessment and intervention noted earlier (e.g., USDHHS, 2001; USPHS, 1999), virtually nothing has been done by licensing boards, training programs, and professional organizations. In fact, certain professional organizations have lobbied against efforts to include suicide assessment and intervention training as a mandatory continuing education requirement (J. Linder-Crow, President of the California Psychological Association, personal communication, December 6, 2010).

While the mental health field has remained stagnant regarding the dissemination of improvements in training regarding suicide assessment and treatment, there has been growing pressure from community and grassroots organizations to ensure that suicide prevention education is provided in specific settings. For example, schools, where the issue of youth suicide has prompted action, have begun requiring mandated training in suicide prevention in many states (SPAN, 2011). Virtually all of these gatekeeper trainings that are required for school employees recommend referral to mental health professionals for potentially at-risk youth. Ironically, there is no such mandatory training for the mental health professionals. It is incomprehensible that, in many states, a teacher is now required to have more training on suicide warning signs and risk factors than the mental health professionals to whom he or she is directing potentially sui-

cidal students. In addition, there is an inherent danger in referring suicidal people to mental health professionals who are not adequately trained; if these suicidal people do not feel that treatment has been effective (which is likely the case with mental health professionals who have not received proper training in treating suicidal patients), they may drop out of treatment, become discouraged about treatment with mental health professionals, and never return to treatment, leaving them at even higher risk for suicide.

The lack of training required of mental health professionals regarding suicide has been an egregious, enduring oversight by the mental health disciplines. On an individual level, one could argue that mental health professionals have an ethical obligation to provide only those services that fall within their area of competence. Few, however, have attained specific competence in the assessment, management, and treatment of individuals who are suicidal. In fact, over the years, numerous authors have specifically called into question the ethics of mental health professionals who, without adequate training, provide service to suicidal patients (e.g., Bongar & Harmatz, 1991; Feldman & Freedenthal, 2006; Jacobson et al., 2004; Rudd, Cukrowicz, & Bryan, 2008). Each of the mental health disciplines has ethical codes which stipulate, in slightly different verbiage, that mental health professionals should not provide services that are beyond their area of competence (American Psychiatric Association, 2010; American Psychological Association, 2002; National Association of Social Workers, 2008). Yet, a majority of mental health professionals will provide services to potentially suicidal patients for whom they are ill-equipped, and, most importantly, potentially incompetent to treat.

This issue, however, goes beyond the individual level and is perhaps more appropriately addressed as an issue in systemic ethics. The system of training mental health professionals has, generally, not prepared them to function in the best interests of their patients in regard to the crucial

issue of assessing and managing patient suicidality. Thus, the glaring deficiency in the mental health educational and training system creates an ethical values conflict for practitioners that needs to be addressed.

SUMMARY

Now is the time to make changes to policy and practice to improve the competence of mental health professionals and the quality of care provided to suicidal patients. This task force of the American Association of Suicidology strongly endorses the following recommendations to ensure that mental health professionals are properly trained and competent in evaluating and managing suicidal patients, the most common behavioral emergency situation encountered in clinical practice. This task force makes these recommendations based on the empirical literature and based on the task force members' collective administrative, clinical, and forensic experience. It is this task force's belief that the implementation of the following general and specific recommendations will be a first step toward ensuring that mental health professionals are competent to recognize, assess, manage, and treat suicidal patients.

Recommendations to Improve Training

General Recommendation: A summit comprised of the national leaders in mental health should be convened to formulate plans for implementing the following recommendations.

The mental health disciplines have, to date, failed to meet the *National Strategy for Suicide Prevention* (USDHHS, 2001) goals of increasing the availability of suicide-specific training. However, collaborative work by the various mental health professions (i.e., the American Psychiatric Association, American Psychological Association, and National Association of Social Workers) can facilitate efforts to address this failure. Given the

longstanding reluctance of these groups to implement meaningful change, the additional presence of vested parties and patient safety organizations, such as the National Action Alliance for Suicide Prevention, the National Alliance on Mental Illness, the Leapfrog Group for Patient Safety, and suicide survivors, would also be encouraged to actively participate in this dialog. The American Association of Suicidology is a willing and capable host to such a summit that will aid in ensuring that the longstanding gap in the training of mental health professionals is finally closed.

This proposed summit is the ideal platform for the leaders from each of the mental health disciplines to initiate the change process that is necessary to address issues such as how to implement certification or programmatic recognition for those mental health professionals who have completed requisite training in the core competencies of suicide assessment and management. We recognize that this summit is a starting point for a change process that will continue to evolve.

Recommendation #1: Accrediting organizations must include suicide-specific education and skill acquisition as part of their requirements for postbaccalaureate degree program accreditation.

Organizations such as the American Psychological Association, the Council on Social Work Education, and the Liaison Committee on Medical Education, among others, have stringent accreditation requirements to ensure the competence and professional readiness of trainees that graduate from their programs. These accrediting bodies for each mental health discipline have similar explicit goals to "protect the interests of students, benefit the public, and improve the quality of teaching, research, and professional practice" (American Psychological Association, 2007, p. 2) by "establishing thresholds for professional competence" (Council on Social Work Education, 2008,

p. 1). To meet these goals, accredited programs that aspire to train the mental health professionals of tomorrow must ensure that specific training in the detection, assessment, treatment, and management of suicidal patients is included in the formal education of these future mental health professionals.

Specifically, these programs should incorporate the core competencies that have been identified in the scientific literature and are considered essential for assessing and managing suicide risk (SPRC, 2006). To aid in the process, Rudd et al. (2008) have provided detailed guidelines for facilitating the adequate education of mental health trainees regarding these competencies. These guidelines offer information for supervisors and instructors to ensure that trainees master the content and acquire the skills related to each domain.

The core competencies have been determined and operationalized. It is now necessary to require training programs to utilize these core competencies in their training of future mental health professionals. Ideally, these abilities would be demonstrated through supervised training with a competent supervisor and suicidal patients, but at a minimum, would require some measure of skills-based demonstration (e.g., supervised role plays).

Recommendation #2: State licensing boards must require suicide-specific continuing education as a requirement for the renewal of every mental health professional's license.

Mental health professionals currently providing care have generally not received the necessary training in suicide assessment and treatment. Practicing mental health professionals must improve and maintain their knowledge of suicide risk and develop their skills in assessment and treating suicidal patients. Continuing education is essential to ensure that providers remain current in their understanding of emerging issues while also maintaining, developing, and increasing their overall competencies, thereby improving ser-

vices to the public (American Psychological Association, 2009). As noted above, however, no states currently require suicide-specific continuing education for any mental health professionals. Yet, a majority of states require ethics training, which mental health professionals are compliant and from which they presumably benefit. Thus, it has been demonstrated that a required continuing education area is feasible to implement without being overly burdensome to mental health professionals.

Recommendation #3: State and federal legislation should be enacted requiring health care systems and facilities receiving state or federal funds to show evidence that mental health professionals in their systems have had explicit training in suicide risk detection, assessment, management, treatment, and prevention.

Because of the noted failure of the mental health field to implement changes that have been recommended and necessary for over 10 years in response to the *NSSP* (USDHHS, 2001), the assistance of the state and federal government is now needed to protect the American public and save the lives of suicidal patients. It is incumbent on health care facilities that receive state and federal funds to ensure that they have appropriately trained mental health professionals who can conduct thorough suicide risk assessments and provide appropriate, competent care to those in suicidal crises. Medical centers, hospitals, and health care institutions that receive federal or state funding should be required to hire only mental health professionals who have evidence of training specifically addressing suicide risk assessment and suicidal patient care. Documentation of such training can be met through a variety of paths: through a mental health professional's graduate training, through continuing education programs, or through a standardized certification program.

The development of a national certification program for mental health professionals,

possibly discipline specific, that is skills-based and empirically driven would greatly increase the overall competence of mental health professionals in the assessment and care of suicidal patients. This is not a novel recommendation, as Knesper et al. (2010) have proposed such a program. A mandate for such certification was drafted in a bill submitted by then U.S. Representative Patrick Kennedy (D-RI; H.R. 5040, 2010). While the bill was not enacted prior to the conclusion of the legislative session, had it passed, agencies that provide health care would have been required to show evidence that their staff members had been properly trained in suicide prevention strategies in a manner consistent with the Institute of Medicine (2002) report and the *NSSP* (USDHHS, 2001).

Recommendation #4: Accreditation and certification bodies for hospital and emergency department settings must verify that staff members have the requisite training in assessment and management of suicidal patients.

Hospitals and emergency departments cannot be considered safe havens from suicide. The Joint Commission (2010a) has noted the presence of systemic shortcomings that contribute to suicide in the hospital and emergency department setting, specifically noting problem areas of “inadequate screening and assessment, care planning and observation; insufficient staff orientation and training; poor staff communication; inadequate staffing; and lack of information about suicide prevention and referral resources” (p. 2).

To protect the health and safety of suicidal patients who are in hospital, medical center, and emergency department settings, health care facilities must be responsible for ensuring that their clinical staff members have been specifically trained in the assessment and intervention skills necessary to work effectively with suicidal patients. Rules or standards implemented by any or all of the institutional accreditation organizations

(e.g., the Centers for Medicare and Medicaid Services, the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities) and state regulatory bodies will motivate facilities to address this problem area. Thus, requiring accredited facilities to have documented evidence that their staff has been adequately trained can address the longstanding patient safety issue of improper assessment and management of suicidal patients. Such documentation could easily be reviewed as part of regularly conducted accreditation inspections.

Recommendation #5: Individuals without appropriate graduate or professional training and supervised experience should not be entrusted with the assessment and management of suicidal patients.

This task force is aware of instances in which organizations regularly place individuals with only bachelor-level preparation or less in situations where they are expected to conduct suicide risk assessments without appropriate supervision and to make management recommendations without prior supervisory review or, in some instances, no supervisory review. Given their lack of professional-level education and training, we find this practice irresponsible and egregious. As this document has clearly demonstrated, even the most educated of mental health professionals have generally been exposed to minimal formal training in this critical, specialized skill. Thus, anyone without formal training who has not been taught the requisite skills embodied in the core competencies as recognized and embodied in those programs designated best practices by SPRC referred to above and has not demonstrated these competencies in practice settings under proper supervision should not be responsible for potentially suicidal patients. The task force stresses the goal of enabling and facilitating quality training to current providers and providers-in-training which should, ultimately, save lives. By recommending competence-based training, we

do not intend to deter professionals from engagement with the topic of suicidality, far from it. As previously noted, such training is easily accessible, not excessively time-consuming, and is available from a variety of excellent sources.

Graduate and residency programs that adequately train their graduates consistent with Recommendation #2 are the logical and most qualified venues to ensure that mental health professionals obtain these skills.

CONCLUDING REMARKS

Improving the training and competence of mental health professionals is one of the most logical ways to prevent suicide and save lives. The current state of training within the mental health field indicates that accrediting bodies, licensing organizations, and training programs have not taken the numerous recommendations and calls to action seriously. The recommendations given earlier, if implemented, would address the deficits in training documented in this report. The positions presented here are consistent with those of other organizations (e.g., IOM, 2002; USDHHS, 2001), but fur-

ther elucidates the crisis in training that has continued to be overlooked and dismissed. The American Association of Suicidology considers this a critical problem, and this task force strongly supports the implementation of the recommendations in this report and those included in the *NSSP* (USDHHS, 2001).

The recommendations that have been articulated will require national leaders from the various mental health disciplines, legislative powers, and accrediting and certifying organizations to come forward promptly and move swiftly to address this longstanding deficit. Unfortunately, the research over the past 30 years has clearly demonstrated that those within the mental health disciplines have been reluctant to address the oft-cited insufficient training in the assessment and management of suicidal patients. This task force concurs with and reinforces Jobs (2011) assertion that “a huge challenge to clinical suicide prevention is the actual competency of clinical practitioners” (p. 389). Now is the time to act. Those responsible for ensuring the competence of mental health professionals have overlooked the topic of suicide for far too long.

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Manuscript Received: February 7, 2012

Revision Accepted: February 21, 2012

**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

| | | | |
|---|---|--|------|
| 1) Name and Title of Person Submitting the Request: Dan Williams | | 2) Date When Request Submitted: 1/17/13 Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others | |
| 3) Name of Board, Committee, Council, Sections: WI PSYCHOLOGY EXAMINING BOARD | | | |
| 4) Meeting Date: 2/06/13 | 5) Attachments: <input type="checkbox"/> Yes <input type="checkbox"/> No | 6) How should the item be titled on the agenda page? Administrative Matters – Discussion and Consideration | |
| 7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both | 8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by <input type="checkbox"/> No | 9) Name of Case Advisor(s), if required: N/A | |
| 10) Describe the issue and action that should be addressed: <ol style="list-style-type: none"> 1) Board Election 2) Chair Appointments 3) Liaison authority and signature process Credentialing / The DSPS credentialing staff will appear and provide the Board with an overview of the credentialing process for the credentials under its purview. Additionally, the Board should work to define the role(s) of its credentialing liaison(s) in an effort to clarify its expectations in terms of credentialing liaison work. DLSC / DLSC monitoring staff will appear and discuss the attached document. 4) Paperless Initiative 5) Staff Update | | | |
| 11) Authorization | | | |
| Signature of person making this request | | | Date |
| Supervisor (if required) | | | Date |
| Executive Director signature (indicates approval to add post agenda deadline item to agenda) Date | | | |
| Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Board Services Bureau Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Executive Assistant prior to the start of a meeting. | | | |

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**PSYCHOLOGY EXAMINING BOARD
2012 BOARD MEMBER APPOINTMENTS
(UPDATED 5/18/2012)**

Screening Panel: Rebecca Anderson, Ph.D., Melissa Westendorf, J.D., Ph.D. **

Application Review Sub-Committee: Daniel Schroeder, Ph.D., Bruce Erdmann, Ph.D. **

DOE Monitoring Liaison: Rebecca Anderson, Ph.D.

Credentialing Liaison: Melissa Westendorf, J.D., Ph.D., Bruce Erdmann, Ph.D.

Continuing Education Liaison: Melissa Westendorf, J.D., Ph.D.

Practice Question Liaison: Melissa Westendorf, J.D., Ph.D., Bruce Erdmann, Ph.D. **

Professional Assistance Procedure (PAP) Liaison: Rebecca Anderson, Ph.D. **

***** Denotes items assigned at the December 2011 meeting. All other items were updated in 2012.***

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(This is the Board of Nursing approved authority)

Board Monitoring Liaison's Roles

Board Monitoring Liaison is a board designee working with department monitors to carry out Board's order. The roles of Board Monitoring Liaison include but are not limited to:

1. Granting stay of suspension as provided under Board's order when the respondent demonstrates sufficient proof of compliance under the order;
2. Removing stay of suspension as provided under Board's order when the respondent repeatedly or substantially violates the order, such as, positive drug screen results, concerned work reports, etc;
3. Granting approval to Respondent's request as provided by the order, such as, approving proposed continuing education courses submitted by the respondent to fulfill education requirement under the order, approving treatment provider, change of employment, etc.

Current Delegated Authorities to Department Monitor and Board Monitoring Liaison

Department Monitor may draft and sign Board orders on behalf of the Board Monitoring Liaison **ONLY** under the following circumstances:

1. Department Monitor can remove CE limitation on the respondent's license if the respondent is only ordered to complete CE course(s), including a nurse refresher course, and he/she has completed the course(s). A petition may be required for the CE limitation to be removed.
2. Department Monitor can suspend the license if the licensee does not pay costs and/or forfeiture or does not complete CE course(s) within the time period specified by the Board Order. When the licensee is in compliance with the order, the Department Monitor can remove the suspension.
3. With permission from the Board Monitoring Liaison, Department Monitor can issue an order granting initial stay of suspension.
4. With permission from the Board Monitoring Liaison, Department Monitor can issue an order removing stay of suspension if there are repeated or substantial violations of Board orders. The stay may be reinstated when the Board Liaison determines that the respondent is in compliance with the order.
5. With permission from the Board Monitoring Liaison, Department Monitor can issue an order granting a temporary reduction in random drug screen frequency if the respondent is unemployed and is otherwise compliant with Board's order until such time the respondent secures employment as a nurse.
6. With permission from the Board Monitoring Liaison, Department Monitor can issue an order granting an extension of time to complete nurse refresher course (non-discipline) for up to 6 months
7. With permission from the Board Monitoring Liaison, Department Monitor can issue an order granting an extension of time to pay proceeding costs up to 90 days.

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**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

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|--|--|--|------|
| 1) Name and Title of Person Submitting the Request: Matthew C. Niehaus | | 2) Date When Request Submitted: 1/18/2013 Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others | |
| 3) Name of Board, Committee, Council, Sections: Psychology Examining Board | | | |
| 4) Meeting Date: 2/6/2012 | 5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | 6) How should the item be titled on the agenda page? Paperless Initiative | |
| 7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both | 8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No | 9) Name of Case Advisor(s), if required: | |
| 10) Describe the issue and action that should be addressed: Brief presentation of how Board Members can sign up for SharePoint access as a part of the paperless initiative. | | | |
| 11) Authorization | | | |
| Matthew C. Niehaus | | | |
| Signature of person making this request | | | Date |
| Supervisor (if required) | | | Date |
| Executive Director signature (indicates approval to add post agenda deadline item to agenda) | | | |
| Date | | | |
| Directions for including supporting documents: <ol style="list-style-type: none"> 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting. | | | |

How to register for a username/password on <http://register.wisconsin.gov> .

In order to access the Board SharePoint site, Board Members must obtain a State of WI/DOA username/password from this site <http://register.wisconsin.gov> . Once registered, Board Members will be provided a DOA credential under the Wisconsin External (wiext) domain. This account is intended to provide users with access to multiple State of Wisconsin web applications, including the DSPS SharePoint site.

To Begin, use the 'Self Registration' link

DOA/Wisconsin Logon Management System - Windows Internet Explorer provided by State of Wisconsin

http://register.wisconsin.gov/AccountManagement/

DOA/Wisconsin Logon Management System

wisconsin.gov home state agencies subject directory

Wisconsin Department of Administration

News | Search | Home

Main Menu | Help | FAQ

DOA/Wisconsin Logon Management System

The DOA/Wisconsin Logon Management System allows authorized individuals to access many DOA Internet applications using a single ID and password. When access to information or services is restricted to protect your privacy or the privacy of others, you will be asked to provide your DOA/Wisconsin Logon and password. Your DOA/Wisconsin Logon and password verifies your identity so that we can provide you with access to your information and services and prevent access by unauthorized individuals.

User Acceptance Agreement

Please note that only certain types of information will be stored in your user profile, as described in the [User Acceptance Agreement](#). Your user profile will never contain records such as driving history, tax information, unemployment compensation, vehicle registrations or prison records.

Sign Up for your DOA/Wisconsin Logon

[Self Registration](#) (Request a DOA/Wisconsin Logon and Password.)

Self Registration allows you to create **your personal** DOA/Wisconsin Logon. This is your key to doing secure business with DOA over the Internet.

Change / Update Your Information

[Profile Management](#) allows you to change your account information, e-mail address and other information.

Change Your Password

[Password Management](#) allows you to change your password.

Forgot Your Logon ID or Password?

[Logon ID/Password Recovery](#) allows you to recover a forgotten DOA/Wisconsin Logon and/or Password.

Updated February 6, 2009
DET - Bureau of Business Applications Services
Content Contact: [BBAS/BA](#)

Wisconsin.gov | Search | Legal | DOA Home

Not sure if you already have DOA/State of WI account?

Use the 'Forgot Your Logon ID or Password' link to check

After accepting the user agreement, complete the 'Account Creation' form.

Indicate 'SharePoint' under the section entitled, 'Systems You Will Access'

Account Creation

* Indicates Required Field

Profile Information

First Name *
Middle Initial
Last Name *
Suffix
E-Mail *
Use this format 6085551234
Phone ext.
Mailing Address
Street Address
City
State/Province
Zip Code -

Systems You Will Access
Use your mouse to highlight the system that you want to access.

Systems *
 *

Account Information
Your Logon ID must be between 5-20 characters and **CAN** be a combination of letters and numbers. Your Logon ID must not contain spaces or special characters.

Logon ID *
Your Password must be 7-20 characters long and **MUST** contain a combination of letters and either numbers or special characters (except the @ ? / signs). Passwords are case sensitive. Your Password cannot contain the Logon ID.
[Password Tip](#)
Password *
Re-enter Password *

Logon ID/Password Recovery
Enter a question and answer for use if you forget your DOA/Wisconsin Logon ID or Password. Your Secret Question and Secret Answer cannot contain your password.
[Secret Question and Answer Tip](#)

Secret Question *
Secret Answer *

Verification
This step helps prevent automated registrations.
If you cannot see the number below [click here](#).

Please enter the number as it is shown in the box to the left. *

Please use a login ID of your first initial followed by your middle initial followed by your last name, as in the example to the left.

Remember your logon ID, as you will need to provide that to DSPS staff in order for you to receive proper access rights.

Once you have been granted permission to access the Board's website, you should receive an automated 'Welcome to SharePoint' email with a link to the site.

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**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

| | | | |
|---|---|---|--|
| 1) Name and Title of Person Submitting the Request: Carolann Puster, Records Management Supervisor | | 2) Date When Request Submitted: 1/18/2013 | |
| | | Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others | |
| 3) Name of Board, Committee, Council, Sections: Psychology Examining Board | | | |
| 4) Meeting Date: Feb 6, 2013 | 5) Attachments: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 6) How should the item be titled on the agenda page? Licensing Status for Credentials renewed with Continuing Education waiver due to retirement. | |
| 7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both | 8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No | 9) Name of Case Advisor(s), if required: | |
| 10) Describe the issue and action that should be addressed: <p>Per PSY 4.02 (h) The board may grant an exemption from the requirements of this section to a licensee who certifies to the board that he or she has permanently retired from the active practice of psychology.</p> <p>(i) A licensee who has been granted an exemption from the requirements of this section based on retirement from the active practice of psychology may not return to the active practice of psychology without submitting evidence satisfactory to the board of having completed at least 40 credits of continuing education for each of the biennia during which the licensee was granted an exemption.</p> <p>To date, if anyone renewing a credential covered under this rule said they are retired, we waive the SIG (CE) requirement and renew them as Active. There is no indicator anywhere to the public that they should not be practicing. Is the board amenable to changing the credential status of those who have declared themselves retired from “Active” status (current and eligible to practice) to the agency’s recommended status “Non-practicing” (current and not eligible to practice).</p> <p>Agency would like to perform this change of status following the renewal period ending 9/30/2013 and use it going forward.</p> | | | |
| 11) Authorization | | | |
| Signature of person making this request | | Date | |
| Supervisor (if required) | | Date | |
| Executive Director signature (indicates approval to add post agenda deadline item to agenda) | | Date | |
| Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting. | | | |

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**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

| | | | |
|---|---|---|--|
| 1) Name and Title of Person Submitting the Request: Sharon Henes Paralegal | | 2) Date When Request Submitted: 22 January 2013 | |
| | | Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others | |
| 3) Name of Board, Committee, Council, Sections: Psychology Examining Board | | | |
| 4) Meeting Date: 6 Feb 2013 | 5) Attachments: <input type="checkbox"/> Yes <input type="checkbox"/> No | 6) How should the item be titled on the agenda page? Discuss and consider revisions to Administrative Rule Psy 4 relating to continuing education | |
| 7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both | 8) Is an appearance before the Board being scheduled? If yes, who is appearing? <input type="checkbox"/> Yes by _____ (name) <input type="checkbox"/> No | 9) Name of Case Advisor(s), if required: | |
| 10) Describe the issue and action that should be addressed: Discuss revisions to Administrative Rule Psy 4 | | | |
| 11) Authorization | | | |
| <i>Sharon Henes</i> | | 22 January 2013 | |
| Signature of person making this request | | Date | |
| Supervisor (if required) | | Date | |
| Bureau Director signature (indicates approval to add post agenda deadline item to agenda) | | Date | |
| Directions for including supporting documents: <ol style="list-style-type: none"> 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Board Services Bureau Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting. | | | |

Chapter Psy 4

REQUIREMENTS FOR RENEWAL

Psy 4.01 Biennial renewal.
Psy 4.02 Continuing education.

Psy 4.03 Renewal of a lapsed license.

Psy 4.01 Biennial renewal. On or before September 30 of the odd-numbered year following issuance of the license, the licensee shall apply for renewal to the department and submit the fee specified in s. 440.08 (2) (a), Stats., and shall meet the continuing education requirements specified in s. Psy 4.02.

History: Cr. Register, September, 1991, No. 429, eff. 10-1-91; am. Register, June, 1999, No. 522, eff. 7-1-99.

Psy 4.02 Continuing education. (1) REQUIREMENTS FOR CONTINUING EDUCATION. (a) Unless granted a postponement or waiver under par. (g), every licensee shall complete at least 40 hours of board-approved continuing education in each biennial registration period, as specified in s. 455.06, Stats. The board may require that not more than 20 continuing education hours in each biennial registration period be acquired within specified topic areas.

(b) Continuing education hours may apply only to the registration period in which the hours are acquired. If a license has been allowed to lapse, the board may grant permission to apply continuing education hours acquired after lapse of the license to a previous biennial period of licensure during which required continuing education was not acquired. In no case may continuing education hours be applied to more than one biennial period.

(c) To meet the continuing education requirement, a licensee shall submit to the board a certificate of attendance upon the board's request.

(d) Unless granted a postponement or waiver under par. (g), a licensee who fails to meet the continuing education requirements by the renewal deadline shall cease and desist from practice.

(e) During the time between initial licensure and commencement of a full 2-year licensure period new licensees shall not be required to meet continuing education requirements.

(f) Applicants from other states applying under s. 455.04 (1) (e) or (4) (f), Stats., shall submit proof of completion of at least 40 hours of continuing education approved by the board within 2 years prior to application.

(g) A licensee may apply to the board for a postponement or waiver of the requirements of this section on grounds of prolonged illness or disability, or on other grounds constituting extreme hardship. The board shall consider each application individually on its merits, and the board may grant a postponement, partial waiver or total waiver as deemed appropriate.

(h) The board may grant an exemption from the requirements of this section to a licensee who certifies to the board that he or she has permanently retired from the active practice of psychology.

(i) A licensee who has been granted an exemption from the requirements of this section based on retirement from the active practice of psychology may not return to the active practice of psychology without submitting evidence satisfactory to the board of having completed at least 40 credits of continuing education for each of the biennia during which the licensee was granted an exemption.

(2) APPROVAL OF CONTINUING EDUCATION PROGRAMS. The board shall approve all of the following programs and courses if relevant to the professional practice of psychology:

(a) Continuing education programs and courses sponsored or co-sponsored by a presenter approved by the committee for the approval of continuing education sponsors of the American psychological association.

(b) Educational programs recognized as approved at the time of attendance as "category I" continuing medical education programs by the council on medical education of the American medical association or the American osteopathic association.

(c) Graduate level courses or continuing education courses relevant to the professional practice of psychology offered by accredited colleges and universities.

(d) Continuing education courses approved by the psychology licensing board in another state where the participant is also licensed.

(e) Publishing a scholarly book or article in a peer-review journal relevant to psychology.

(3) CREDIT FOR TEACHING AND PRESENTING. Continuing education credit shall be granted for teaching and presenting any of the programs or courses in sub. (2) (a), (b), (c) or (d), but no credit will be granted for subsequent presentations of the same material.

(4) PROOF OF ATTENDANCE AT CONTINUING EDUCATION PROGRAMS. Applicants for renewal shall certify their attendance at required continuing education, but are not required to submit certificates of attendance unless the board requests the applicant to do so. The board shall conduct a random audit of 10 percent of all licensees on a biennial basis for compliance with continuing education requirements, and shall audit any licensee who is under investigation by the board for alleged misconduct.

(5) APPROVAL OF UNCOMPENSATED EVALUATION ASSISTANCE SERVICES. (a) The board shall accept for continuing education credit voluntary, uncompensated services provided by psychologists in assisting the department of health services in the evaluation of community outpatient mental health programs, as defined in s. 51.01 (3n), Stats., and approved by the department of health services according to rules promulgated under s. 51.42 (7) (b), Stats. Four hours of assistance, including hours expended in necessary training by the department of health services, shall be deemed to equal one hour of acceptable continuing education for the purposes of this section.

(b) Psychologists wishing to apply for continuing education credit under this subsection shall register in advance with the board, and shall notify the board on forms provided by the board of the dates and the total number of hours in any biennium for which the applicant will be available to provide assistance. The board shall make referrals to the department of health services in the order received pursuant to requests for assistance received by the board from that department.

Note: Forms are available upon request to the board office located at 1400 East Washington Avenue, P.O. Box 8935, Madison, WI 53708.

(6) LIMITATION ON CREDIT. The board may grant no more than 20 hours of credit for uncompensated evaluation assistance services, no more than 20 hours of credit for publishing a scholarly book or article, and no more than 20 hours of credit within any specific continuing education programs.

History: Cr. Register, September, 1991, No. 429, eff. 10-1-91; cr. (5), (6), Register, October, 1995, No. 478, eff. 11-1-95; am. (1) (a), (b) and (d), (2) (a) and (3), cr. (1) (g) to (i), (2) (f) and (4), Register, February, 1996, No. 482, eff. 3-1-96; r. (4) (c),

am. (6), Register, December, 1997, No. 504, eff. 1-1-98; corrections in (5) made under s. 13.93 (2m) (b) 6., Stats., Register, December, 1997, No. 504; r. and recr. (2) and (4), r. (3), Register, June, 1999, No. 522, eff. 7-1-99; r. (4) (b), Register, June, 2001, No. 546, eff. 7-1-01; CR 02-124: am. (1) (c), (2) (intro.) and (c), (4) and (6), cr. (2) (e) and (3) Register July 2003 No. 571, eff. 8-1-03; **CR 04-021: am. (2) (intro.) and (c) Register July 2004 No. 583, eff. 8-1-04; corrections in (5) made under s. 13.92 (4) (b) 6., Stats.**

Psy 4.03 Renewal of a lapsed license. Failure to renew a license by September 30 of odd-numbered years shall cause the license to lapse. A licensee who allows the license to lapse may apply to the board for renewal of the license as follows:

(1) If the licensee applies for renewal of the license less than 5 years after its expiration, the license shall be renewed upon payment of the renewal fee and fulfillment of the continuing education requirements.

(2) If the licensee applies for renewal of the license more than 5 years after its expiration, the board shall make an inquiry as it finds necessary to determine whether the applicant is competent to practice as a psychologist or private practice school psycholo-

gist in this state, and shall impose any reasonable conditions on renewal of the license that the board considers appropriate. An applicant under this subsection is presumed to be competent to practice as a psychologist or private practice school psychologist in this state if at the time of application the applicant is licensed by a similar examining board of another state or territory of the United States or of a foreign country or province whose standards, in the opinion of the board, are equivalent to or higher than the requirements for licensure as a psychologist under s. 455.04 (1), Stats., or as a private practice school psychologist under s. 455.04 (4), Stats. The examining board shall require each applicant under this subsection to have completed at least 40 hours of continuing education in the biennium preceding the application for renewal and to pass the appropriate examination specified under s. 455.045 (1) (b) or (2) (b), Stats.

History: Cr. Register, September, 1991, No. 429, eff. 10-1-91; am. Register, November, 1992, No. 443, eff. 12-1-92; am. (intro.) and (2), Register, June, 1999, No. 522, eff. 7-1-99; CR 02-124: am. (2) Register July 2003 No. 571, eff. 8-1-03.

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