EVERETT GASKINS HANCOCK LLP
Attorneys and Counselors at Law

August 15, 2018

North Carolina Psychology Board
895 State Farm Road, Suite 101
Boone, NC 28607

Attn: Dr. Robert W. Hill, Chair

RE: Request for Rulemaking

Dear Dr. Hill:

We represent the Petitioners identified below. Two of them are licensed psychologists (LPs) and four are licensed psychological associates (LPAs). Affidavits of each of the Petitioners are included in the attached Appendix as Exhibits 1-6. Pursuant to N.C. Gen. Stat. § 150B-20 and 21 N.C.A.C. 54.2401 and .2402, the Petitioners through counsel hereby petition for rulemaking and show to the North Carolina Psychology Board ("the Board") the following in support thereof:

1. This is a petition to conduct rulemaking to amend Section 21 N.C.A.C. 54 .2008(h) to eliminate career-long supervision of master's-level psychologists ("LPAs") so that LPAs can hold an independent and unrestricted license after three (3) years.

2. A draft of the proposed rule as changed is attached hereto and as Exhibit 10 of the Attachment. In substance, supervision would be required for a minimum of three (3) calendar years consisting of a minimum of 4,500 hours of post-licensure supervision.

3. The reasons for the proposed rule change are that:

- There are no reliable empirical data indicating an increased risk of harm to patients by allowing independent LPA practice after three years of supervision;
- There are no reliable empirical data indicating improvement in patient outcomes from career-long supervision;
- Career-long supervision imposes an unjustifiable and inequitable economic burden on LPAs;
- Career-long supervision unfairly disqualifies LPAs from receiving payment for services from many insurers and governmental entities;
- Career-long supervision negatively impacts LPA employability in contrast to other licensed master's-level providers of mental health services;

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- Career-long supervision decreases the availability of LPAs to serve the public (particularly in non-urban areas); and

- The current supervision requirement has contributed to the decline of the psychology discipline in North Carolina relative to other licensed mental health care disciplines.

4. The effect on existing rules would be to reduce supervision from career-long to three (3) calendar years.

5. Data supporting the proposed rule change are contained in the Appendix ("App.") attached hereto and made a part hereof.

6. The effect on existing practices would be to make psychological services more readily available to the public (particularly in non-urban areas), less expensive, more readily covered by insurance and governmental programs; and would reduce operational costs to LPAs; all without sacrificing patient outcomes.

7. Those most likely to be affected by the proposed rule change are:

- LPAs with three (3) or more calendar years of practice who will be relieved of the unjustifiable, inequitable and costly supervision requirement;

- The people of North Carolina who will benefit from increased access to care and improved affordability;

- Those considering a career of service as an LPA; and

- The supervisors who benefit financially from the current supervision requirement.

Specific names and addresses are not known by the Petitioners, except as set forth below.

8. The names and addresses of the Petitioners are:

Les Brinson, PhD, LP
4617 Limerick Drive
Raleigh, NC 28704

Vinston J. Goldman, PhD, LP
723 Jerome Road
Durham, NC 27713

Flora Dunbar, MA, LPA
1814-205 Nantuckett Lane
Charlotte, NC 28270

Janet Heuring, MA, LPA
6700 Rollingwood Drive
Raleigh, NC 27613

Tara Luellen, MA, LPA
823 Shackleton Road
Apex, NC 27502

Carol Williams, MA, LPA
2026 Quail Circle
Creedmoor, NC 27522

Respectfully submitted,

EVERETT GASKINS HANCOCK LLP

E.D. Gaskins, Jr.

Katherine A. King

Attachments

CC: Dr. Les Brinson (w/ attachments)
Dr. Vinston J. Goldman (w/ attachments)
Ms. Flora Dunbar (w/ attachments)
Ms. Janet Heuring (w/ attachments)
Ms. Tara Luellen (w/ attachments)
Ms. Carol Williams (w/ attachments)
Executive Director Daniel Collins (w/ attachments)

Proposed Amended Rule 21 NCAC 54.2008(h)

(h) Supervision shall be provided in individual, face-to-face, sessions which shall last no longer than 2 hours or less than 30 minutes by an individual who shall be recognized as an appropriate supervisor as defined in Rule .2001 of this Section. A Psychological Associate shall receive a minimum of one hour per month of individual supervision in any month during which he or she engages in activities requiring supervision. The rates of supervision specified in this Paragraph shall be provided for each separate work setting in which the Psychological Associate engages in the activities requiring supervision. The term "post-licensure" in this Paragraph shall refer to the period following issuance of a Psychological Associate license by the North Carolina Psychology Board. The term "supervised practice" in this Paragraph shall refer to activities requiring supervision as specified in G.S. 90-270.5(e) and 21 NCAC 54 .2006. Except as provided in Paragraph (g) of this Rule, minimum supervision requirements shall be as follows:

For a Psychological Associate with less than 3 calendar years consisting of at least 4500 hours of post-licensure supervised practice, minimum supervision shall be provided as follows:

No. of hours per month engaging in activities that require supervision	No. of hours of required individual supervision per month
1-10	1
11-20	2
21-30	3
31 plus	4

After a minimum of 3 calendar years consisting of at least 4500 hours of post-licensure supervised practice, no further supervision is required provided that a Psychological Associate shall:

(A) Make application on an application form provided by the Board;

(B) Document that all performance ratings for the preceding 3 years and 4500 hours of post-licensure supervised practice have been average or above average;

(C) Have received at least one calendar year of supervision from the most recent supervisor; and

(D) Have the recommendation of the most recent supervisor that no further supervision be required.

Appendix to the Petition for a Rule Change to
End Career Long Supervision of LPA's
in North Carolina
August 15, 2018

Index

I. Introduction

N.C. Gen. Stat. § 90-270.5(e) (Exhibit 7, App. p. 19) sets forth the requirement that licensed psychological associates ("LPAs") must be supervised by qualified licensed psychologists ("LPs") or other professionals "in accordance with Board rules specifying the format, setting, content, time frame, amounts of supervision, qualification of supervisors ..." (Emphasis supplied).

The Board rules implementing the statute are 21 NCAC 54 .2006 and .2008 (Exhibit 8, App, pp. 21-22). Rule .2008(h) sets forth the "time frame" element of the requirement. It provides time frames for three levels of supervision, with the times frame for level 3 supervision continuing for the duration of the LPAs career.

There has long been ongoing discussion and debate concerning the clinical skills of master's-level compared to doctoral-level psychologists and thus the need for career-long supervision. (See e.g., Terminal Master's-Level Training in Counseling Psychology: Skills Competencies, and Student Interests, Professional Psychology: Research and Practice, American Psychological Association, 1990) (Exhibit 9, App. p. 24). That debate has contributed to nine states (Alaska, Arkansas, Kansas, Kentucky, Oklahoma, Oregon, Tennessee, Vermont, and West Virginia) eliminating career-long supervision of master's-level psychologists. (Affidavit of Williams, Ex. 6, App. p. 18).

Other master's-level mental health care licensees are already permitted to practice independently in North Carolina, as reflected in Section II. The affidavits of the six Petitioners (App. Ex. 1-6, pp. 1-18) speak directly to the negative impact of the current career-long supervision rule on LPAs, the practice of psychology in North Carolina, and the public.

Your Petitioners now request a change to Rule .2008(h) to eliminate supervision of LPAs after three years and thus permit independent and unrestricted practice. The proposed amended Rule .2008(h) is included as Exhibit 10 of the Appendix, p. 27.

II. Information Concerning Licensed Mental Health Care Professionals in N.C.

There are at least five allied licensed mental health care professional disciplines in North Carolina which provide assessment of personality functioning leading to hypotheses, inferences and conclusions regarding personality functioning and/or counseling or other interventions with a clinical population for the purpose of preventing or eliminating symptomatic, maladaptive or undesired behavior. Psychology has both doctoral-level and master's-level practitioners. Professional counselors, clinical addiction specialists, clinical social workers and marriage and family therapists require only a master's degree. Only one – master's-level psychologist – currently requires career-long supervision. Psychology and the other four disciplines are depicted in the table and graph on the following pages which reflect the number of licensees in effect per year for each discipline for 2013 through 2017/2018, inclusive, and the growth or decline of licensees in each discipline in percentage and numbers. The table and chart indicate a 4% decline in LPAs, an 8% increase in LPs while the other four disciplines have grown from 24% to 165%.[1] (See Table and Chart attached, pp. 2A and 2B).

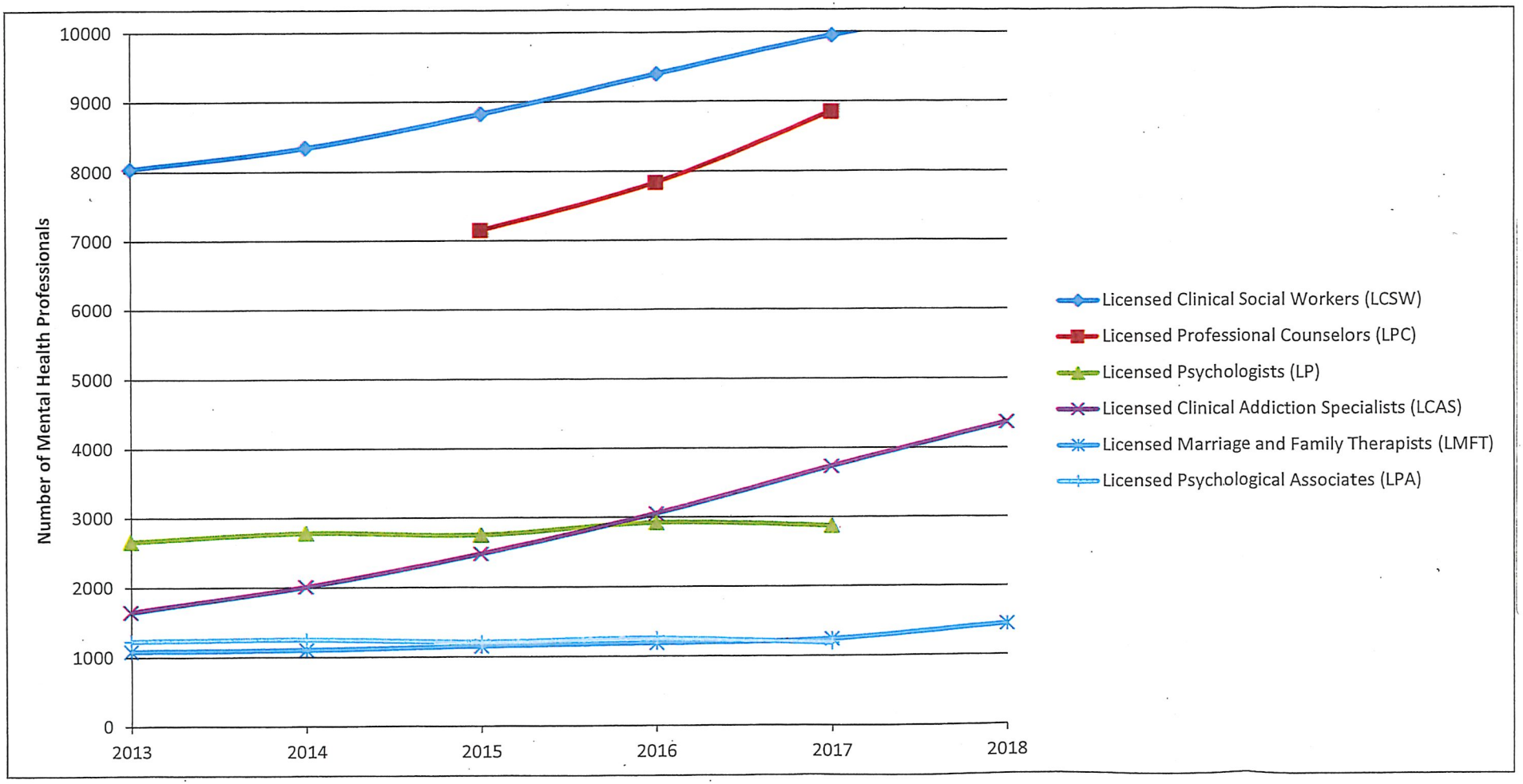
[1] The data reflected in the table and chart for psychologists was published in the Annual Reports of the Psychology Board posted on the N.C. Psychology Board website and includes all LP and LPA licensees. The data in Section VI reflects only actively practicing psychologists and psychological associates as reported by the UNC Cecil G. Sheps Center for Health Service Research & Data.

North Carolina Allied Licensed Healthcare Professionals

Number of Licensees in NC

	LICENSED PSYCHOLOGISTS (LP)	LICENSED PSYCHOLOGICAL ASSOCIATES (LPA)	LICENSED PROFESSIONAL COUNSELORS (LPC)	LICENSED CLINICAL ADDICTION SPECIALISTS (LCAS)	LICENSED CLINICAL SOCIAL WORKERS (LCSW/LCSWA)	LICENSED MARRIAGE & FAMILY THERAPISTS (LMFT)
2013	2,662	1,234	Not available	1648	8046	1088
2014	2,783	1,254	Not available	2012	8351	1106
2015	2,756	1,215	7153	2483	8831	1158
2016	2,926	1,261	7837	3058	9398	1194
2017	2,876	1,186	8858	3735	9952	1244
2018	Not available	Not available	Not available	4374	10343	1451
Growth Since 2013	214	-48	1705	2726	2297	363
% Growth Since 2013	8%	-4%	24%	165%	29%	33%
	Data obtained from North Carolina Psychology Board Annual Reports posted online	Data obtained from North Carolina Psychology Board Annual Reports posted online	Data obtained from Board Administrator of the North Carolina Board of Professional Counselors	Data obtained from Executive Director of North Carolina Substance Abuse Professional Practice Board	Data obtained from Executive Director of NC Social Work Certification and Licensure Board	Data obtained from Executive Director of North Carolina MFT Licensure Board

2A


Number of Mental Health Professionals
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
2013
2014
2015
2016
2017
2018
Licensed Clinical Social Workers (LCSW)
Licensed Professional Counselors (LPC)
Licensed Psychologists (LP)
Licensed Clinical Addiction Specialists (LCAS)
Licensed Marriage and Family Therapists (LMFT)
Licensed Psychological Associates (LPA)

2B

III. There Is No Increased Risk to the Public from Independent Practice by LPAs After Three Years of Supervision.

In 2012 the Board of Directors of the North Carolina Psychological Association ("NCPA") and the Executive Committee of the North Carolina Association of Professional Psychologists ("NCAPP") formed a joint workgroup ("the Workgroup") to address concerns arising in the practice of psychology in North Carolina. Among the four major issues addressed was the requirement of career-long supervision of LPAs.

After reviewing the data provided by the Workgroup, the chairperson of the Board on February 26, 2013, wrote a letter to the Workgroup (Exhibit 11, App. p. 29) which addressed the supervision issue in pertinent part as follows:

> First, whether LPAs may practice independently after three years of supervision of all practice. The Workgroup provided the Board with data which indicated that there is no increased risk of harm to the public when independent practice is obtained by master's-level practitioners after three years of supervised practice. As a result, the Board supports the proposal.

The information relied on by the Workgroup is consistent with that contained in an article appearing in the Counseling and Psychotherapy Research journal, March 2007, entitled, The Impact of Clinical Supervision on Counsellors and Therapists, Their Practice and Their Clients. A Systematic Review of the Literature. (Exhibit 12, App. p. 31). ("... [N]o studies in this review offer substantial evidence to support improvement in client outcome as a [result of long-term supervision].") Id. at App. p. 40. See also The Competency of Masters Psychologists as Mental Health Professionals: A Literature Review, Journal of Psychological Practice, 2007 (Ex. 13, App. p. 43). ("In summary, masters psychologists appear to have established professional competency in service delivery and are widely held in high regard by mental health employers.") Id. at App. p. 53.

In summary, although supervision appeared to some "to offer opportunities for supervisees to improve practices and gain in confidence, ... the link to improved outcome for

clients is tentative and no studies in this review offer substantial evidence to support improvement in client outcomes." (Ex. 12 at App. p. 40).

As attested by former Board Member Les Brinson in his affidavit:

> 18. In fact, to date, there has been no evidence provided by doctoral-level psychologists, psychological advocacy of representative groups, or any other body, to show that LPA independence would result in increased incidents of patient harm or neglect or decreased quality of patient care.
>
> 19. The research on such matters, with which I am familiar, is unequivocal in rebutting these notions. Master's-level psychologists have demonstrated a track record of practicing safely and ethically as independent practitioners in a number of states and other countries, including Canada.
>
> 20. My own observations in training, evaluating, monitoring, supervising, and receiving accolades from employers in mental health who provide internships and subsequent employment for our master's-level psychologists' result in my support of the efforts for LPAs to gain independence as professional psychological service providers in North Carolina.

(Brinson Affidavit, Ex. 1, App. p. 3).

There is no empirical data known to the Petitioners supporting the perspective that continued supervision after three years of practice improves client outcome in the practice of clinical psychology or is otherwise necessary to protect the health or safety of the public.

IV. Other Master's-Level Mental Health Professionals Do Not Require Career-Long Supervision.

All five licensing boards discussed below were created by the North Carolina General Assembly for the same purpose as stated in their respective statutory mandates: to protect the public.

The North Carolina Marriage and Family Therapy Board ("M&F Board") was established in 1979. Marriage and family counseling is defined in pertinent part as "the diagnosis and treatment of psychological aspects of mental and emotional disorders." N.C. Gen. Stat. § 90-270.47(3b).

The M&F Board is authorized to grant to qualified applicants who hold a master's degree licenses as "licensed marriage and family therapists associates." N.C. Gen. Stat. § 90-270.54A. After three years of supervision pursuant to M&F Board rules, associates can obtain independent licensure as "licensed marriage and family therapists" with no further supervision. Id.

The North Carolina Board of Licensed Professional Counselors ("Counseling Board') was established in 1983. Counseling is defined in pertinent part as "evaluating and treating mental disorders and other conditions through the use of a combination of clinical mental health and human development principles, methods, diagnostic procedures, treatment plans and other psychotherapeutic techniques ..." N.C. Gen. Stat. § 90-330(3)a.

The Counseling Board is authorized to issue licenses as "licensed professional counselor associates" to qualified applicants who hold a master's degree. N.C. G.S. § 90-336(c). After 3,000 hours of supervised practice, associates can obtain independent licensure as "licensed professional counselors." Id. Counseling Board rules establish that the required supervision is not permitted at a rate greater than 40 hours per week. 21 N.C.A.C. 53 .0205. That can result in two years or less of supervision.

The North Carolina Social Work Certification and Licensure Board ("Social Work Board") was also established in 1983. Social work is defined in pertinent part as, "the professional application of social work theory and methods to the biopsychological diagnosis, treatment or prevention of emotional and mental disorders." N.C. Gen. Stat. § 90B-3(6).

The Social Work Board is authorized to issue licenses as "licensed clinical social worker associate" to qualified applicants who hold a master's degree. N.C. Gen. Stat. § 90B-7. After two years of specified supervision pursuant to Social Work Board rules, associates can obtain independent licensure as "licensed clinical social workers." Id.

The North Carolina Substance Abuse Professional Practice Board ("Substance Abuse Board') was established in 1993. Substance abuse practice is defined in pertinent part as, "The assessment, evaluation, and provision of counseling and therapeutic service to persons suffering from substance abuse or addiction." N.C. Gen. Stat. § 90-113.31A(24).

The Substance Abuse Board is authorized to issue licenses as "licensed clinical addiction specialist associates" to qualified applicants who hold a master's degree. N.C. Gen. Stat. § 90-113.40(c). After two years of supervision pursuant to Substance Abuse Board rules, associates can obtain independent licensure as "licensed clinical addiction specialists." Id.

The North Carolina Psychology Board ("Psychology Board") was established in 1967. Psychology is thus the oldest of the five allied health care disciplines licensed at the master's-level in North Carolina. The practice of psychology is defined in pertinent part as, "The observation, description, evaluation, interpretation, or modification of human behavior by the application of psychological principles, methods and procedures for the purpose of preventing or eliminating symptomatic, maladaptive, or undesired behavior or of enhancing interpersonal relationships, work and life adjustment, personal effectiveness, behavioral health, or mental health." N.C. Gen. Stat. § 90-270.2(8).

The Psychology Board is authorized to issue licenses as "licensed psychological associate" to qualified candidates who hold a master's degree. N.C. Gen. Stat. § 90-270.2(7). The Psychology Board is also authorized to issue licenses as "licensed psychologist" to qualified candidates who hold a doctoral degree. N.C. Gen. Stat. § 90-270.2(6). Both licensed psychologists and licensed psychological associates are authorized to engage in the practice of psychology and to represent themselves to the public as "psychologists." N.C. Gen. Stat. § 90-270.2(9). Licensed psychological associates cannot become a "licensed psychologist" without obtaining a doctoral degree. N.C. Gen. Stat. § 90-270.11(a). However, there is no requirement that a licensed psychological associate obtain a doctoral degree to remain in practice, but rather can obtain a "permanent" license as a psychological associate. N.C. Gen. Stat. § 90-270.11(b).

The Psychology Board is authorized to establish the nature, extent and duration of supervision required by a licensed psychological associate for "assessment of personality functioning; neuropsychological evaluation; psychotherapy, counseling and other interventions with clinical populations for the purpose of preventing or eliminating symptomatic, maladaptive, or undesired behavior; and, the use of intrusive, punitive or experimental procedures, techniques, or measures." N.C. Gen. Stat. § 90-270.5(e). (Ex. 7, App. p. 19).

Unlike any of the other boards described above, the rules of the Psychology Board provide for three levels of supervision, and the "time frame" for the final level of supervision is for the duration of licensure of a psychological associate. Thus under current Board rules a master's-level psychologist can never obtain an independent and unrestricted license to practice psychology in North Carolina. This circumstance is particularly concerning in view of survey results, cited by Vinston J. Goldman in his affidavit, that North Carolina employers found master's-level psychologists were "among the better trained master's-level clinicians." (Goldman Affidavit, Ex. 2, App. p. 6).

V. Career-long Supervision Unfairly Disqualifies LPAs from Insurance and Governmental Payment for Services and Other Benefits Enjoyed by Independent Practitioners.

Mental health care services are frequently covered by private insurance as well as government insurance such as Medicare and Medicaid. Thus a significant factor for those seeking mental health care is the availability of coverage for the treatment they receive. Further, the services provided by the five allied mental health care disciplines frequently overlap, as evidenced by the statutory definitions as set forth in Section IV.

Although Medicaid provides reimbursement for LPA professional services, Medicare does not because LPAs cannot achieve "independent" licensure as required by Medicare regulations. (Heuring Affidavit, Ex. 4, App. p. 12).

Similarly, although Blue Cross-Blue Shield provides coverage in North Carolina, most other private insurers do not, including United Behavioral Health, Tricare, Aetna, Humana, etc. Id. (See Eligibility Chart, p. 8A).

Further, Blue Cross Blue Shield provides only limited coverage because LPAs do not hold "independent" licenses. Specifically, telehealth reimbursement is not available for LPA telehealth psychological services, but is available to other mental health practitioners who hold "independent" licenses making those professionals more convenient and accessible than LPAs. Id. This distinction is enforced by Blue Cross Blue Shield even though this Board has confirmed that LPAs may provide psychological services via telehealth, as is sometimes preferable as a result of transportation issues, child care, etc. or when dealing with acute situations.

LPAs in North Carolina are also disqualified from providing services to veterans through the Department of Veteran Affairs, although other mental health providers may do so because they hold "independent" licenses. (Heuring Affidavit, Ex. 4, App. p. 13).

Similarly, the American Red Cross does not permit LPAs in North Carolina to qualify as a Disaster Mental Health Volunteer. (Brinson Affidavit, Ex. 1, App. p. 2). However, other

Major Panel/Agency - Eligibility for Provider Participation

Panel/Agency	Open to LPAs?	Open to other MA providers without Career-Long Supervision?	Which Ones?
Medicaid	Yes	Yes	LCSW, LCAS, LMFT, LPC, LPA
BCBS State Health Plan	Yes	Yes	LCSW, LCAS, LMFT, LPC, LPA
Tricare	No	Yes	LCSW, LMFT, LPC
Medicare	No	Yes	LCSW, LMFT, LPC
Optum	No	Yes	LCSW, LMFT, LPC
Cigna	No	Yes	LCSW, LMFT, LPC, LCAS
United Behavioral Health (UBH)	No	Yes	LCSW, LMFT, LPC
Humana	No	Yes	LCSW, LMFT, LPC
Aetna	No	Yes	LCSW, LMFT, LPC
Coventry	No	Yes	LCSW, LMFT, LPC
Magellan Behavioral Health	No	Yes	LCSW, LMFT, LPC
Volunteering for the American Red Cross as MH provider	No	Yes	LCSW, LMFT, LPC
US Department of Veterans Affairs	No	Yes	LCSW, LMFT, LPC
Health Resources and Services Administration Student Loan Repayment Assistance Program (serving high-needs populations)	No	Yes	LCSW, LMFT, LPC

Data collected by Athena Psychological Services staff from November of 2016 to July 2018

master's-level mental health professionals may do so because they hold an "independent" license.

In addition LPAs are not eligible for the National Health Service Corps Loan Repayment Program for the same reason. That program provides loan repayment assistance to mental health providers who provide services to underserved populations in selected areas, but only if they hold an "independent" license. (Heuring Affidavit, Ex. 4, App. p. 13).

Though LPA clinical services are approximately 25% less costly than those of LPs, as reflected in both Blue Cross and Medicaid schedules, clients seeking the services of psychologists are not likely to choose LPAs to provide those services because many insurers will not reimburse for LPA services. Id. Similarly, in choosing among the several licensed mental health care providers in North Carolina who hold master's degrees, clients are more likely to choose those providers whose services are more widely covered by insurance and providers who can render reimbursable telehealth services.

Further, clients receiving therapeutic services from LPAs through employment-related Blue Cross Blue Shield insurance are constantly at risk of having their treatment coverage lost should their employer decide to change insurance carriers to one which does not pay for LPA services. If the client changes therapists, such change disrupts the therapeutic relationship between therapist and client which can negatively impact the change/healing process. This is detrimental to both the client (therapeutically) and the therapist (financially).

All of these competitive disadvantages for LPAs can be eliminated by deleting the requirement for career-long supervision and thus allowing LPAs to become "independent" practitioners.

VI. Eliminating Career-Long Supervision Would Help Meet the Need for Mental Health Care Professionals in N.C., Particularly in Rural and Underserved Areas.

In October 2014 the President of the North Carolina Psychological Association wrote an op-ed column for the Raleigh News & Observer. (Ex. 14, App. p. 57). In it she noted that there are not enough health care professionals in North Carolina to meet the needs of our state.

This observation remains true. The United States Census Bureau reported that the population of North Carolina was 10,273,419 in 2017 with 3,591,151 residing in the six most populous urban counties and 6,682,268 people residing in the remaining 94 suburban and rural counties. (See General Population Statistics, p. 10A). The number of psychologists per capita in the State of North Carolina in 2017 was 1 psychologist per 2,912 individuals. The disparity in per capita availability of psychological services is stark. The six most populous counties had 1 psychologist per 1,976 individuals, while the remaining suburban and rural counties had 1 psychologist per 3,908 individuals. (See Psychologists in North Carolina, p. 10B)

If the suburban counties are taken out of the equation, the picture looks even bleaker for rural counties. In 2017, eleven rural counties in North Carolina did not have a single provider of psychological services. In 2017, twelve rural counties in North Carolina had only one provider of psychological services. Twenty counties had only LPA psychologists. (See Psychologists in 48 Rural NC Counties, p. 10C). In the forty-eight rural counties, 71% (72 out of 101) of the practicing psychologists are LPAs. (See Psychologists in 48 Rural NC Counties: LPAs and LPs in 2017, p. 10D).

These data reflect that rural counties are underserved by psychologists and that LPAs are substantially more prevalent in the forty-eight rural counties examined than are LPs. Looking at the number of licensed psychologists as reflected in the chart on page 2A, only about 1% of LPs (29 out of 2,258) practice in the forty-eight rural counties while over 8% (72 out of 852) of LPAs practice there. That means LPAs are eight times more likely to practice in underserved rural counties than LPs. Thus the limitations on LPAs as described in Section V

General Population Statistics

Population of North Carolina as of July 1, 2017:	**10,273,419***
Population of Urban Counties as of July 1, 2017:	**3,591,151**
Durham County	311,640
Forsyth County	376,320
Guilford County	526,953
Mecklenburg County	1,076,837
New Hanover County	227,198
Wake County	1,072,203
Population of Rural / Suburban Counties as of July 1, 2017:	**6,682,268**

*All data received from the U.S. Census Bureau located at https://www.census.gov/quickfacts/.

Psychologists in North Carolina*

Psychologists Licensed in North Carolina as of July 1, 2017:	**3,527****
Psychologists Licensed in Urban Counties as of July 1, 2017:	**1,817**
Psychologists Licensed in Rural / Suburban Counties as of July 1, 2017:	**1,710**

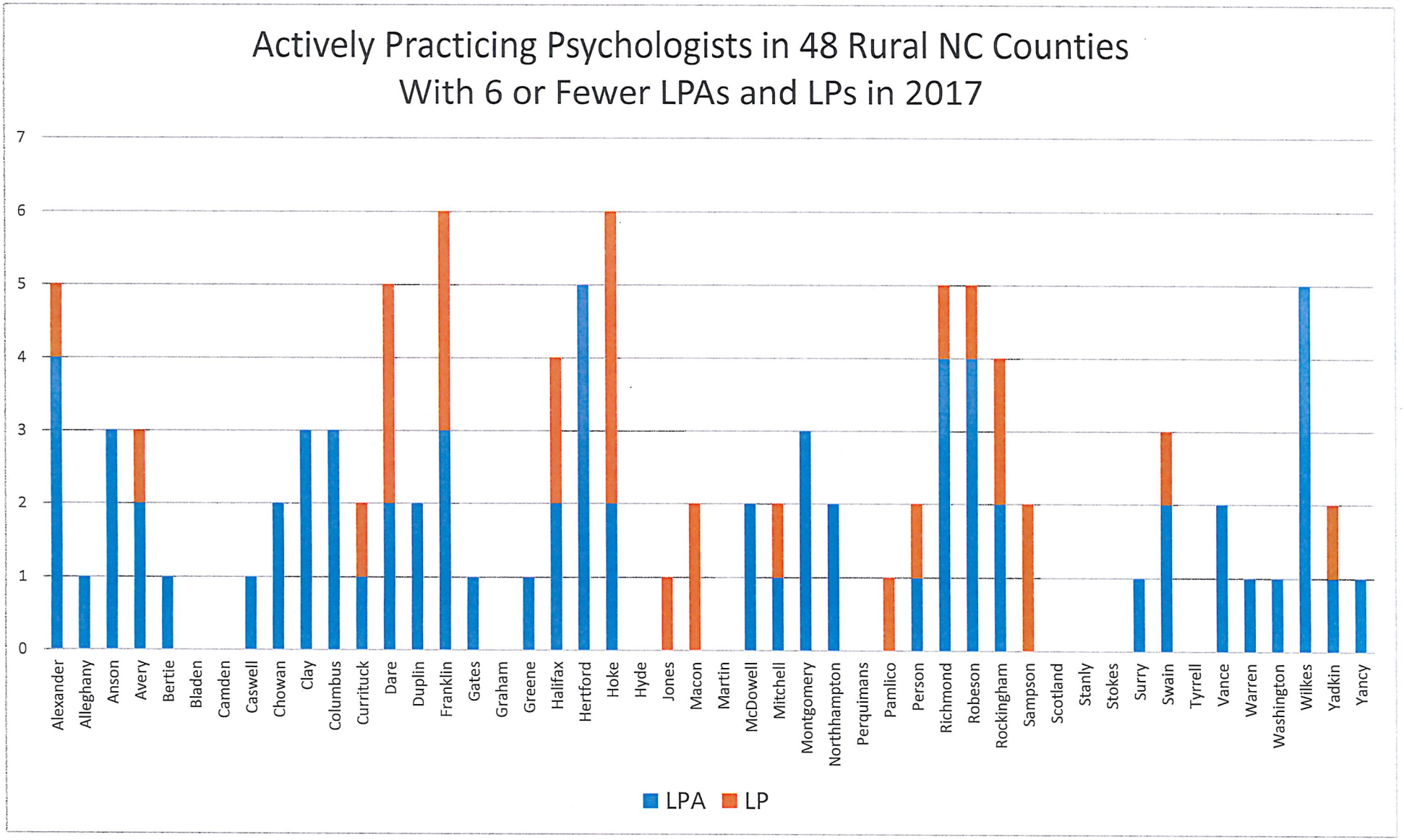
*The term "psychologists" includes licensed psychologists and licensed psychological associates.

**All data received from UNC Cecil G. Sheps Center for Health Services Research. This data includes only actively practicing licensees.

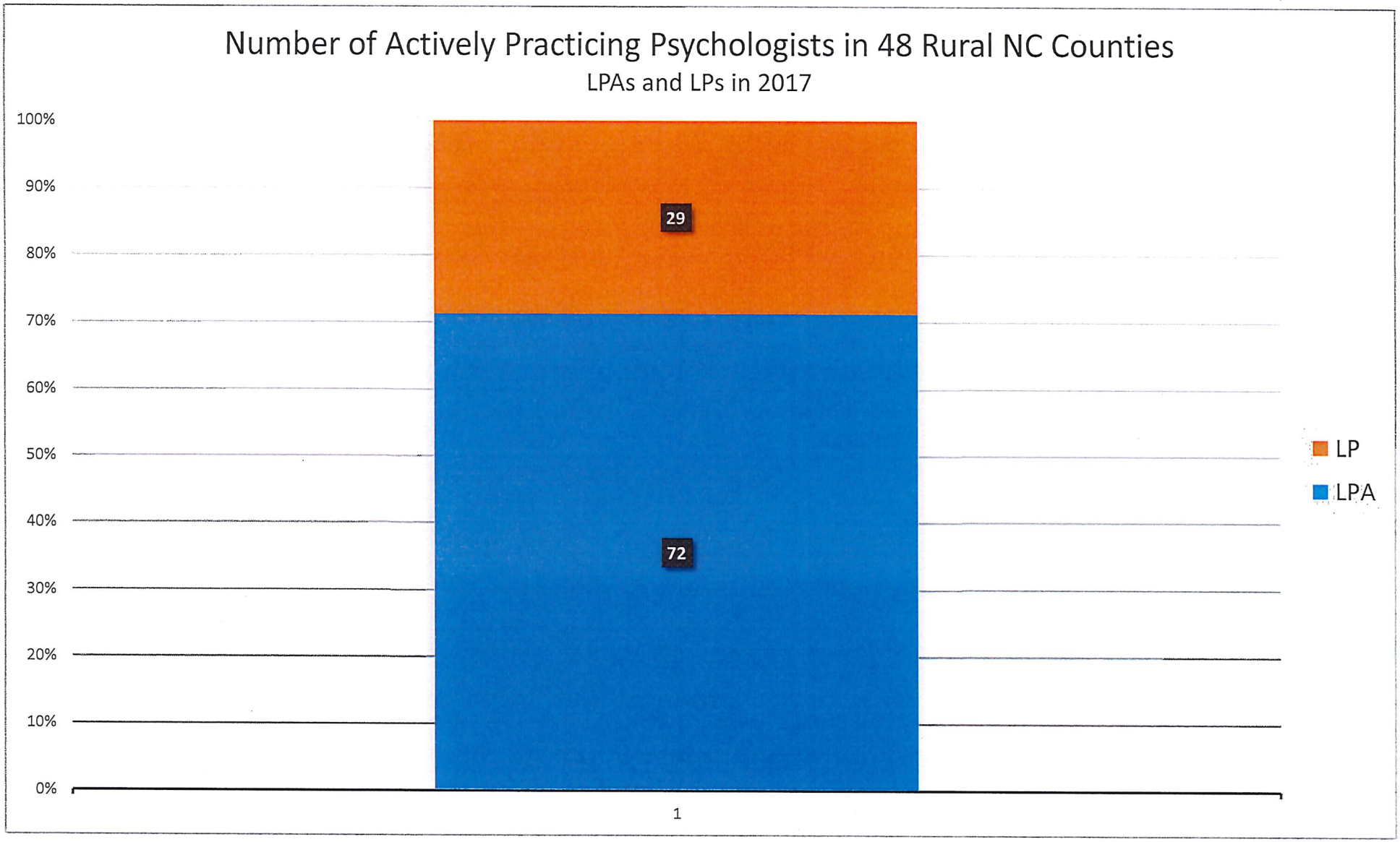
Psychologists Per Capita in North Carolina*

Psychologists Per Capita as of July 1, 2017:	**1: 2,912**
Psychologists Per Capita in Urban Counties as of July 1, 2017:	**1: 1,976**
Psychologists Per Capita in Rural / Suburban Counties as of July 1, 2017:	**1: 3,908**

*Per capita ratio calculated by dividing population by psychologists licensed in given geographical area.



Source: 2017 Psychologists Database from NC Health Professions Data System (HPDS) Available through the UNC Cecil G. Sheps Center for Health Services Research



Source: 2017 Psychologists Database from NC Health Professions Data System (HPDS) Available through the UNC Cecil G. Sheps Center for Health Services Research

disproportionately limit access to psychological services by the public in rural counties. Making an LPA license more attractive and competitive with other mental health licenses will likely increase the availability of LPAs in North Carolina, particularly in rural areas.

VII. Career-Long Supervision Has Contributed to a Decline in the Number of Psychology Licensees in N.C. Relative to Other Licensed Mental Health Professionals.

North Carolina has had licensed master's-level clinical addiction specialists, clinical social workers, licensed professional counselors, and marriage and family therapists as well as LPAs since 1993. Currently, all but master's-level psychologists are permitted to practice independently after no more than three years of supervised practice.

As explained previously in Section V, that results in limitations on LPAs concerning insurance payments and telehealth services, services to veterans, loan forgiveness, and volunteer opportunities. In additional LPAs bear the financial burden of LP supervision at the rate of $75-$150 per hour each month for the duration of their careers. (Heuring Affidavit, Ex. 4, App. p. 13).

To become a doctoral-level psychologist usually requires at least five years of study. None of the master's-level mental health licensees in North Carolina discussed herein require more than three years, and some of them require less than three years of education. All the disciplines but master's-level psychology result in an unrestricted license after no more than three years of supervision.

If one wants to pursue a career in clinical mental health services in North Carolina, why would one choose to pursue a doctorate degree in psychology usually requiring at least five years of study or a three year master's degree in psychology resulting in a restricted LPA license when one can obtain any of the other master's degrees and an "independent" license to provide mental health services in three years or less? The apparent answer is that fewer and fewer are doing so, as Section II illustrates. Between 2013 and 2017/2018 the number of LP psychologists has increased by 214 (8%); LPA psychologists have decreased by 48 (-4%); and the other four master's-level health mental care providers have increased as follows: licensed professional counselors by 1.705 (24%); licensed clinical addiction specialists by 2,726 (165%);

licensed clinical social workers 2,297 (29%); and licensed marriage and family counselors by 363 (33%). (See Chart and Graph, pp. 2A-2B).

These data reflect that psychology as a discipline is declining in North Carolina, relative to other mental health care disciplines. (Dunbar Affidavit, Ex. 3, App. p. 9). The Board has contributed to that decline by its rule requiring career-long supervision with all its competitive disadvantages compared to other master's-level mental health care disciplines despite the Board's conclusion in 2013 that no public need is met by that rule.

VIII. Conclusion

There are no empirical data which support the need for continued supervision of qualified master's-level psychologists after three years in order to protect the public. Continuing career-long supervision restricts the availability of LPAs to meet the need for psychological services (particularly in rural areas where they are most needed), represents a cost burden to the LPA, disqualifies the LPA from many insurance reimbursements and other benefits enjoyed by other master's-level mental health care professionals in North Carolina, and has contributed to the continued decline in North Carolina in practicing psychology licensees relative to other mental health care disciplines.

The Psychology Board can and should address these issues by making the rule change as requested so as to provide LPAs in North Carolina with independent and unrestricted licenses.

Appendix to Request for Rulemaking

Index of Exhibits

EXHIBIT 1

STATE OF NORTH CAROLINA
COUNTY OF WAKE

AFFIDAVIT

Les Brinson, being first duly sworn, does affirm and state as follows:

1. I am a legally competent person and have knowledge of the facts recited herein, except for those matters stated upon information and belief, as to which I maintain a good faith belief as to their truth.

2. I am a Licensed Psychologist and served two terms on the NC Psychology Board. For the second term, I was elected Vice Chair.

3. For approximately forty years, I have maintained a small practice that occasionally included the supervision of LPAs, some of whom graduated from our program at North Carolina Central University.

4. I am formerly a professor and Chair of the North Carolina Central University Department of Psychology. I have been privileged to train and to determine standards for training of master's-level psychologists for nearly forty years. Additionally, I had the responsibility of monitoring clinical placements of many of our master's-level students.

5. In these orbits, I have seen many master's-level psychologists whose professional skills far exceed that of doctoral-level practicing psychologists. This may be explained by the fact that the doctorial psychologists often are required to or merely gravitate toward non-clinical services like research, administration, specific bulleted consultation, etc. where the financial rewards are greater. Meanwhile, the clinical skills of the LPA's are expanding and being sharpened by direct clinical service provisioning.

6. Thus based on my own observations over the years, after two or three years of direct supervision, there is no measured additional benefit to the supervisee, a fact that is repeatedly supported by the research with which I am familiar.

7. On the other hand, there are clearly benefits for supervisors in terms of remunerations. Not only do doctoral-level supervisors gain the status and financial rewards of providing career-long supervision to their master's-level colleagues, they are also ensured much wider access to provide psychological services to community members through both employment and insurance panel participation.

   a. In North Carolina, all insurance panels of which I am aware (with the exception of Blue Cross-Blue Shield and Medicaid) require "independent" licensure status in order to obtain a contract and reimbursement for services.

   b. As such, the endless supervision effectively blocks LPAs from practicing in their line of work on most insurance panels and in most clinical employment settings.

8. The required career-long supervision is so restrictive, it even prohibits an LPA from being eligible to volunteer with the American Red Cross as a clinician.

9. Other than the fact that "we do it because it's required" and "we have always done it," I have wondered for more than two decades why career-long supervision for LPAs is still required. There have been multiple legislative advocacy efforts to challenge and end it but none have prevailed. Given the independent successes of many of our allied master's level professionals (counseling, social work, marriage and family therapists, addiction specialists, etc.), the issue is ripe for reconsideration.

10. It is important that the entire North Carolina practicing psychology community pause and review or update themselves on their own history of independence from medical professionals, particularly psychiatry, and consider the case of Blue Shield of Virginia v. McCready, 457 U.S. 465 (1982).

a. The primary influence at that time was "M.D. authoritarianism," meaning "the doctor knows best and should not be questioned."

b. That served the medical professionals well through several court challenges; however, on June 16, 1980, the Court of Appeals was no longer accepting of such and ruled that psychologists should be independent under the guidelines of the Sherman Act regarding sanctity of free trade.

11. Doctoral-level psychologists during the 1970s and early 1980s often felt the process for seeking independence from psychiatrists was demeaning and costly by way of repeated court battles against the well-heeled psychiatry groups and insurance companies.

12. Numerous insurance companies had in effect allowed psychiatrists to control the marketplace by requiring them to order psychotherapy, supervise the psychotherapy, and even bill for the psychotherapy provided by psychologists.

13. As the arguments advanced by the opposition it was apparent that required oversight from psychiatrists was unfounded and wrapped in fear without any science to back their claims that somehow the public would be harmed unless psychiatrists act as the lead clinician involving all mental health care throughout the mental healthcare system, which also served to provide psychiatrists an economic advantage.

14. Unfortunately, history tends to repeat itself and thus, it seems that now doctoral-level psychologists and their lobbying efforts are relegating master's-level colleagues to the same position they once held.

15. Master's-level psychologists are in a very similar predicament as the doctoral-level psychologists were in the 1970s and early 1980s.

a. More specifically, LPAs are now struggling for their independence, which includes the right to serve the public consistent with their training as certified by licensure and consistent with APA's ethical standards without the oversight from an allied professional.

b. LPA's are also struggling to have fair access to the healthcare marketplace and to receive due compensation for the services rendered.

c. The stark difference is that doctoral-level psychologists in their struggle with the psychiatrists did not have available the research that addresses the matters of non-beneficial and endless clinical supervision, as the growing body of literature holds now.

16. It is not always clear why doctoral-level psychologists oppose their master's-level colleagues joining them in independent status as allied professionals. Variances in reimbursement rates (LPAs are less expensive) and supervision fees provide evidence for the obvious financial gain; however, courts have established that unnecessary supervision restrictions are in violation of the law.

17. What is known is that in the 1970s and 1980s, psychiatrists had little or no data to support their position and efforts to restrict the practice of doctoral-level psychologists. Despite this, psychiatrists stood firm in their position without any empirically supported evidence.

18. In fact, to date, there has been no evidence provided by doctoral-level psychologists, psychological advocacy of representative groups, or any other body, to show that LPA independence would result in increased incidents of patient harm or neglect or decreased quality of patient care.

19. The research on such matters, with which I am familiar, is unequivocal in rebutting these notions. Master's-level psychologists have demonstrated a track record of practicing safely and ethically as independent practitioners in a number of states and other countries, including Canada.

20. My own observations in training, evaluating, monitoring, supervising, and receiving accolades from employers in mental health who provide internships and subsequent employment for our master's-level psychologists' result in my support of the efforts for LPAs to gain independence as professional psychological service providers in North Carolina.

21. For the reasons stated above, I support the proposed rule change to amend 21 N.C.A.C. 54.2008(h) to provide that supervision for qualified Licensed Psychological Associates cease after three years with at least 4,500 hours of supervised practice, and, thus, an unrestricted licensure status shall then be granted.

Further Affiant sayeth naught.

8/8/2018
Date

Les Brinson, Ph.D

State of North Carolina
County of Wake

Sworn to and subscribed before me this 8 day of August, 2018.

Dionisia L Bowen
NOTARY PUBLIC

Dionisia L Bowen
(printed name of notary public)

My Commission Expires: 7/21/2020

DIONISIA L. BOWEN
NOTARY
PUBLIC
WAKE COUNTY, NC

EXHIBIT 2

STATE OF NORTH CAROLINA
COUNTY OF WAKE

AFFIDAVIT

Vinston J. Goldman, being first duly sworn, does affirm and state as follows:

1. I am a legally competent person and have knowledge of the facts recited herein, except for those matters stated upon information and belief, as to which I maintain a good faith belief as to their truth.

2. I am a licensed psychologist (LP). However, I have experience practicing at both the LP and LPA levels. I served nine years on the Board of Directors of the North Carolina Psychological Foundation (NCPF) and the Board of Directors of the North Carolina Psychological Association (NCPA). I also served nine years as co-chair of the NCPF Scientific, Academic and Student Affairs Committee (SASA), for which I received the 2014 NCPF President's Award for dedication and service.

3. My primary job now is that of Associate Professor and Coordinator of the master's-level Psychology Graduate Program at North Carolina Central University (NCCU). I have served on the faculty at NCCU for 30 years and have been Coordinator for the last 22 years. As an associate professor and Coordinator, I have had the honor to help train professionals who provide, as licensed psychological associates (LPAs), much needed direct care services to the citizenry of North Carolina.

4. Over the years, my involvement in matters related to master's-level training and licensure for psychologists has included teaching; program development; practicum/internship memoranda of agreement development; telephone conversations with the Psychology Board Staff Psychologists regarding clarification of rules; having Psychology Board Staff Psychologists make presentation to graduate classes regarding ethics, legal issues, practice, and avoidance of pitfalls; and appearing before the Psychology Board to provide input with regard to a rule change.

5. I strongly support continuing the practice of psychology at the master's-level in North Carolina. Historically, master's-level psychologists have been a bedrock for service delivery to the citizenry of North Carolina. This is particularly true of their role in state institutions and agencies.

6. The purpose of this Affidavit is to request that the Board make a rule change to 21 NCAC 54 .2008(h) that would allow LPAs to practice independently with an unrestricted license after three years and at least 4500 hours of supervised practice.

7. The Board addressed, in its February 26, 2013 letter by Kristine M. Herfkens, Ph.D, ABPP, Chairperson, to Erica Wise, Ph.D, Psychology Practice Act Workgroup, the issue of independent practice for master's-level psychologists as follows:

   a. The question posed was "whether LPA's may practice independently after three years of supervision of all practice...."

b. The Board stated, "The Workgroup provided the Board with data which indicated that there is no increased risk of harm to the public when independent practice is obtained by master's level practitioners after three years of supervised practice. As a result, the Board supports this proposal."

8. The career-long supervision requirement dismays and frustrates students and alumni of our program as I have learned through many conversations. I am asked the basic question, "What is the logic in having such a requirement?" The answer is not evident to me or to the students and alumni – particularly when the Psychology Board determined in 2013 that there was no increased risk of harm to the public by removing this requirement.

9. The career-long supervision requirement for master's-level psychologists is particularly striking and frustrating to our alumni in view of survey results of North Carolina employers who found that master's-level psychologists "were 'among the better trained' master's-level clinicians." [MacKain, S.J., Tedeschi, R. G., Durham, T. W., & Goldman, V. J. (2002). So What *Are* Master's-Level Psychology Practitioner's Doing? Surveys of Employers and Recent Graduates in North Carolina. Professional Psychology: Research and Practice, Vol. 33, No. 4, p. 410.]

10. To my knowledge, the number of LPAs practicing in North Carolina is decreasing at the same time that there is an increasing need for mental health services. I suspect that at least some students over the years have chosen to pursue practice in another discipline due to the restriction associated with the career-long supervision requirement. Whereas LPAs must incur the financial expense of career-long supervision, their counterparts in other mental health disciplines do not.

11. The career-long supervision requirement has harmed LPAs both in terms of insurance and employment eligibility.

a. Alumni of our Program have expressed frustration in not being able to receive payment from various insurance companies and governmental entities for their provision of psychological services because of the lack of an independent license.

b. Furthermore, alumni have expressed that they are not eligible for employment at various entities because they do not hold an independent license, whereas persons with master's-level licensure in other disciplines are eligible because they do hold such license.

12. The limited eligibility for employment of LPAs has even affected my ability as Coordinator to place students in the private sector for internships, because there are increasingly fewer LPAs available to provide supervision.

13. Alumni of our Program believe that they are being unfairly discriminated against in the provision of mental health services to the North Carolina citizenry. I concur. I have reflected over the years on the matter of whether to allow independent licensure for master's-level psychologists, and I have come to the conclusion that allowing independent practice after a

reasonable number of years of supervised practice is not only the right (ethical) thing to do, it is also the practical thing to do.

14. The North Carolina Psychology Board has the opportunity to change a rule that has served as a diathesis for the decreased availability of mental health services in North Carolina and for unfair trade practice.

15. I believe that the Board's adoption of the proposal to allow LPAs to practice independently after three years of supervised practice is indeed consistent with the Board's acting responsibly to protect the public. I therefore request that the Board implement a rule change to 21 NCAC 54 .2008(h) that would allow LPAs to practice independently with an unrestricted license after three years and at least 4500 hours of supervised practice.

Further Affiant sayeth not.

08-06-2018
Date

Vinston J. Goldman
Vinston J. Goldman, Ph.D, LP, HSP-P

State of North Carolina
County of Wake

Sworn to and subscribed before me this 6 day of August, 2018.

Martha E. Kelly
NOTARY PUBLIC

Martha E. Kelly
(printed name of notary public)
My Commission Expires: 9/30/2022

EXHIBIT 3

STATE OF NORTH CAROLINA
COUNTY OF WAKE

AFFIDAVIT

Flora Dunbar, being first duly sworn, does affirm and state as follows:

1. I am a legally competent person and have knowledge of the facts recited herein, except for those matters stated upon information and belief, as to which I maintain a good faith belief as to their truth.

2. I am licensed as a psychological associate by the North Carolina Board of Psychology and have been since 1983. I was awarded a Masters of Arts degree in Clinical Psychology from East Carolina University in 1974.

3. I am also licensed as a professional counselor by the North Carolina Board of Licensed Professional Counselors. I am a Board Certified-TeleMental Health Provider (BC-TMH).

4. For thirty-four years, I have been adhering to the supervision requirement set forth in the North Carolina Psychology Practice Act.

5. I respectfully request that the North Carolina Psychology Board make a change regarding career-long supervision of Psychological Associates. Specifically, I request that Rule .2008(h) be changed to read that supervision for Licensed Psychological Associates cease after three years with at least 4500 hours of supervised practice, and, thus, an unrestricted licensure status shall then be granted.

6. North Carolina Master's level practitioners in every other mental health discipline are allowed by their regulatory boards to practice independently after a period of reasonable supervision. LPAs are the lone exception who are still subjected to career-long supervision. This differential is unjustified, especially when graduate-level coursework in the clinical practice of psychology is nearly identical for master's- and doctoral-level students at North Carolina universities.

7. The Psychology Board has a mandate to protect the public health, safety, and welfare of the citizens of our state who receive psychology services. The public's access to our psychologists and the viability of the psychology discipline in NC both impact public welfare and are legitimate concerns for the Psychology Board.

8. I believe that the continuous supervision of licensed psychological associates ("LPAs") greatly handicaps North Carolina psychology licensees from fully offering their services via the private sector to citizens who need them.

   a. In my experience, private agencies now prefer to hire or contract with mental health professionals who can practice independently and are therefore eligible for reimbursement by a broad range of insurers. Many

LPAs forego establishing a private practice for the same reason. As a result, master's-level psychologists are becoming increasingly invisible on the front lines of private mental health.

b. Based on my review of 2017 data, 71% of all psychologists in North Carolina's rural counties are LPAs. In 20 counties, LPAs are the only psychologists present. Many citizens in these rural counties will have difficulty accessing an LPA, unless they are prepared to pay out of pocket, since the supervision requirement blocks LPAs from being credentialed with most insurers.

c. There is a consensus within the profession that significantly fewer psychologists are available per capita in rural areas. Enabling LPAs to become more accessible to rural counties can help reduce the shortfall of psychological services in these areas.

9. LPAs comprise the lion's share of psychologists offering psychology services to high-need clients and/or the uninsured through public state agencies and facilities operated through NC Department of Health and Human Services (DHHS) (e.g. NC State Correctional Facilities, Developmental Centers, Critical Access Behavioral Health Agencies).

a. While doctoral-level psychologists may work for these public agencies in administrative or supervisory roles, they do not usually provide direct psychological services to clients.

b. LPAs are the only group of mental health providers in North Carolina whose numbers are declining. In my opinion, this fact is likely related to the over-regulation of LPAs as compared to other MA level providers who are able to practice independently. This decline of LPAs does not bode well for future availability of psychologists in the public sector.

10. In my experience, most TeleMental Health companies do not contract with LPAs in North Carolina because LPAs are unable to practice without restriction. TeleMental Health companies typically require that clinicians be independent practitioners who are not under supervision. I have only been able to contract with a TeleMental Health company as a Licensed Professional Counselor (LPC).

11. I worked with a state-funded agency as a play therapist and staff psychologist for fifteen years. The restricted licensure of LPAs negatively affected my practice at the agency and the efficiency of the agency as a whole.

a. The agency served children from birth to age six who were experiencing problems in social and emotional development.

b. The program typically had a long waiting list of referrals from parents, Social Services, preschools, and attorneys.

c. Although I could serve the children covered by Medicaid, I could not serve children with conventional insurance coverage. Conventional insurers would not credential me because of my supervision requirement.

d. When I had openings in my caseload and other clinicians did not, I was unable to see additional patients.

e. This was frustrating and inefficient for the whole team and denied important treatment to families and children.

12. Over the years, a number of individuals wishing to pursue a master's degree for work in the field of mental health asked my advice about how to proceed with their training. If they want to study psychology, I routinely advised them to be prepared to pursue a doctoral degree or risk professional marginalization and financial hardships as an LPA.

13. I urge the Board to amend section 21 NCAC 54 .2008(h) of the North Carolina Administrative Code to eliminate career-long supervision of Licensed Psychological Associates and grant an unrestricted license to LPA candidates who successfully complete three years and at least 4500 hours of supervised practice. This rule change will assure that citizens have unimpeded access to the full psychology workforce in North Carolina and will enable the discipline of psychology to thrive across our state.

08/09/2018
Date

Flora Dunbar, MA, LPA, LPC
Flora Dunbar, MA, LPA, LPC

State of North Carolina
County of ~~Wake~~ Mecklenburg

Sworn to and subscribed before me this 9th day of August, 2018.

Christopher K. Wheeler

NOTARY PUBLIC

Christopher K. Wheeler

(printed name of notary public)

My Commission Expires: 02/14/2022

EXHIBIT 4

STATE OF NORTH CAROLINA
COUNTY OF WAKE

AFFIDAVIT

Janet Heuring, being first duly sworn, does affirm and state as follows:

1. I am a legally competent person and have knowledge of the facts recited herein, except for those matters stated upon information and belief, as to which I maintain a good faith belief as to their truth.

2. I have been licensed as a psychological associate by the North Carolina Board of Psychology and certified as a health service provider for almost three years. I am also licensed as a clinical addiction specialist by the North Carolina Substance Abuse Professional Practice Board. Lastly, I am certified as a clinical trauma professional by the International Association of Trauma Professionals.

3. I provide psychological assessments and psychotherapy to individuals six years of age and older struggling with depression, anxiety, panic attacks, PTSD, chronic pain issues, substance use disorders, and trauma/PTSD and more. I have been providing behavioral health treatment services in the community for over ten years.

4. I request a rule change under the rules permitted by the North Carolina Psychology Practice Act regarding the current mandate for Licensed Psychological Associates (LPAs) to maintain clinical supervision beyond three years of supervised practiced and throughout the entirety of our careers.

5. I propose that Rule .2008(h) of the North Carolina Psychology Board rules be amended to read that supervision for Licensed Psychological Associates cease after three years with at least 4,500 hours of supervised practice, and, thus, an unrestricted and independent licensure status shall then be granted.

6. I believe that this change will not only improve the access and continuity of therapeutic services provided to the citizens of North Carolina but will also alleviate the current restraint of trade that master's level psychologists endure in the mental health marketplace.

7. I firmly believe that most master's level psychologists, including myself, meet and often times exceed the current standards set forth for LPAs in the NC Psychology Practice Act.

a. On May 7th 2015, I graduated with institutional honors from North Carolina Central University with my Master's in Arts.

b. I had three years of graduate education (62 credits) and over 760 hours of clinical internship hours/practicum in psychology with a clinical concentration.

c. My clinical internship hours were completed over the course of ten months under the court psychologist for Durham County providing psychological evaluations and psychotherapy for incarcerated individuals with severe and persistent mental illnesses.

d. Prior to receiving my Master's in Art, I had nearly a decade of experience serving those with behavioral health issues through research, community outreach, certified substance use counseling, and working on a number of intensive community mental health teams.

8. I considered earning my doctoral degree but did not enroll in a doctoral program for the following reasons:

a. In January of 2015, I was informed by a professor at UNC Chapel Hill that I was not in a position to be an attractive candidate for their program because I was too "clinical" and lacked a "rigorous research" background.

b. I believed that my ten years of prior clinical experience in the field of behavioral health would have been an asset to a clinical psychology doctoral program, but I was mistaken.

c. I was then told by the same UNC-CH professor that if I wanted to pursue a doctoral degree at their intuition and "seriously" be considered, I should suspend my clinical work and transition into full-time research for no less than a year or two.

d. Unfortunately, this was not an attractive option for me because I was already nearly $80,000.00 in student loan debt from a three year clinically concentrated psychology master's program, and I already felt well-prepared to serve as a clinician.

9. In November of 2015, I passed the Examination for the Professional Practice of Psychology (EPPP) at the doctoral level. I finished my employment providing clinical services under doctoral level providers in the community and pursued my dream to build my own private practice with the mission to provide exceptional customer service combined with high quality clinical care.

10. However, I soon learned that I would need to overcome additional obstacles and hurdles imposed upon my practice as an LPA, especially relative to other master's level practitioners providing services in the community (LCSW, LPC, LMFT, etc.).

11. In regards to collecting fees for services rendered, the vast majority of insurance panels providing third party payment in North Carolina required that my license be "independent" before they would consider me for a contract as a provider.

a. Examples of such panels excluding LPAs from coverage include United Behavioral Health, Medicare, Tricare, Aetna, Humana, etc.

b. Blue Cross Blue Shield of North Carolina and Medicaid are the only two insurance carriers that allows LPAs to be credentialed with their panels.

c. Telehealth reimbursement is not available through Blue Cross Blue Shield of North Carolina for LPA telehealth psychological services because. It is only available for mental health practitioners who have an "independent" license, making these professionals more convenient and accessible than LPAs.

d. LPAs are also not permitted to provide services to veterans through the Veterans Administration because we lack an "independent" license.

e. In addition, for the same reason LPAs are not eligible for the National Health Services Corp Loan Repayment Program which provides loan repayment assistance to mental health providers who provide services to underserved populations.

12. Sadly, no matter how many years LPAs have been service providers, their clients must cover their own cost for sessions held online utilizing HIPPA-approved telehealth technology if transportation problems, inclement weather, disabilities, health issues and communicable diseases, or the need to stay home with dependents prevents clients from driving to an office visit. Meanwhile, social workers, professional counselors, marriage and family therapists, and other master's level mental health practitioners can provide clinical care online and be reimbursed by insurance companies for their services rendered.

13. Currently, these challenges, amongst others, place my practice at a professional and clinical disadvantage as a result of my inability to obtain an independent mental health license with the North Carolina Psychology Board compared with other master's level mental health providers and LPs, even though according to insurance schedules LPA rates are 25% less costly than LP rates, and that reduction in rate is often passed down to the consumer. On a weekly basis, potential consumers inquiring about services are turned away because I am not eligible to accept their insurance.

14. Furthermore, the clients receiving therapeutic services are constantly at risk of having their treatment coverage lost should their employer decide to change their contracted insurance carrier.

a. When this unfortunate issue arises, a negotiation for a new self-pay rate (typically a 30-50% fee cut for myself so as not to further burden the client) or a referral to start their therapeutic services over again with a different community provider is the consequence.

b. It cannot be overstated that the dilemma of a client's changing insurance carrier (typically unwilling to reimburse LPAs) thwarts a therapist's efforts to uphold the vital evidenced-based practice of establishing and maintaining a strong therapeutic alliance during the change/healing process with clients.

c. This is directly detrimental to both client (therapeutically) and therapist (financially) and occurs all too often in a constantly changing and increasingly expensive healthcare marketplace.

d. Although I do my best to negotiate a fair sliding fee scale for consumers in this position, I must consider that as an LPA I am already incurring additional practice costs for supervision at a rate of $300.00 per month, unlike most of my fellow clinicians in the mental health field and face the prospect of paying $75.00-$150.00 per month for the rest of my career for LP supervision.

15. This is my official request for a rule change to Rule .2008(h) to create a pathway for an independent license for LPAs after three years with at least 4,500 hours of supervised practice.

a. I believe that LPAs will have demonstrated enough education, competence, and ethical adherence after this time to serve clients safely with an unrestricted license.

b. A requirement of 4,500 hours of supervised practice prior to unrestricted licensure is a greater length of time than what is required for other master's level mental health practitioners (LMFTs, LCSWs, LPCs etc.).

c. Additionally, it is also my belief that the suggested rule change will improve access to care and affordability of mental health services for all citizens in North Carolina, as many are currently unable to use their health insurance when seeking care from a considerable portion of psychologists (LPAs) in North Carolina.

Further Affiant sayeth naught.

8/6/18
Date

Janet Heuring, MA, LCAS, LPA, HSP-PA, CCTP

State of North Carolina
County of Wake

Sworn to and subscribed before me this 6th day of August, 2018.

NOTARY PUBLIC

Joshua V. Davis
(printed name of notary public)

My Commission Expires: 04-15-2019

JOSHUA V. DAVIS NOTARY PUBLIC WAKE COUNTY, NC

EXHIBIT 5

STATE OF NORTH CAROLINA
COUNTY OF WAKE

AFFIDAVIT

Tara Luellen, being first duly sworn, does affirm and state as follows:

1. I am a legally competent person and have knowledge of the facts recited herein, except for those matters stated upon information and belief, as to which I maintain a good faith belief as to their truth.

2. I have seven years of experience practicing psychology. I have attained licensure as an LPA in three different states and passed the national licensure exam (EPPP) well above the level required of doctoral level psychologists in all fifty states.

3. Currently, LPAs in North Carolina must obtain a master's degree in psychology and pass licensure examinations (both on the national and state level) before being granted licensed status; however, thereafter, career-long supervision is mandated without the possibility of attaining independent practice, no matter the experience gained and/or expertise demonstrated.

4. Before moving to North Carolina, I was an LPA licensed in the state of Kentucky and practicing there at an inpatient facility. Based upon my score on the national licensure exam and my seven years of experience, if I were to return to Kentucky, I would be eligible to obtain an unrestricted license and to practice without supervision.

5. Unlike in Kentucky, that option is not afforded to me here in North Carolina, despite the research that shows that master's-level psychologists do not pose a threat to the public or their clients when they are allowed to practice independently of supervision in the states where an unrestricted license can be obtained.

6. Individuals with a master's degree are able to practice independently in North Carolina if licensed as a social worker, marriage and family therapist, professional counselor, or addiction specialist. Licensed psychological associates are the outliers limited to career-long supervision.

7. In light of my education and experience, I believe that I offer services at the same level as other master's level mental health care providers and therefore believe the career-long supervision requirement for LPAs alone is unjust and unwarranted.

8. Given that LPAs hold a "restricted license" in North Carolina, we are not approved providers for most insurance carriers.

   a. Blue Cross Blue Shield of North Carolina and Medicaid are the only two insurance carriers that recognize LPAs as providers and, thus, are the only two insurance carriers that we can accept from clients.

b. All other clients must utilize self-pay in order to receive services from us, even though most of them have some type of insurance for which they're already paying but which we cannot accept.

c. This not only poses significant financial implications for LPAs attempting to make a living and build a career in the state of North Carolina (given that we will oftentimes discount our self-pay client services so as not to further burden our clients), but it also restricts the clients to whom we can offer services, causing client access to competent mental health providers to be limited without justification.

d. Additionally, the restricted license prevents master's-level psychologists from obtaining gainful employment; I, myself, was turned down for several positions simply given that my license is not independent and the problems this poses for insurance reimbursement, which ultimately resulted in me accepting a job outside of the field of psychology.

9. I support the proposal before the Board to amend 21 N.C.A.C. 54.2008(h) to eliminate career-long supervision for Licensed Psychological Associates after three years and at least 4,500 hours of supervised practice, followed by unrestricted licensure status thereafter.

10. I request this change to achieve parity with other master's-level mental health care providers as well as to improve patient access and therapeutic continuity.

Further Affiant sayeth naught.

8/6/2018
Date

Tara Luellen, MA/LPA, HSP-PA
Tara Luellen, MA, LPA, HSP-PA

State of North Carolina
County of Wake

Sworn to and subscribed before me this 6 day of August, 2018.

NOTARY PUBLIC

DEREK T. TAYLOR
NOTARY PUBLIC
WAKE COUNTY, NC

Derek T Taylor
(printed name of notary public)

My Commission Expires: 5-4-2020

EXHIBIT 6

STATE OF NORTH CAROLINA
COUNTY OF WAKE

AFFIDAVIT

Carol Williams, being first duly sworn, does affirm and state as follows:

1. I am a legally competent person and have knowledge of the facts recited herein, except for those matters stated upon information and belief, as to which I maintain a good faith belief as to their truth.

2. In 2015, I obtained my license to practice psychology in North Carolina as a Licensed Psychological Associate, passing the Examination for the Professional Practice of Psychology (EPPP) on my first attempt. Before obtaining my psychology license, I worked in the field of mental health exclusively for eight years.

3. Since obtaining my license, I have continued honing my psychology skills through pursuing additional formal education, including academic and board (BACB) certification in applied behavior analysis.

4. Despite my academic credentials with honors, experience, and published work, I was not accepted into any of the doctoral clinical psychology programs to which I applied, here in North Carolina. Unfortunately, following completion of my master's degree, I was not in a position to move out of state to pursue a doctorate degree.

5. Instead I obtained work as a Licensed Psychological Associate in North Carolina, where under the current rules of the Psychology Board, I am required to have supervision for the length of my career. My current supervision requirement is four hours per month.

6. Because of the career-long supervision requirement for licensed psychological associates, my ability to practice is unduly restricted. This is seen in the following ways:

   a. When I began to consider practicing outside of an established facility, I found that due to supervision requirements, I would be unable to secure credentialing with insurance panels.

   b. Initially I was informed by the North Carolina Psychology Board that I would be unable to even secure a simple business license outside of a sole-proprietorship, due to the LPA license being considered a restricted license. (Recently, I have found from other sources that the North Carolina Psychology Board has revisited that decision and reversed this erroneous conclusion.)

   c. I at one time worked with an outside agency providing much needed therapeutic services in the community. However, my compensation was insufficient to adequately cover the expenses associated with additional supervision and semi-private practice. Consequently, I closed my practice.

7. Due to the restricted license associated with the LPA license, the fees associated with unending supervision, and the inability to secure credentialing with insurance panels, I am

unable to pursue my own practice in psychology within the scope of my education, experience, and ability.

8. I am informed and believe that at least nine states have eliminated career long supervision for master's level psychologists: Alaska, Arkansas, Kansas, Kentucky, Oklahoma, Oregon, Tennessee, Vermont and West Virginia.

9. I request that the North Carolina Psychology Board amend Rule .2008(h) to read that supervision for Licensed Psychological Associates no longer be required after three years and at least 4500 hours of supervised practice and that an unrestricted licensure status be granted afterward.

10. In so doing the North Carolina Psychology Board will allow me to practice within the scope of my ability, but also, to more effectively compete with similar master's level practitioners, who are not subject to permanent license restrictions.

11. This change will provide the potential for improved access to care for consumers, including possible telehealth services, particularly in areas where there is a dearth of doctorate level practicing psychologists.

12. Additionally, this would allow me to provide volunteer services with various agencies in times of disaster such as we have all witnessed in recent years. My experience in trauma informed care and therapy would be a valuable asset to offer, except that I am unable to do so as a result of the restricted license designation.

Further Affiant sayeth naught.

08-01-18
Date

Carol E. Williams, MA, LPA, HSP-PA

State of North Carolina
County of Wake

Sworn to and subscribed before me this 1 day of ~~July~~ August, 2018.

Anna C Norwood
NOTARY PUBLIC

Anna C Norwood
(printed name of notary public)

My Commission Expires: January 7, 2019

ANNA C. NORWOOD NOTARY PUBLIC GRANVILLE COUNTY, NC

EXHIBIT 7

§ 90-270.5. Application; examination; supervision; provisional and temporary licenses.

(a) Except as otherwise exempted by G.S. 90-270.4, persons who are qualified by education to practice psychology in this State must make application for licensure to the Board within 30 days of offering to practice or undertaking the practice of psychology in North Carolina. Applications must then be completed for review by the Board within the time period stipulated in the duly adopted rules of the Board. Persons who practice or offer to practice psychology for more than 30 days without making application for licensure, who fail to complete the application process within the time period specified by the Board, or who are denied licensure pursuant to G.S. 90-270.11 or G.S. 90-270.15, may not subsequently practice or offer to practice psychology without first becoming licensed.

(b) After making application for licensure, applicants must take the first examination to which they are admitted by the Board. If applicants fail the examination, they may continue to practice psychology until they take the next examination to which they are admitted by the Board. If applicants fail the second examination, they shall cease the practice of psychology per G.S. 90-270.4(h), and may not subsequently practice or offer to practice psychology without first reapplying for and receiving a license from the Board. An applicant who does not take an examination on the date prescribed by the Board shall be deemed to have failed that examination.

(c) All individuals who have yet to apply and who are practicing or offering to practice psychology in North Carolina, and all applicants who are practicing or offering to practice psychology in North Carolina, shall at all times comply with supervision requirements established by the Board. The Board shall specify in its rules the format, setting, content, time frame, amounts of supervision, qualifications of supervisors, disclosure of supervisory relationships, the organization of the supervised experience, and the nature of the responsibility assumed by the supervisor. Individuals shall be supervised for all activities comprising the practice of psychology until they have met the following conditions:

(1) For licensed psychologist applicants, until they have passed the examination to which they have been admitted by the Board, have been notified of the results, have completed supervision requirements specified in subsection (d) of this section, and have been informed by the Board of permanent licensure as a licensed psychologist; or

(2) For licensed psychological associate applicants, until they have passed the examination to which they have been admitted by the Board, have been notified of the results, and have been informed by the Board of permanent licensure as a licensed psychological associate, after which time supervision is required only for those activities specified in subsection (e) of this section.

(d) For permanent licensure as a licensed psychologist, an otherwise qualified psychologist must secure two years of acceptable and appropriate supervised experience germane to his or her training and intended area of practice as a psychologist. The Board shall permit such supervised experience to be acquired on a less than full-time basis, and shall additionally specify in its rules the format, setting, content, time frame, amounts of supervision, qualifications of supervisors, disclosure of supervisory relationships, the organization of the supervised experience, and the nature of the responsibility assumed by the supervisor. Supervision of health services must be received from qualified licensed psychologists holding health services provider certificates, or from other psychologists recognized by the Board in accordance with Board rules.

(1) One of these years of experience shall be postdoctoral, and for this year, the Board may require, as specified in its rules, that the supervised experience be comparable to the knowledge and skills acquired during formal doctoral or

postdoctoral education, in accordance with established professional standards.

(2) One of these years may be predoctoral and the Board shall establish rules governing appropriate supervised predoctoral experience.

(3) A psychologist who meets all other requirements of G.S. 90-270.11(a) as a licensed psychologist, except the two years of supervised experience, may be issued a provisional license as a psychologist or a license as a psychological associate, without having received a master's degree or specialist degree in psychology, by the Board for the practice of psychology.

(e) A licensed psychological associate shall be supervised by a qualified licensed psychologist, or other qualified professionals, in accordance with Board rules specifying the format, setting, content, time frame, amounts of supervision, qualifications of supervisors, disclosure of supervisory relationships, the organization of the supervised experience, and the nature of the responsibility assumed by the supervisor. A licensed psychological associate who provides health services shall be supervised, for those activities requiring supervision, by a qualified licensed psychologist holding health services provider certification or by other qualified professionals under the overall direction of a qualified licensed psychologist holding health services provider certification, in accordance with Board rules. Except as provided below, supervision, including the supervision of health services, is required only when a licensed psychological associate engages in: assessment of personality functioning; neuropsychological evaluation; psychotherapy, counseling, and other interventions with clinical populations for the purpose of preventing or eliminating symptomatic, maladaptive, or undesired behavior; and, the use of intrusive, punitive, or experimental procedures, techniques, or measures. The Board shall adopt rules implementing and defining this provision, and as the practice of psychology evolves, may identify additional activities requiring supervision in order to maintain acceptable standards of practice.

(f) A nonresident psychologist who is either licensed or certified by a similar Board in another jurisdiction whose standards, in the opinion of the Board, are, at the date of his or her certification or licensure, substantially equivalent to or higher than the requirements of this Article, may be issued a temporary license by the Board for the practice of psychology in this State for a period not to exceed the aggregate of 30 days in any calendar year. The Board may issue temporary health services provider certification simultaneously if the nonresident psychologist can demonstrate two years of acceptable supervised health services experience. All temporarily licensed psychologists shall comply with supervision requirements established by the Board.

(g) An applicant for reinstatement of licensure, whose license was suspended under G.S. 90-270.15(f), may be issued a temporary license and temporary health services provider certification in accordance with the duly adopted rules of the Board. (1967, c. 910, s. 5; 1977, c. 670, s. 4; 1979, c. 670, s. 3; 1985, c. 734, s. 4; 1993, c. 375, s. 1; 2012-72, s. 1.)

EXHIBIT 8

21 NCAC 54 .2006 PSYCHOLOGICAL ASSOCIATE ACTIVITIES

(a) The assessment of overall personality functioning by a psychological associate requires supervision. The assessment of personality functioning involves any assessment or evaluative technique which leads to conclusions, inferences, and hypotheses regarding personality functioning. This includes:

(1) all statements regarding personality attributes, features, traits, structure, dynamics, and pathology or assets;

(2) the use of personality assessment techniques which include, but are not limited to, observation, interviewing, mental status examinations, word association tests, diagnostic play therapy, and autobiographical techniques; and

(3) the use of standardized personality techniques or tests. Examples of techniques or tests include, but are not limited to, the following: Rorschach, Thematic Apperception Test, sentence completion tests, the House Tree Person, Minnesota Multiphasic Personality Inventory, the California Personality Inventory, The Millon tests, the 16PF, and all other self-report inventories and questionnaires, as well as scales and check lists completed by others. The tests identified in this Rule as requiring supervision do not constitute an exhaustive list, only the most commonly utilized measures.

Not requiring supervision are screening techniques which lead to simple descriptors of persons which may be completed by a variety of professional and non-professional observers and are interpreted by other parties.

(b) The conduct of neuropsychological evaluations by psychological associates requires supervision. Not requiring supervision are neuropsychological screenings which lead to simple behavioral descriptions rather than clinical interpretations, or the administration of rating devices which may be completed by a variety of professional and non-professional observers and are subsequently interpreted by other parties.

(c) Psychotherapy, counseling, and any other interventions with a clinical population for the purpose of preventing or eliminating symptomatic, maladaptive, or undesired behavior provided by a psychological associate require supervision. Clinical populations include persons with discernible mental, behavioral, emotional, psychological, or psychiatric disorders as evidenced by an established Axis 1 or Axis II diagnosis or V Code condition in the then current DSM and all persons meeting the criteria for such diagnoses. Interventions other than psychotherapy and counseling that are encompassed by this definition include, but are not limited to, psychological assessment, psychoanalysis, behavior analysis/therapy, biofeedback, and hypnosis. Supervision is required when the psychological associate is providing an intervention to persons within a clinical population, directly with the person(s) or in consultation with a third party, for the purpose of preventing or eliminating symptomatic, maladaptive, or undesired behavior. Supervision is required for the design or clinical oversight of interventions for persons within a clinical population, such as biofeedback techniques and behavior intervention programs; however, supervision is not required for the actual implementation of such interventions that were designed for others to implement, which may or may not constitute ancillary services.

(d) The use, including authorization, of intrusive, punitive, or experimental procedures, techniques, or measures by a psychological associate requires supervision. These procedures, techniques, or measures include, but are not limited to, seclusion, physical restraint, the use of protective devices for behavioral control, isolation time-out, and any utilization of punishment techniques involving aversive stimulation. Also included in this definition are any other techniques which are physically intrusive, are restrictive of human rights or freedom of movement, place the client at risk for injury, or are experimental in nature (i.e., in which the efficacy and degree of risk have not previously been clinically established).

(e) Supervision is required for a psychological associate who provides clinical supervision to other service providers who are engaged in activities which would require supervision if directly provided by the psychological associate.

History Note: *Authority G.S. 90-270.5(e); 90-270.9;*
Eff. October 1, 1991;
Amended Eff. October 1, 2006.

21 NCAC 54 .2008 PSYCHOLOGICAL ASSOCIATE

(a) Except as provided in this Rule, a Psychological Associate practicing psychology in North Carolina shall receive supervision for activities specified in G.S. 90-270.5(e) and 21 NCAC 54 .2006.

(b) A Psychological Associate whose professional practice is limited to those activities other than those specified in G.S. 90-270.5(e) and 21 NCAC 54 .2006 as requiring supervision shall not be required to receive supervision.

(c) A Psychological Associate who is a regular salaried employee of the State Department of Public Instruction or a local board of education, and whose professional activities are limited only to those for which he or she is employed by that agency, shall not be required to receive supervision. This exemption shall not apply to individuals who contract with the Department of Public Instruction or local boards of education for the delivery of psychological services which otherwise require supervision in the schools.

(d) A Psychological Associate who engages in the practice of psychology in a jurisdiction other than North Carolina shall not be required to receive supervision for those services rendered in another jurisdiction so long as said services are rendered in a manner consistent with the jurisdiction's legal requirements.

(e) A written, notarized supervision contract form shall be filed within 30 days of a change in the conditions specified in the supervision contract form on file with the Board and within 30 days after receiving written notification from the Board that the filing of a new form is necessary to provide for the protection of the public or the regulation of the practice of psychology. A supervision contract form shall document either that supervision is required and shall be received, or that supervision is not required. A separate supervision contract form shall be filed for each separate work setting. If receiving supervision from more than one supervisor to meet the minimum requirements, a separate supervision contract form shall be filed with each individual supervisor.

(f) A supervisor shall report to the Board that agreed upon supervision has occurred and shall file a final report upon termination of supervision. If not receiving supervision, it shall be the responsibility of the Psychological Associate to report such to the Board. A report shall be submitted to the Board within 30 days after receiving written notification from the Board that such is due, within 2 weeks of termination of supervision, and within 2 weeks of a change in the conditions specified in the supervision contract form on file with the Board.

(g) Additional supervision and reporting to the Board may be required in cases where previous evaluations or other information (e.g. reference letters, ethical complaints, etc.) suggests possible problems in the supervisee's competence or adherence to ethical standards. Additional documentation or an interview with the Board or its designated representative(s) may be required when questions arise regarding the supervisee's practice due to information supplied or omitted on supervision contract forms and reports or when required forms are not filed with the Board.

(h) Supervision shall be provided in individual, face-to-face, sessions which shall last no longer than 2 hours or less than 30 minutes by an individual who shall be recognized as an appropriate supervisor as defined in Rule .2001 of this Section. A Psychological Associate shall receive a minimum of one hour per month of individual supervision in any month during which he or she engages in activities requiring supervision. The rates of supervision specified in this Paragraph shall be provided for each separate work setting in which the Psychological Associate engages in the activities requiring supervision. Minimum hours of supervision required for each work setting shall not be split between more than two supervisors. The term "post-licensure" in this Paragraph shall refer to the period following issuance of a Psychological Associate license by the North Carolina Psychology Board. The term "supervised practice" in this Paragraph shall refer to activities requiring supervision as specified in G.S. 90-270.5(e) and 21 NCAC 54 .2006. Except as provided in Paragraph (g) of this Rule, minimum supervision requirements shall be as follows:

(1) Level 1. For a Psychological Associate with less than 3 calendar years consisting of at least 4500 hours of post-licensure supervised practice, minimum supervision shall be provided as follows:

No. of hours per month engaging in activities that require supervision	No. of hours of required individual supervision per month
1 - 10	1
11 - 20	2
21 - 30	3
31 plus	4

(2) Level 2. After a minimum of 3 calendar years consisting of at least 4500 hours of post-licensure supervised practice, minimum supervision may be provided as follows:

No. of hours per month	No. of hours of required

engaging in activities that require supervision	individual supervision per month
1 - 20	1
21 plus	2

To be approved by the Board for this level of supervision, a Psychological Associate shall:

(A) make application on an application form provided by the Board;

(B) document that all performance ratings for the preceding 3 years and 4500 hours of post-licensure supervised practice have been average or above average;

(C) have received at least one calendar year of supervision from the most recent supervisor; and

(D) have the recommendation of the most recent supervisor for this level of supervision.

(3) Level 3. After a minimum of 5 calendar years consisting of at least 7500 hours of post-licensure supervised practice, a minimum of 1 hour per month individual supervision may be provided to a Psychological Associate who engages in activities requiring supervision. To be approved by the Board for this level of supervision, a Psychological Associate shall:

(A) make application on an application form provided by the Board;

(B) document that all performance ratings for the preceding 5 years and 7500 hours of post-licensure supervised practice have been average or above average;

(C) have received at least one calendar year of supervision from the most recent supervisor; and

(D) have the recommendation of the most recent supervisor for this level of supervision.

(i) The frequency and scope of supervision may, at the discretion of the supervising psychologist, be modified provided that the minimum rate of supervision as defined in Paragraph (h) of this Rule is provided. The supervising psychologist of record may review, approve, and monitor additional individual or group supervision to be provided to the supervisee by a Licensed Psychological Associate, Licensed Psychologist holding a permanent or provisional license, or a professional from a related discipline. Such supervision shall not substitute for the minimum requirements specified in Paragraph (h) of this Rule.

(j) Contract and report forms shall be provided by the Board.

History Note: *Authority G.S. 90-270.4(c); 90-270.5(e); 90-270.9;*
Eff. July 1, 1997.

EXHIBIT 9

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1990, Vol. 21, No. 3, 216-218

0735-7028/90/$00.75

BRIEF REPORTS

Terminal Master's-Level Training in Counseling Psychology: Skills, Competencies, and Student Interests

C. Edward Watkins, Jr., and Lawrence J. Schneider
University of North Texas

Michaelene Manus and Julie Hunton-Shoup
Department of Educational Psychology and Leadership Studies
Kent State University

We surveyed directors of terminal master's-level counseling psychology programs to determine perceptions about (a) the skills and competencies in which their students received training and (b) the interest and commitment of their students to different areas of training and practice. The data were also compared with the survey data of Schneider, Watkins, and Gelso (1988) in an effort to examine similarities and differences between master's-level and doctoral-level training in counseling psychology. Discussion about master's-level programs' training emphases and the master's vs. doctoral training issue is provided.

For almost 40 years now, debate about the place of master's-level training in psychology has continued unabated (Watkins, Campbell, & McGregor, 1989). Thus far, the majority of attention and concern has been directed toward the master's degree in clinical psychology (e.g., Perlman, 1985). But there are a number of terminal master's-level counseling psychology programs in existence (American Psychological Association [APA], 1988), and very little is currently known about them. In this survey study, we were interested in trying to get a better grasp of two areas: (a) the degree to which master's-level counseling psychology programs train their students in different skills and competencies and (b) the degree to which students are interested in and committed to different areas of training and practice. We also were interested in comparing this information with information on doctoral-level counseling psychology programs (Schneider, Watkins, & Gelso, 1988).

Method

Participants

Participants were either coordinators of the counseling program or department chairpersons. On the basis of *Graduate Study in Psychology and Associated Fields* (APA, 1988), 37 programs were identified as offering the terminal master's degree in counseling psychology. Of the 37 possible respondents, 31 (84%) returned their questionnaires.

Instrument

We used a three-page, 50-item questionnaire in which we asked respondents to (a) indicate the adequacy of their respective program's training in different areas of skill and competency (1 = *very weak* and 9 = *very strong*) and (b) indicate the degree to which students seemed interested in and committed to different areas of skill and competency (1 = *very little* and 9 = *very much*). The questionnaire that we used (with the exception of Item 29; see Table 1) was identical to Schneider et al.'s (1988) questionnaire.

Procedure

We mailed a questionnaire packet composed of an explanatory letter, the questionnaire, and a return envelope to all possible respondents. After this, two follow-up mailouts were conducted to further increase returns.

Results

The respondents rated their graduate students' preparedness to practice in 20 specialty areas (for the means and standard

C. EDWARD WATKINS, JR., received his PhD in counseling psychology from The University of Tennessee at Knoxville in 1984. He currently is an Associate Professor in the Department of Psychology at The University of North Texas. His research interests include professional issues in counseling psychology, psychological assessment, and multicultural counseling.

LAWRENCE J. SCHNEIDER received his PhD in counseling psychology from Southern Illinois University at Carbondale in 1972. Currently he is an Associate Professor of Psychology at The University of North Texas. Private practice and professional issues, social influence processes, and marriage and family therapy are his major research interests.

MICHAELENE MANUS received her master's degree in counseling from Kent State University. She is currently a doctoral student in the counseling psychology program at Kent State. Her research interests focus on personality assessment, object relations theory, and women's issues.

JULIE HUNTON-SHOUP is a doctoral student in counseling psychology at Kent State University. Her research interests focus on structured groups, anger management, and research methodology.

WE EXPRESS our sincere appreciation to the training directors who took part in this survey.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to C. Edward Watkins, Jr., Department of Psychology, University of North Texas, Denton, Texas 76203-3587.

Table 1
Program Directors' Perceptions of Training Effectiveness and Student Interests

Survey item	Training effectiveness: Master's programs *M*	*SD*	Doctoral programs *M*	*SD*	*t*(70)	Student interests: Master's programs *M*	*SD*	Doctoral programs *M*	*SD*	*t*(65)
1. Preparedness for doing educational–vocational counseling	4.55	2.00	6.56	1.72	4.58*	4.03	1.85	4.28	1.81	0.55
2. Preparedness for doing social–emotional counseling	7.54	1.69	8.12	1.09	1.74	8.00	1.05	8.44	0.65	2.25
3. Preparedness for doing marital/family counseling	6.00	2.14	5.68	2.02	−0.58	7.36	1.60	7.00	0.98	−1.11
4. Preparedness for doing crisis intervention	5.87	1.75	5.37	1.59	−1.27	6.42	1.67	5.63	1.52	−2.02
5. Preparedness for doing group counseling/therapy	6.00	1.85	6.73	1.53	1.91	6.42	1.63	6.58	1.18	0.47
6. Preparedness for doing primary prevention work	5.40	2.22	5.60	1.86	0.41[a]	5.23	2.08	5.42	1.75	0.41
7. Comprehension of personality theory	6.65	1.33	6.76	1.39	0.35	5.13	1.89	6.08	1.57	2.25
8. Comprehension of vocational development theory	4.43	2.16	6.63	1.59	4.94**	3.77	2.05	4.63	1.64	1.90
9. Training in use of projective tests	3.55	2.46	4.92	2.45	2.35	4.52	2.25	6.17	1.54	3.55
10. Training in use of vocational interest tests	4.65	2.01	6.51	1.52	4.49*	4.36	2.01	5.11	1.30	1.85
11. Training in use of aptitude tests	4.58	2.26	5.65	1.62	2.34	4.74	1.86	4.81	1.31	0.17
12. Training in use of objective personality tests	6.00	2.18	6.48	1.32	1.16	5.87	1.88	6.52	1.29	1.67
13. Training in use of neurological tests	2.45	2.06	3.87	1.82	3.09	3.00	1.76	5.41	1.50	6.00[b]*
14. Training in supervision of other service providers	3.10	2.01	5.93	1.99	5.96*	4.39	2.53	6.61	1.29	4.63*
15. Training in writing formal diagnostic/psychological reports	5.48	2.39	5.92	1.70	0.90	5.41	2.11	6.22	1.51	1.80
16. Training in program evaluation	4.16	2.37	4.45	1.85	0.58	3.87	2.41	4.67	1.20	1.76
17. Training in administration skills	3.48	2.16	3.65	1.72	0.36	4.00	2.30	4.19	1.31	0.49
18. Training in test construction	4.13	2.09	4.55	1.81	0.91	2.74	1.69	3.81	1.28	2.94
19. Training in consultation	4.45	1.84	5.34	1.85	2.02	5.10	2.14	6.14	1.48	2.35
20. Training to do independent research in counseling	5.45	2.23	7.38	1.19	4.72*	4.45	2.22	5.88	1.43	3.17
21. Major focal point of initial practicum training	2.00	1.27	3.83	2.07	4.34*					
22. Major focal point of additional practicum training	2.48	2.10	2.65	1.18	0.42[c]					
23. Becoming eligible for licensure						7.59	1.76	8.82	0.39	4.06[d]*
24. Preparing for a career in teaching/academics						4.63	1.77	5.15	1.39	1.33[d]
25. Making contributions to the literature						3.60	1.87	5.61	1.43	4.95**
26. Making presentations at professional meetings						4.40	2.01	5.92	1.47	3.56[b]*
27. Being active in APA Division 17						3.28	1.75	5.60	1.41	6.45[b]*
28. Becoming a member of APA						3.83	2.21	6.93	1.72	6.37*
29. Becoming a member of AACD[f]						4.80	2.10			

Note. APA = American Psychological Association. AACD = American Association for Counseling and Development. Items 1–8 were rated on a *very weak* (1) to *very strong* (9) dimension, and Items 9–20 and Items 23–28 on a *very little* (1) to *very much* (9) dimension. On Items 21 and 22, the numeral 1 on a 1–9 scale was labeled *much more on personal than vocational*, 9 was labeled *much more on vocational than personal*, and 5 was labeled *about the same for personal and vocational counseling*.
[a] $df = 69$. [b] $df = 64$. [c] $df = 68$. [d] $df = 63$. [e] $df = 61$. [f] This item was added to the questionnaire for this survey.
* $p < .001$.

deviations of these ratings, see Table 1, Items 1–20). According to one-way repeated measures analyses of variance (ANOVAs) and Newman-Keuls post hoc comparisons (contained in an extended report that is available from C. Edward Watkins, Jr.), social–emotional counseling, use of objective personality tests, writing formal diagnostic/psychological reports, and doing independent research were rated higher than most other areas. For the doctoral data of Schneider et al. (1988) and the results of the *t* tests comparing the two data sets, see Table 1. Doctoral-training directors rated their programs as more effective in vocational psychology, supervision, and research. The doctoral respondents also indicated that the focus of their students' initial

practicum experience was less heavily weighted toward personal counseling than was master's students' initial practicum experience (Item 21).

Respondents next rated their students' career interests in various areas of practice (see Table 1). Again, according to one-way repeated-measures ANOVAs and Newman-Keuls post hoc comparisons, social–emotional and related forms of counseling and use of objective personality tests were rated higher than most other areas. For the doctoral data of Schneider et al. (1988) and the results of the *t* tests comparing the two data sets, see Table 1. The doctoral-training directors rated their students' career interests as higher in projective testing, neurological testing, and supervision.

Last, respondents rated their master's-level students' interests in several professional activities (see Table 1, Items 23–29). Students were not highly interested in becoming involved in the APA, Division 17 (Counseling), or in making scholarly contributions, but they were seen as more interested in joining the American Association for Counseling and Development (AACD). According to *t* test comparisons made with the doctoral data (see Table 1), doctoral students were rated as being more interested than master's students in becoming involved in Division 17 and the APA, obtaining licensure, and making scholarly contributions.

Discussion

The terminal master's programs in counseling psychology provided their students with training in a variety of areas. The areas receiving strongest training emphases, however, focused on individual and group counseling (including marital/family and crisis work), objective personality testing, and report writing. In similar fashion, students' primary professional interests were considered to focus on these areas. Training effectiveness and students' career interests corresponded nicely, for the most part. The data suggest that master's programs are most oriented toward therapeutic treatment and personality assessment. These emphases perhaps reflect basic changes occurring within counseling psychology itself and the practitioner slant of the terminal master's degree in psychology (Fitzgerald & Osipow, 1986; Watkins et al., 1989).

As the results indicated, training in doctoral as opposed to master's programs was perceived as more effective in vocational, research, and supervision areas. These differences may reflect two simple facts: (a) that a greater amount of attention is typically given to these content areas over the course of a doctoral program and (b) that students who are willing to invest in several years of training beyond the master's degree may be more career committed to certain areas of interest. Furthermore, it may be that some of the identified areas are most consistent with advanced doctoral (rather than master's) training in a scientist–practitioner model (e.g., research, supervising others). Thus the differences between the doctoral and master's ratings largely may be a function of (a) the extra time, study, and investment involved in obtaining a doctoral degree and (b) the greater breadth of experience and exposure to psychological knowledge that one obtains during the process.

What about interests in professional activities? The limited interest that students were seen as having in joining the APA and Division 17 is perhaps the most disturbing aspect of the data. But students were seen as having moderate interest in joining the AACD. This may also reflect two simple facts: (a) that the APA and its Division 17 are primarily oriented toward and committed to the doctoral-level psychologist and (b) that the AACD recognizes, caters to, and is largely composed of master's-level practitioners. As a result, master's-level psychologists may feel more accepted and consider their professional affiliation needs better addressed by the AACD than by the APA (cf. Perlman, 1985). As long as the APA does not more readily include master's-level psychologists, one can expect them only to turn their professional associations and commitments elsewhere.

In summary, terminal master's-level counseling psychology programs provide students with a broad range of training experiences, but they seem most oriented toward therapeutic treatment and personality assessment. Master's students seemingly have many interests similar to those of doctoral students, but doctoral training is considered more effective in the vocational, research, and supervision areas.

Our study, though interesting, is not without limitations. Of most concern is that we asked directors to cite their students' interest in different areas of training. Perhaps a better strategy would have been to ask students these questions directly. Second, the master's and doctoral ratings were made by different groups of directors at different times. These differences need to be borne in mind when our results are considered.

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EXHIBIT 10

Proposed Amended Rule 21 NCAC 54.2008(h)

(h) Supervision shall be provided in individual, face-to-face, sessions which shall last no longer than 2 hours or less than 30 minutes by an individual who shall be recognized as an appropriate supervisor as defined in Rule .2001 of this Section. A Psychological Associate shall receive a minimum of one hour per month of individual supervision in any month during which he or she engages in activities requiring supervision. The rates of supervision specified in this Paragraph shall be provided for each separate work setting in which the Psychological Associate engages in the activities requiring supervision. The term "post-licensure" in this Paragraph shall refer to the period following issuance of a Psychological Associate license by the North Carolina Psychology Board. The term "supervised practice" in this Paragraph shall refer to activities requiring supervision as specified in G.S. 90-270.5(e) and 21 NCAC 54 .2006. Except as provided in Paragraph (g) of this Rule, minimum supervision requirements shall be as follows:

For a Psychological Associate with less than 3 calendar years consisting of at least 4500 hours of post-licensure supervised practice, minimum supervision shall be provided as follows:

No. of hours per month engaging in activities that require supervision	No. of hours of required individual supervision per month
1-10	1
11-20	2
21-30	3
31 plus	4

After a minimum of 3 calendar years consisting of at least 4500 hours of post-licensure supervised practice, no further supervision is required provided that a Psychological Associate shall:

(A) Make application on an application form provided by the Board;

(B) Document that all performance ratings for the preceding 3 years and 4500 hours of post-licensure supervised practice have been average or above average;

(C) Have received at least one calendar year of supervision from the most recent supervisor; and

(D) Have the recommendation of the most recent supervisor that no further supervision be required.

EXHIBIT 11

North Carolina Psychology Board

Kristine M. Herfkens, Ph.D.
ABPP
Chairperson

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February 26, 2013

Erica Wise, Ph.D.
Psychology Practice Act Workgroup
ewise@email.unc.edu

Dear Members of the Workgroup:

The North Carolina Psychology Board members wish to thank you for providing us with the data you provided to address each of the points we raised in our letter of January 22, 2013. The Board also appreciates the time you spent meeting with its members on February 15, 2013, and reviewing the data with us.

On February 19, 2013, the Board convened a meeting via conference call to review the data you presented to consider its position about the Workgroup proposals. As previously, the Board reviewed this proposal with its sole purpose as whether these revisions would serve to protect the public of North Carolina. The Board saw the proposal as presenting four major issues. First, whether LPAs may practice independently after three years of supervision of all practice. Second, whether the licensure of LPAs should cease after September 30, 2018. Third, whether LPAs should no longer be permitted to use the title psychologist. Fourth, whether there should be a new category of licensure labeled "licensed school psychological associate." The Board revisited all of these issues as detailed below.

First, whether LPA's may practice independently after three years of supervision of all practice. The Workgroup provided the Board with data which indicated that there is no increased risk of harm to the public when independent practice is obtained by master's level practitioners after three years of supervised practice. As a result, the Board supports this proposal.

Second, whether the licensure of LPAs should cease after September 20, 2018. The Board appreciates the data that the Workgroup provided; however, the Board's position about this issue remains unchanged. It is the Board's view that this proposal would not serve to protect the public of North Carolina. If there are no longer LPAs, then the public need for services by master's level psychologists would be unmet. The Board does not find that other mental health professionals, specifically, LPCs or LCSWs, who are not trained as psychologists are trained, would be able to provide these necessary services. Without this level of licensure, this need would either be unmet or an exemption may be created in some agencies to allow these

individuals to practice unlicensed, and, therefore, unregulated. None of these options would protect the public of North Carolina. As a result, the Board does not support this change.

Third, whether LPAs should no longer be permitted to use the title psychologist. The Board's position about this proposal remains unchanged. The data presented by the Workgroup did not provide sufficient reason for the Board to change its position about this proposal. LPAs practice psychology under the same Psychology Practice Act as LPs, and as a result, it may lead to public confusion if they could not also call themselves psychologists. Therefore, the Board does not support this change.

Fourth, whether there should be a new category of licensure labeled "licensed school psychological associate." The Board's position about this proposal remains unchanged. It is the Board's position that this change would also serve to confuse the public and is unnecessary. School psychologists practice psychology under the same Psychology Practice Act as all other psychologists and such a change may lead to public confusion and would not protect the public of North Carolina. Therefore, the Board does not support this change.

Members of the Board thank you for providing us with data and meeting with us about this proposal. We recognize that the Workgroup has spent many hours and resources working on this proposal and shares our interest in protecting the public. We appreciate being given the opportunity to further comment on the proposed revisions.

Sincerely,

Kristine M. Herfkens, Ph.D., ABPP
Chairperson

EXHIBIT 12

Counselling and Psychotherapy Research, March 2007; 7(1): 54–65

Routledge
Taylor & Francis Group

ORIGINAL ARTICLE

The impact of clinical supervision on counsellors and therapists, their practice and their clients. A systematic review of the literature

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Abstract
In 2005 the British Association for Counselling and Psychotherapy (BACP) commissioned a systematic review of the research evidence related to the impact of supervision on counsellors and psychotherapists, their practice and their clients. This paper reports on some of the findings of this review, specifically from articles published in this area since 1980. Detailed inclusion and exclusion criteria were agreed. EPPI-Reviewer software was used to organise and analyse the articles that met the inclusion criteria. This article reviews 18 individual published studies. The quality of evidence is variable, but supervision is consistently demonstrated to have some positive impacts on the supervisee.

Keywords: *Supervision, supervisee, counselling, psychotherapy, systematic review*

Introduction

Supervision of counselling and psychotherapy practice is widely promoted as an essential aspect of ethical and effective therapy and is seen as the cornerstone of continuing professional development. The Ethical Framework for Good Practice of Counselling Psychotherapy (BACP, 2003) stresses the importance of supervision as supporting the practitioner in adhering to the ethical framework and being a crucial aspect of the infrastructure that underpins professional practice. In the UK, the British Association for Counselling and Psychotherapy (BACP) requires all accredited therapists to have supervision throughout their career and other organisations representing counsellors and psychotherapists strongly recommend supervision. Requirements for the supervision of therapists vary in different countries; in the USA, where most research into supervision is conducted, it is only trainees who routinely participate in supervision. A previous scoping search of supervision (Wheeler, 2003) found only 11 studies that had been conducted in Britain and only 6 studies that related to experienced practitioners, highlighting the way in which supervision research is skewed towards work with trainees.

There have been six reviews of supervision literature in recent years. The general conclusion is that various aspects of supervision, the supervisor or the relationship with the supervisee have an effect on the supervisee and their understanding of the process of therapy and practice with clients (Guest & Beutler, 1988; Hansen et al., 1982; Kilminster & Jolly, 2000; Lambert & Ogles, 1997; Milne & James, 2000; Freitas, 2002). Inspection of the inclusion criteria for these reviews reveals considerable variety. For example the Kilminster and Jolly (2000) review focussed entirely on supervision in medical settings. The Lambert and Ogles (1997) comprehensive review made methodological rigour its priority and the Milne and James (2000) review focussed specifically on cognitive behavioural supervision in the health professions with a majority of their identified studies coming from the field of learning disabilities.

There are many definitions of supervision, but for the purposes of the systematic review reported here the definition provided by Inskipp and Proctor (2001) was used:

> A working alliance between the supervisor and counsellor in which the counsellor can offer an account or recording of her work; reflect on it; receive feedback and where appropriate, guidance. The object of this alliance is to enable the counsellor to gain in ethical competence, confidence, compassion and creativity in order to give her best possible service to the client. (p. 1)

Supervision is understood to be a formal relationship in which there is a contractual agreement that the

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What does this study explore?

- A summary of research studies that provide some evidence of the impact of supervision the therapist, their practice, and their clients

therapist will present their work with clients in an open and honest way that enables the supervisor to have insight into the way in which the work is being conducted. The supervisor is understood to be accountable to the professional body to which the supervisee has allegiance (Wheeler, 2003, p. 8).

Answering questions through systematic review techniques

Systematic reviews aim to find as much as possible of the research relevant to particular research questions. They synthesise research findings in a form that is easily accessible to those who make policy or practice decisions, using explicit methods to identify what can reliably be said on the basis of these studies. In this way, systematic reviews reduce the bias that is potentially an element in other approaches to reviewing research evidence (EPPI-Centre, 2006a).

Well-formulated questions are a crucial aspect of systematic reviews as they determine which key components to focus on in the initial search for relevant studies.

Wheeler's (2003) scoping search revealed studies on models of supervision, the relationship, experiences of supervision, good and bad supervisors, training supervisors, cross-cultural dynamics, the process, roles and many other topics. Supervisees reported how valuable supervision is, but evidence to support the assumption that supervision makes a difference to clinical practice and therapist well being was not immediately obvious in many studies. Client outcome studies give an indication of the impact of supervision, but they are few.

Practitioners are well aware of the increasing demand for evidence based practice and service provision is increasingly dependent on clinical governance guidelines. Supervision is continually said to be a professional requirement but easy access to evidence of its efficacy is not obviously in the public domain. Having identified the gaps in the previous supervision review and recognising the need for tangible evidence of supervision efficacy the review question was formulated as:

> What impact does clinical supervision have on the counsellor or therapist, their practice and their clients?

Structure of review tasks

The review is a modified version of a Cochrane Review (Higgins and Green, 2005) and conducted with the use of EPPI-Reviewer software. Preparation for conducting the review involves careful consideration of the scope and focus of the work. The process is rigorous and well defined while maintaining a practical perspective. Tasks include:

- Identifying the precise definition of a systematic review question
- Determining the criteria for study selection
- Creating and using a protocol for recording the search process
- Creating and using a protocol for reviewing, recording and rating the relevance and methodological quality of each study
- Analysing the data collected from the studies as appropriate
- Ensuring that the analysis takes account of the different training systems and models of counselling and psychotherapy used internationally that may influence outcome.
- Writing a report

Scope of the review: Defining inclusion and exclusion criteria

It was decided to include published and unpublished work in English from 1980. The review sought to find and analyse empirical research (both quantitative and qualitative) that produced data that had been subject to systematic analysis; discursive articles and case studies were excluded.

It was important to include studies that had an objective measurement of the impact of supervision on the supervisee, however knowledge of the literature suggested that this would severely limit the number of studies that would be identified and the criteria were extended to include self-report. However, self-report of satisfaction with supervision was specifically excluded, as satisfaction would not necessarily correlate with the development of competence or other benefits of supervision. Studies would only be included if a valid and reliable instrument was used to quantify the impact of supervision on the supervisee or if there was a methodologically rigorous qualitative analysis of the impact.

For this review it was decided that the supervisees must be counsellors or psychotherapists or other professionals who have had a substantial training as counsellors or psychotherapists and who were specifically engaged in a counselling role with clients. Hence psychiatrists, psychiatric nurses, occupational therapists and other health professionals having supervision were excluded. There are a considerable number of studies that report on supervision of family therapy. However, family therapy often involves immediate supervision from a supervisor behind a screen, with an audio link or even in the therapy room, which was considered to be substantially different from one-to-one, face-to-face supervision that relies on recall or tape recordings of therapy

sessions. Hence supervision studies of family therapy were excluded.

Supervision often happens in pairs or groups, particularly during training, but group supervision was only included if it related to therapeutic work with individuals or couples. Group and individual supervision focusing on group work studies were excluded, as the focus of the review was on the supervision of individual or couple work. Studies were only be included if they specifically focussed on a supervision intervention that related to work with real clients. Supervision of role-play sessions for the purpose of skill development were excluded. A lot of supervision research is undertaken in the USA and, thus, most studies relate to the supervision of trainees. Careful attention was paid, therefore, to recording whether the supervision relates to trainees or experienced practitioners.

Technology is finding a role in counselling and psychotherapy and supervision is no exception. When on line or telephone supervision of counselling and psychotherapy met the other inclusion criteria for the review they were included. One to one peer supervision or peer group supervision was excluded as it would be unlikely to have reliable estimates of supervision quality.

Search Strategy

The 2003 scoping search on supervision was used as the main source of articles prior to 2002. A further search strategy was devised for studies from 2002 to early 2006.

A search strategy recording proforma was devised. Key words were identified for the search and these keywords were used in searching electronic bibliographic databases (including ERIC, PsychInfo, Medline, EMBASE, WorldCat Dissertations, IBBS and the Cochrane Database). Relevant journals were hand searched for articles from 2002. Also, bibliographies of books on supervision published since 2002 were consulted. Information was recorded about all studies that might meet the inclusion criteria after a superficial inspection of abstracts (see Figure 1 for an overview of the literature search and retrieval). Studies were included or excluded after reading the full text of possible articles.

All relevant citations were downloaded into the Endnote bibliographic referencing system; screening of citations was conducted using Endnote. When this initial screening was complete 448 references were uploaded into the EPPI Reviewer system.

EPPI-Reviewer

EPPI provides a comprehensive on line system for storing all information and citations for a systematic review, and for analysing and synthesising data. The methodology, expertise and tools developed within the EPPI-Centre have resulted in reviews being undertaken in many fields, appraising and synthesising a broad range evidence for all research questions and thus potentially to include all types of study (EPPI-Centre, 2006b).

Reviewing, recording and rating relevance and methodology of each study

The EPPI-Reviewer software was programmed with the inclusion and exclusion criteria and the articles were reviewed against these criteria. A data extraction proforma was designed and programmed into the software for recording information from included studies. This data extraction procedure addressed pertinent questions such as type of study and research, along with reliability and validity issues such as research methodology, subjects, sample size, and research bias. The relevance of each study to the review question was scrutinised. Studies that did not meet the inclusion criteria were excluded from the review.

The quality of included papers was assessed. Each study was ranked on a scale of 1–5 on how methodologically sound it was (1 = Not at all/5 = Excellent) and how well it fitted with the inclusion criteria (1 = Not at all/5 = Very Well). Each study was given a score for its overall quality on a 1–5 scale (1 = Very Poor/5 = Very Good), taking numerous factors into account: sample procedures, allocation of control comparison groups, study biases, factors favourable to developing and delivering the intervention, study limitations, inconsistencies in reporting, and the relevance of findings for the future development of supervision.

A team of four participated in the data extraction process. At least two members of the project team engaged in data extraction with full papers and a third person compared data extraction forms to confirm final decisions about each study. Any uncertain decisions were discussed with another member of the team.

Results

Table I provides details of eighteen of the included studies: authors, aims of each study, tools used, key findings and the overall quality rating of the research. Fourteen studies were undertaken in the USA (one of these being in USA and Canada); two each were from the UK and Sweden. The majority of samples are taken from a trainee population. The age range for supervisees was between 22–54 years old with early 30's being the approximate average supervisee age. Limited information was offered about the therapeutic modalities of supervisors; where details were provided orientation was as follows: Humanistic (2 studies), Psychodynamic (6 studies), Cognitive Behavioural (2 studies), Integrative (2 studies), Elective (3). 9 studies did not state the theoretical orientation of the supervisor.

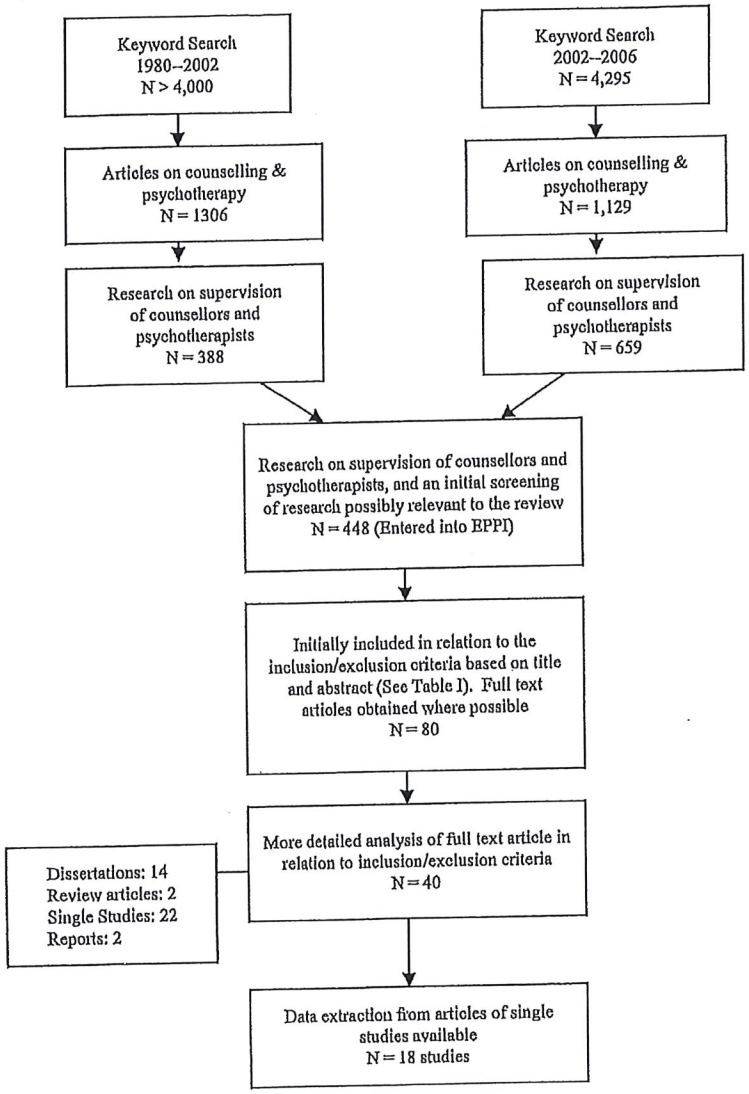

Figure 1. Overview of literature search and retrieval.

Categorisation of impacts of the supervisee

The studies on the impact of supervision on the supervisee are categorised in terms of: self-awareness, skills, self-efficacy, timing and frequency of supervision, theoretical orientation, support and outcome for the client.

Self-awareness

Two studies indicated that self-awareness is enhanced through supervision. Borders (1990) qualitative investigation into supervisee's perceptions of their development during their first semester of practice produced results that indicate that through supervision supervisees experienced significant increases on three developmental dimensions; they perceived themselves as more aware of their own motivations and dynamics, less concerned about their performance during a session and less dependent on their supervisors for direction and support. Raichelson et al. (1997), in another qualitative study focused on parallel process in supervision and found that through the parallel process, supervisees become more comfortable inviting negative transference feelings into the therapy; and that supervisees gain a deeper awareness of counter-transference issues and subjective emotional responses to clients. They gain an appreciation of the value of non-verbal, behavioral enactments and feel freer to act spontaneously, warmly and interpersonally in the therapeutic process. In summary, supervisees could be described as having gained in self-awareness, particularly as it relates to their interaction with clients.

Table 1. Detailed information of research studies reviewed.

Authors	Aims of the Study	General Research Approach	Research Tools	Results that Relate to the Impact of Supervision on the Supervisee?	Quality Score
Borders, L.D. (1990)	To investigate supervisees' perceptions of developmental changes during their first practicum semester with regard to self-awareness, autonomy and acquisition of theory and skills.	Quantitative	Supervisee Levels Questionnaire (McNeill, Stoltenberg and Pierce, 1985)	Supervisees reported significant increases on the three dimensions of development in the model. They perceived themselves as more aware of their own motivations and dynamics, less concerned about their performance during a session and less dependent on their supervisors for directions and support. They also reported more consistent application of acquired skills and knowledge when working with clients.	3 – Average
Cashwell, T.H., & Dooley, K. (2001)	To determine what effect receiving or not receiving clinical supervision on a regular basis would have on counseling self-efficacy.	Quantitative	Counseling Self-Estimate Inventory (CPSE) Larson et al. (1992)-supervisee	Those counselors receiving clinical supervision indicated higher levels of counseling self-efficacy than those not receiving clinical supervision.	2 – Poor
Couchon, W.D., & Bernard J.M. (1984)	To investigate whether the timing of supervision makes a difference to the outcome with counsellor and client	Mixed-methods	Mainly quantitative but supervision tapes were used to compile future oriented strategies list. Counseling Evaluation Inventory Video recording-supervisee and supervisor Client satisfaction with counseling	Supervision sessions conducted just prior to counseling (4 hours) appeared to have been more focused and seemed to be more of a 'planning session' for upcoming counselling. Follow through from supervision to counseling was greatest at this time. Supervision sessions held the day before counseling appeared to be more content-orientated, characterised by a focus on conceptual material taught by the supervisor. Because of the quantity of material in these supervision sessions, counselor follow thorough from supervision to counseling was lower at this time.	3 – Average
Dodenhoff, J.T. (1981)	(a) How does interpersonal attraction between supervisor and trainee affect counselor trainee behavior? (b) How do influencing messages influence counselor trainee behavior? (c) What is the interaction between interpersonal attraction and influencing messages?	Quantitative	Counselor Rating Form (Barak & LaCrosse, 1975) Rating Scale for Outcome (RSO; Storrow, 1960) Counselor Evaluation Rating Scale (CERS); Myrick & Kelly, 1971)	Trainees who were attracted to their supervisors were rated as more effective by supervisors on two measures, although attraction was not related to clients' perceptions of outcomes. A direct style of supervision was related to trainee effectiveness, but on only one of three measures of the dependent variable.	3 – Average
Efstation, J.F.; Patton, M.J., & Kardash, C.M. (1990)	The development of the Supervisory Working Alliance Inventory (SWAI) to measure the relationship in counsellor supervision	Quantitative	Supervision Working Alliance Inventory (SWAI) (Friendlander & Ward, 1984)	There is a significant correlation between some aspects of the Supervisory Styles Inventory, the Supervision Working Alliance Inventory and the Self-efficacy inventory: self efficacy inventory and supervision being task centred, self efficacy and rapport with the	5 – Very Good

Table I (*Continued*)

Authors	Aims of the Study	General Research Approach	Research Tools	Results that Relate to the Impact of Supervision on the Supervisee?	Quality Score
			Supervisory Styles Inventory (SSI) (Friendlander & Ward, 1984) Self-efficacy Inventory (SEI) (Friendlander & Snyder, 1983)	supervisor, self efficacy inventory and the attractiveness of the supervisor. The Supervision Working Alliance Inventory is a valid instrument.	
Guest, P.D., & Beutler, L.E. (1988)	To investigate the relationship between changes in the theoretical orientation and values of psychotherapy trainees and the orientation and values of their supervisors	Mixed-methods	Theoretical Orientation Questionnaire (Sundland, 1977a, 1977b) Value Survey (Rokeach, 1973, 1979) Locus of Control (Rotter, 1966) Personality (Esyenck & Esyenck, 1969)	The results showed: a) that beginning trainees value support and technical direction b) that with experience trainees come to value supervisors who hold complex, dynamic views of change c) that advanced trainees place increasing value on the assessment of personal issues and relationships that may affect the psychotherapy process	3 – Average
Ladany, N., Ellis, M.V., & Friedlander, M.L. (1999)	To investigate whether self efficacy and satisfaction increase as the working alliance becomes stronger.	Mixed-methods	Trainee Personal Reaction Scale revised, (Holloway and Wampold, 1984) Self Efficacy Inventory-SEI (Friedlander and Snyder, 1983) Working Alliance Inventory trainee version (Bahrick, 1990)	Changes in alliance were not predictive of changes in trainee's self-efficacy. However, improvements in the emotional bond between trainees and supervisors were associated with greater satisfaction.	3 – Average
Lehrman-Waterman, D. & Ladany, N. (2001)	The development and validation of the Evaluation Process Within Supervision Inventory (EPSI).	Quantitative	Evaluation Process Within Supervision Inventory (EPSI)	Evidence of reliability and validity for the EPSI measure. *Effective evaluation practices are:* a) predictive of a stronger working alliance. b) associated with stronger perception of supervisor influence and self-efficacy. c) Predictive of greater trainee satisfaction d) Have no significant relationship with trainee training level.	3 – Average
Milne, D.L., Pilkington, J., Gracie, J., & James, I. (2003)	To assess the effectiveness of CBT supervision in terms of its observed impact on a supervisee and her patient.	Qualitative	Video recording –supervisee, supervisor and client Cross-sectional design with 20 tapes from the same dyad being	The study provides limited evidence that supervision in CBT can be effective, as measured by appropriate changes in therapy consequent upon supervision.	3 – Average

Table 1 (*Continued*)

Authors	Aims of the Study	General Research Approach	Research Tools	Results that Relate to the Impact of Supervision on the Supervisee?	Quality Score
			used. Qualitative collection of data with some quantitative analysis of data	There is considerable thematic transference of an appropriate kind from supervision to therapy.	
Ogren, M.L., Jonsson, C.O., & Sundin, E.C. (2005)	To examine supervisee's and supervisors' view on focus and group climate in group supervision and their relationship with supervisee's attained skill.	Quantitative	Modified Self Evaluation Scale (MSES) – A Swedish version (Olsson, 1996) of Buckley et al., (1982) Self Evaluation Scale TAC – Topics and Climate Inventory (Olsson, 1996)	Attention to group process, psychodynamic processes, professional attitudes and theoretical aspects accounted for supervisees' perceptions of attained skill.	3 – Average
Ogren, M. L., & Jonsson, C.O. (2003)	To explore the attainment of psychotherapeutic skill of students before and after group supervision, and to compare Supervisee ratings with Supervisor ratings.	Quantitative	Modified Self Evaluation Scale (MSES) – A Swedish version (Olsson, 1996) of Buckley et al., (1982) Self Evaluation Scale	For the inexperienced therapist, group supervision contributes to greater skill, increasing confidence and self-esteem in the ability to handle important aspects of dynamic psychotherapy.	5 – Very Good
Patton, M.J., & Kivlighan, D. M. (1997)	To examine the extent to which the trainee's perception of the supervisory working alliance is related to outcomes of the supervisory process: (a) the client's perception of the working alliance in counselling and (b) the trainee's adherence to the prescribed counselling approach.	Mixed-methods	Supervisor Working Alliance Inventory (Efstation et al., 1990) Working Alliance Inventory (Horvath and Greenberg, 1989) Observation and video taping of supervisee	The supervisory working alliance has a differential impact on the types of learning that occur in supervision. The supervisory working alliance not only indexes the trainee's comfort in the supervisory relationship but also is related to the trainee's performance in counselling.	3 – Average
Raichelson, S.H., Herron, W.G., Primavera, L.H., & Ramirez, S.M. (1997)	To identify the degree to which parallel process exists in supervision and the specific effects of parallel process in psychotherapy supervision.	Mixed-methods	Parallel Process Survey designed for the study Qualitative item analysis of form and content of statements from survey	As a result of parallel process supervisees: a) cope with negative transference feelings b) are more aware of awareness of counter-transference c) understand nonverbal behaviour d) learn from supervision e) act spontaneously and warmly in the therapeutic process.	3 – Average
Steinhelber, J., Patterson, V., Cliffe, K., & Legoullon, M. (1984)	To investigate the amount of supervision and the congruence of therapeutic orientation between the therapist, the supervisor and the therapy and patient change.	Quantitative	Global Assessment of Functioning (Endicott, Spitzer, Fleiss and Cohen, 1976) Patient problem and diagnosis	Congruent supervision was more frequent with patients seen one or more times weekly. Prescription of medication was related to non-congruent supervision. Amount of supervision was not related to patient change.	2 – Poor

Table I (*Continued*)

Authors	Aims of the Study	General Research Approach	Research Tools	Results that Relate to the Impact of Supervision on the Supervisee?	Quality Score
Strozier, A.L., Kivlighan, D.M., & Thoreson, R.W. (1993)	To examine the cognitive aspects of supervision. To assess the applicability of the intentions and reactions paradigm for supervision, as well as the usefulness of the analytic technique of sequential analysis.	Mixed-methods	Session Evaluation Questionnaire (Stiles & Snow, 1984) Supervisor Intentions List Hill and O'Grady's Therapist Intention List (1985). Helpfulness Rating Scale (Elliott, 1985) Supervisee Reactions System (Hill et al., 1988)	There are meaningful sequential relationships between a supervisor's intentions and a supervisee's reactions. The sequential analyses were able to predict what led to work in supervision on the part of the supervisee. The supervisor's explore, assessment, restructure and change interventions led to supervisee's reaction of therapeutic work. Supervisee development is facilitated by focus on the relationship, support and challenge.	2 – Poor
Tracey, T.J., & Sherry, P. (1993)	To determine the validity of Kiesler's (1993) three-stage complementarity model of successful supervision by examining the interactive sequence of behaviors in successful and less successful supervisory dyads over time.	Mixed-methods	Supervision Outcome Questionnaire devised for study. Audio recordings of all supervision sessions for one year.	The results of the study were not supportive of Kiesler's (1993) hypothesized three-stage model of complementarity in supervision. No stage differences were found in the sequence of trainee and supervisor responses across the groups.	3 – Average
Vallance, K. (2004)	To explore counsellor perceptions of the impact of counselling supervision on clients.	Qualitative	Open-ended questions and semi-structured interviews	Overall, supervision does directly and indirectly impact client work in a range of helpful and unhelpful ways. *Supervision leads to*: a) increased confidence, congruence, focus, freedom and safety in the client work b) professional development through increased congruence and confidence c) supervisees not being distracted by their own emotions d) supervisees monitoring their work e) development of ethical decision making f) insight into client dynamics	3 – Average
Worthen, V., & McNeill, B.W. (1996)	To investigate good supervision events.	Qualitative	Interviews-supervisee	Outcomes of Good Supervision: • Strengthened confidence • Refined professional identity • Increased therapeutic perception • Expanded ability to conceptualise and intervene • Positive anticipation to re-engage in the struggle • Strengthened supervisory alliance	3-Average

Skills

Five studies provided evidence of skill development as a product of supervision. Borders (1990) found that supervisees reported a more consistent application of acquired skills and knowledge when working with clients as a result of supervision. Patton and Kivlighan (1997) reported that supervisees developed knowledge about building and maintaining relationships and that it was highly likely that they then used this knowledge with clients. They also demonstrated that the supervisory working alliance has a differential impact on the types of learning that occur in supervision. Raichelson et al. (1997) examined the effects of parallel process in supervision. As noted above they found that supervisees learn about a range of skills, including subjective response to the patients, inviting negative transference feelings into the therapy and nonverbal/behavioural enactments. Worthen and McNeill (1996) identified a range of outcomes of good supervision, including a supervisee's expanded ability to conceptualise and intervene when working with clients. In a study on group supervision Ogren and Jonsson (2003) revealed that supervision contributes to greater skill, with the likelihood that this skill development enhances a supervisee's ability to manage key aspects of the psychotherapeutic process. Ogren et al. (2005) also found that in group supervision, supervisees' perceptions of attained skill were a result of attention to group process, psychodynamic processes, professional attitudes and theoretical aspects. These studies indicate that both individual and group supervision improves counselling skills in a number of different ways.

Self-efficacy

Counsellors' self-efficacy beliefs are "the primary causal determinant of effective counselling action" (Larson and Daniels, 1998, p. 180), and are therefore an important component of supervision. Five studies examined supervision and self-efficacy. Cashwell and Dooley (2001) found higher estimates of self-efficacy in counsellors in supervision than those not receiving supervision. In the process of developing and validating the 'Evaluation Process Within Supervision Inventory' Leherman-Waterman and Ladany (2001) also found that effective evaluation practices were associated with stronger perception of supervisor influence and self-efficacy. Ladany et al. (1999) investigated whether self-efficacy increased as the working alliance became stronger, but found no evidence to support this assertion. In the process of validating the Supervision Working Alliance Inventory, Efstation et al. (1990) found a significant correlation between self-efficacy and supervision being task centred, rapport with the supervisor and the attractiveness of the supervisor.

Timing and frequency

The timing of supervision is an under researched aspect of supervision but two studies considered it. Couchon and Bernard (1984) investigated whether the timing of supervision made any difference to the outcome of supervision. They found that when supervision took place at different times the content of supervision did alter. For example, supervision conducted just prior to counselling (4 hours, same day) was more focused on planning for upcoming counselling, whereas supervision the day before a counselling session seemed to be more characterised by a focus on conceptual material taught by the supervisor. The follow through from supervision to counselling seemed to be greater when supervision was on the same day as counselling (within 4 hours), in comparison with supervision the day before counselling. Steinhelber et al. (1984) found that the amount of supervision bore a positive relationship to patient attendance. These results provide an indication that the timing and amount of supervision influence the process and outcome of supervision.

Theoretical orientation

Awareness, development and changes in theoretical orientation reflect the ongoing development of the supervisee, as indicated in two studies. Guest and Beutler (1988) examined the theoretical orientations and values of psychotherapy trainees. They suggest that "several years after training, early supervisory experiences may still exert an effect on one's theoretical position" (p. 653). With experience, trainees come to value supervisors who hold complex, dynamic views of change, implying that the theoretical orientation of trainees was developing. Milne et al. (2003) assessed the effectiveness of CBT supervision and found that appropriate thematic transference from supervision to therapy occurred and that observation of the thematic transfer enhanced the supervisee's awareness of how various CBT methodologies can promote change.

Support

Supervision offers a range of support for therapists. Strozier et al. (1993) examining the cognitive aspects of supervision, found that along with challenge, an environment that provides support facilitates supervisee development and that supervisees' experience of support was a result of supervisors focusing on the relationship between them both.

Client outcome

An assumed function of supervision is to improve outcomes for clients. Three studies considered the perspective of clients. Milne et al. (2003) assessed

What does this study tell us?

- Supervision has an impact on therapist self-awareness, skills, self-efficacy, theoretical orientation, support and outcomes for the client. The timing and frequency of supervision has some differential impact

the effectiveness of CBT supervision in terms of its observed impact on a supervisee and her patient. Supervision can be effective, as measured by appropriate changes in therapy consequent upon supervision. Also, there was considerable thematic transference of an appropriate kind from supervision to therapy, however, as pointed out by Milne et al. (ibid, p. 200), this does "not support the notion that a complete 1:1 transfer of actions from supervision to therapy necessarily makes for good therapy". In a qualitative study, Vallance (2004) explored counsellors' perceptions of the impact of counselling supervision on work with clients. She found that emotional support from supervision benefits counsellors and directly impacts on client work, as it ensures that counsellors are not distracted by their own emotions and prevents contamination of the client processes. Steinhelber et al. (1984) also found that congruence of theoretical orientation between supervisor and trainee supervisee was related to patient change as measured by the Global Assessment Scale (Endicott et al., 1976).

Summary

These findings enable the practice of supervision to be considered more fully and offer insight into what might be of most value for the supervisee. They indicate that supervision has positive impacts on the supervisee, whereby supervisees grow and develop through supervision. It is further evident that supervision has some impact on key developmental areas, such as skills and self-efficacy. The findings indicate that change can be measured. However, the strength of these findings needs to be considered in relation to the quality and methodological rigour of studies. Since these results are mainly from studies that have been undertaken with trainees it needs to be recognised that along with supervision, other factors may influence supervisees' development. There are numerous methodological problems associated with supervision research; many were observed in these reports, but an examination and discussion of these is beyond the scope of this paper.

The usefulness of these findings to supervisory practice is mixed. Supervision does seem to offer opportunities for supervisees to improve practice and gain in confidence, which raises the likelihood that client outcome is improved as a result of supervision. However, the link to improved outcome for clients is tentative and no studies in this review offer substantial evidence to support improvement in client outcomes. Furthermore, the majority of studies examined impacts over relatively short periods of time; the longer term impact of supervision is unknown.

Conclusions

Studies in this review provide evidence of the ways in which supervision impacts on the supervisee. Only two out of eighteen studies met the criteria to be classified as very good, an indication of the inherent complexity of supervision research. A key outcome of this review is recognition of the need to formulate a clearly defined research agenda for supervision, that takes account of long term supervision, experienced practitioners, methodological plurality including triangulation and last but not least, the client!

Acknowledgements

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Full review

Following on from this interim report the full review will be completed and available from BACP in summer, 2007 (see www.bacp.co.uk/email: bacp@bacp.co.uk).

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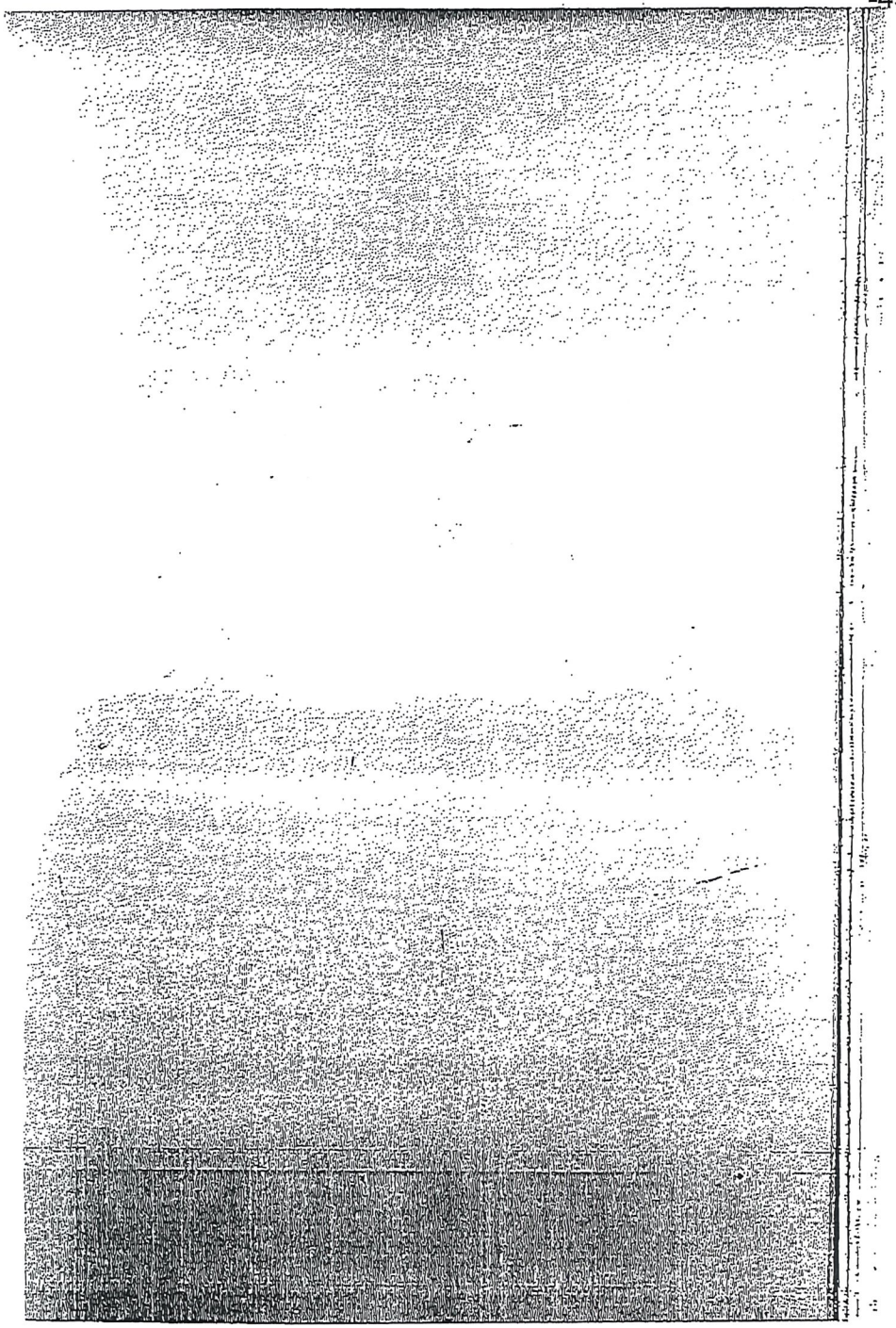
EXHIBIT 13



The Competency of Masters Psychologists as Mental Health Professionals: A Literature Review

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Abstract

This article reviews the literature concerning the professional competency of masters psychologists in contrast to the claims of some doctoral psychologists. Effectiveness data from the field is put forth to answer the empirical question of whether competent professionals are trained at the master's level. Findings of studies published in peer-reviewed journals indicate these practitioners perform capably in a variety of roles and are utilized in similar ways as other mental health professionals. Employers have routinely engaged masters psychologists in positions of real responsibility and viewed them as essential in mental health delivery systems. Barriers to more successful employment, including licensing and reimbursement issues, are noted. Finally, a professional approach is proposed to reconcile the discrepancy between the public statements of some doctoral psychologists and factual data.

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Psychologists, state regulators, managed care companies, and advocates may benefit from a review of the professional literature concerning the competency of masters psychologists[1] as mental health providers. A great discrepancy exists between what the literature indicates about their competence and what some doctoral psychologists say. Concerns voiced regarding the competence of these providers are all too often based on myths, fears, and special interests (Actkinson, 2005; Hays-Thomas, 2000; Perlman & Lane, 1981) rather than factual data or a scholarly review. *Ensuring the Future of Professional Psychology* by Cantor (1999) is a prime example. In the article, masters psychologists are viewed as a liability to the future of professional psychology and bona fide threat to the public's safety. The author portrays this advanced group of professionals as mere trained technicians who are inadequately prepared and unqualified for competent service delivery. Aside from guild policies formed around and supported by these types of public characterizations, these statements have important ethical and legal implications.

Reasons for reviewing the literature in this area also concern our ethics code and its application to masters psychologists. Conspicuous is the limited number of doctoral trainers engaged in the act of advocacy for their masters graduates, particularly when one considers the aspirational ethics of the profession. The ideal of beneficence requires trainers to look after the welfare and rights of those they train and at least attempt to resolve any apparent conflicts in a professionally responsible way that avoids or minimizes harm. As future mental health professionals, graduates with masters in psychology face significant barriers in the current marketplace, largely due to the campaign of some psychologists to define the field of professional psychology strictly as a doctoral profession.

Hays-Thomas (2000) notes, "on the topic of education and employment at the master's level, our discourse, policy, and strategy are motivated by political factors internal to psychology, in the near absence of data that could inform and guide better decisions" p. 344. She urges psychologists to attend to the needs for research in this area in order to develop public policies based on science "rather than on guild interests and the attempt to protect professional turf" p. 344. Left undetermined, however, is the question of who will fund or produce the data necessary to answer the largely empirical questions about the professional competencies and performance of masters psychologists.

The Literature

Surprisingly or not, no comprehensive reviews on masters psychologists exist in the published literature despite considerable research and the significance of masters issues in our profession. Brief reviews as introductions to new studies are as comprehensive as it gets. Lowe (1997) reviewed the employment success of masters psychologists alongside of published and unpublished surveys of masters graduates. Twenty years earlier, Colliver, Havens, and Wesley (1985) cited several earlier surveys of mental health employers as part of an introduction to their study. The current literature review seeks to expand on this meager beginning and examine in greater detail what the data says about the competence of masters psychologists in contrast to what is said by some doctoral psychologists. A total of eighteen studies are included in this review. Thirteen examine the occupational fitness of masters psychologists from employers' points of view and three of these studies concurrently investigate the employment experiences of program graduates. The remaining studies regard the reports of degree holders and former graduates of applied masters programs in psychology.

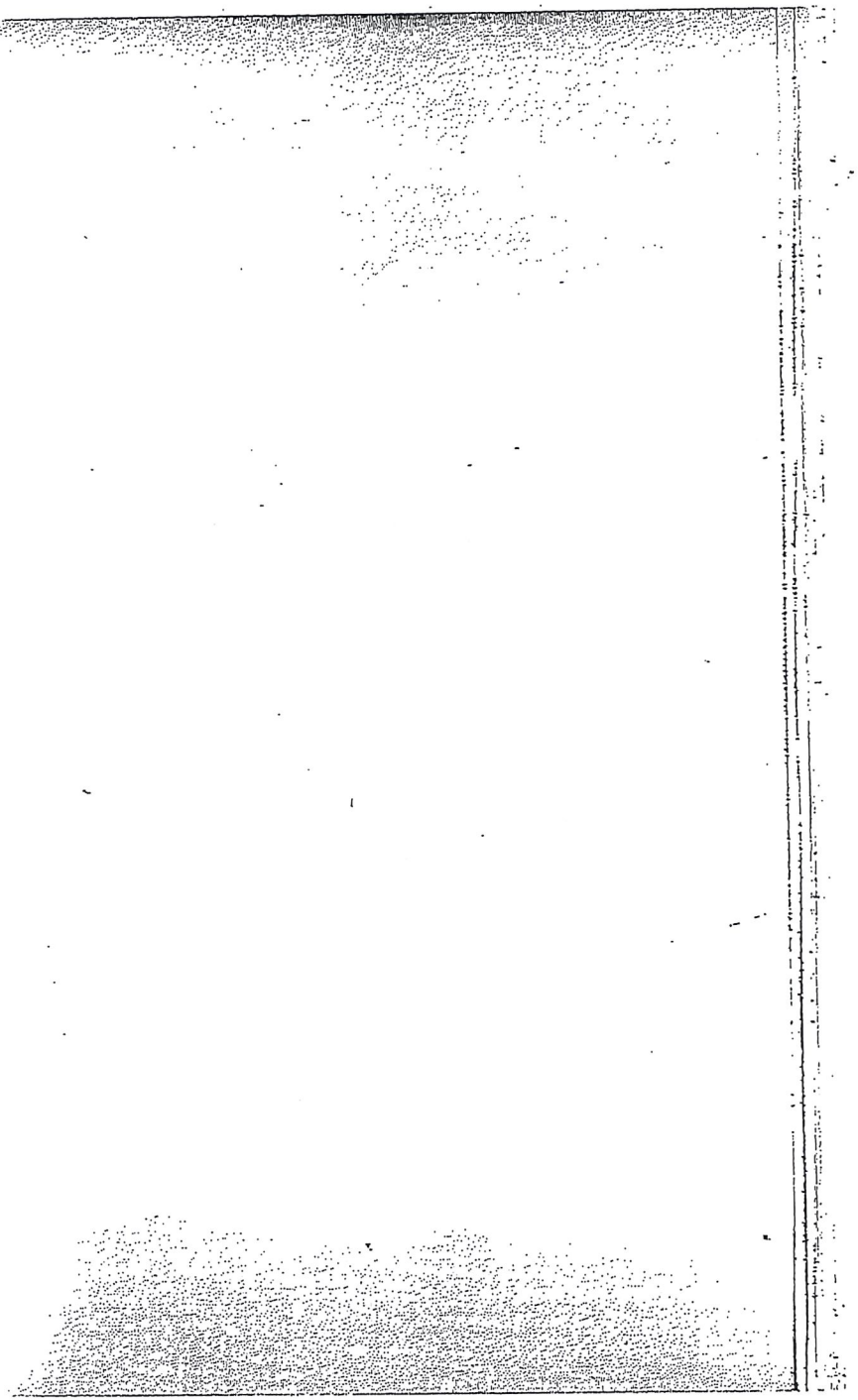
Research in this area typically involves qualitative methods with surveys, questionnaires, or interviews of employers, degree holders and program graduates. National, statewide, and local samples have been collected. Sources of data include mental health institutions, university programs, and degree holding practitioners across local regions, states and the entire U.S. Research findings have been remarkably consistent and supportive of masters psychologists. Over the last twenty-five years, researchers have analyzed hundreds and hundreds of surveys from studies of mental health delivery systems. These systems included public and private, for-profit and not-for-profit, federal, state, and local hospitals, agencies, and centers. Unfortunately, often it is not reported how many agencies or providers were exempt from state practice acts, or whether or not masters psychologists were working under supervision, or were licensed under other non-psychological titles. What researchers and the empirical literature makes known about the competence of masters psychologists follows.

What the Literature Reveals

Professionals with master's degrees in psychology are a desired, sought after group. Consistently high rates of employment reflect the widespread endorsement of masters psychologists (Dimond, Havens, Rathnow, & Colliver, 1977; Hosie, West, & Mackey, 1993; Lowe, 1997; MacKain, Tedeschi, Durham, & Goldman, 2002; Perlman, 1985; Richert & Fulkerson, 1987; Sevens, York, & Perlman, 1971; Slane, Nelson, & Siegfried, 1990; Smith & Soper, 1978; West, Hosie, & Mackey, 1987). For example, West et al. (1987) in a survey of employers published in a directory of the National Institute of Mental Health, found that 89% of the respondents employed masters psychologists. This percentage falls approximately midway between the percentages of agencies employing professionals with masters degrees in counseling (80%) and social work (95%). A chi-square analysis revealed no statistical difference in general employment rates by degree earned (psychology, counseling, and social work), as well as no statistically significant variations between large geographic regions. Researchers concluded graduates with master's degrees in psychology, counseling, and social work were not significantly different in employment patterns in comprehensive mental health service agencies.

Most recently, MacKain, Tedeschi, Durham, and Goldman (2002) investigated public health service agencies in North Carolina, including community mental health centers, state correctional institutions, state psychiatric hospitals, residential facilities for individuals with developmental disabilities, and substance abuse treatment centers. Approximately 97% of potential employers in the state reported utilizing the services of masters psychologists who were licensed professionally by the state as psychological associates. Unfortunately, this study reports neither how many agencies were exempt from the state's practice act, nor how many of these employers hired non- or other-licensed practitioners. Interestingly, a considerable proportion of their sample of program graduates was not licensed in psychology or employed in states or positions for which licensure was required.

Research historically places a majority of masters psychologists in applied settings, particularly community mental health centers and non-profit organizations. These professionals also work in private, for-profit, research, and academic settings, albeit in smaller numbers. Surveying a rather unique group, Perlman (1985) revealed private practice, community mental health centers, outpatient clinics, and mental hospitals



accounted for two-thirds of all primary job settings for APA-affiliates at the time. Perlman discovered masters psychologists had "the professional identity of a clinical practitioner and work[ed] in a variety of service-delivery settings engaged in professional clinical activities." When surveying graduates of applied masters programs in psychology, Slane, Nelson, and Seigfried (1990) reported the most common settings for employment were community mental health centers and non-profit settings, followed by school settings, doctoral programs, and for-profit settings. Investigators considered these employment patterns to be most characteristic of clinical and counseling graduates, and to a lesser extent, community psychology graduates. Colliver et al. (1985) surveyed 386 mental health agencies throughout the U.S. and found masters psychologists served essentially the same client populations as other mental health professionals.

National staffing patterns further suggest masters psychologists have demonstrated capability in business and industry. Hosie, West, and Mackey (1993) surveyed employers in the U.S. using a nationwide directory of employee assistance programs. The overall percentage of agencies employing masters psychologists was exactly equal to the percentage of agencies employing doctoral psychologists (33%). Moreover, the percentages of agencies employing psychologists with masters degrees far exceeded the percentages of agencies hiring those with doctorates for two of the three discrete types of employee assistance programs. Again, state licensing and applicability were not reported.

Expectations, Roles, and Responsibilities

Employers have been successful in finding viable positions for masters psychologists. They maintain high expectations and regularly engage these professionals in a variety of roles and responsibilities (Perlman, 1985; Richart & Fulkerson, 1987; White & Linquist, 1982; Wienberg, 1979). For example, employers in southern California expected masters psychologists to spend a great deal of their time providing "direct treatment services to clients and in testing and training activities" (White & Linquist, 1982). Offering support from another angle, research on recent graduates of masters programs and degree-holders confirms masters psychologists report being engaged by employers in a variety of professional roles including therapeutic intervention, psycho-

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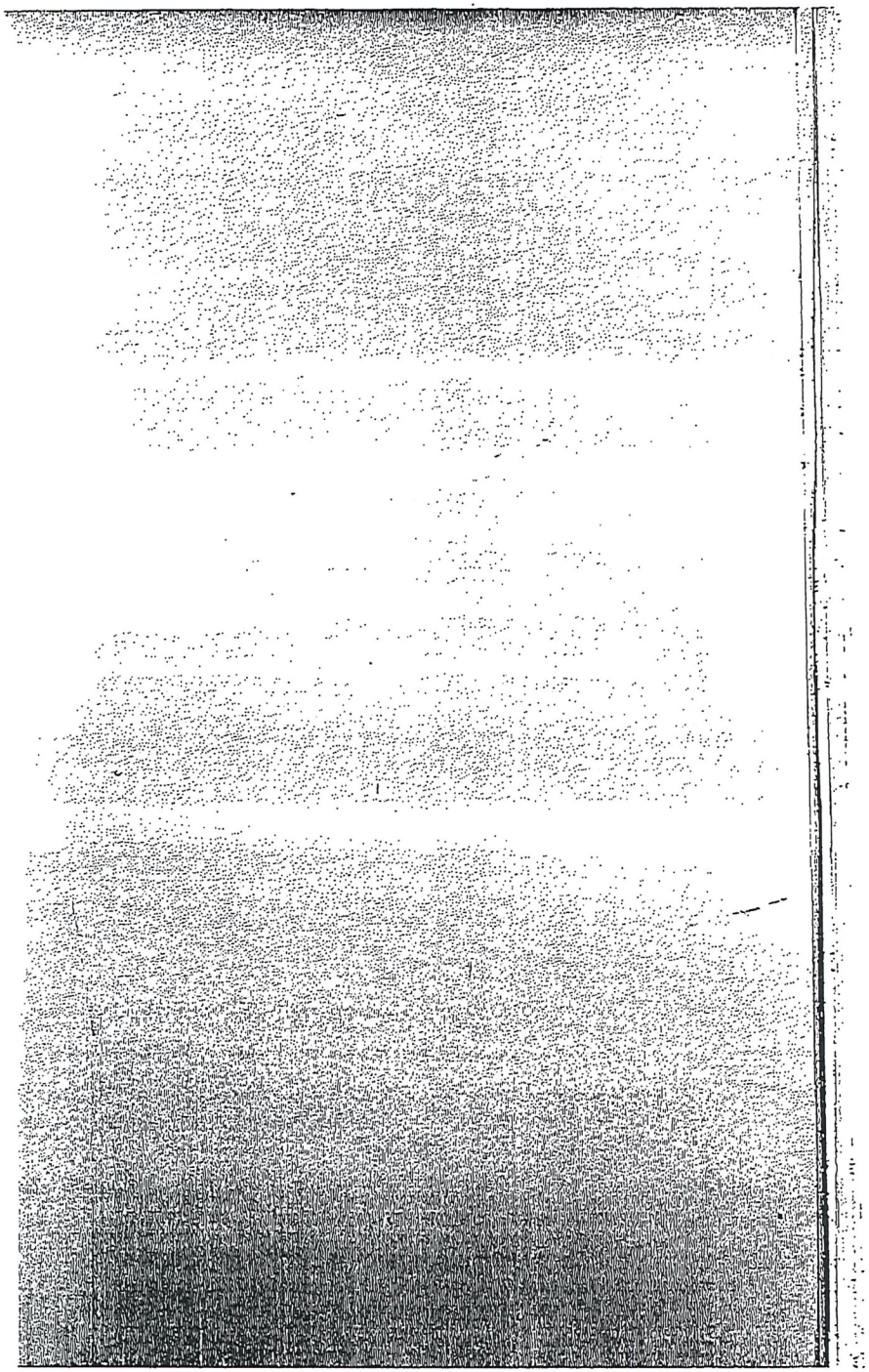
diagnostic testing, research, training, teaching, supervision, consultation, administration, and program direction (LeUnes, Bourgeois, & Oppenheimer, 1982; Perlman, 1985; Trent, 1993).

Other noteworthy responsibilities in the literature include supervision, training, and research. Trent (1993) revealed a notable finding related to supervision. State health service agencies in Tennessee reported masters psychologists spending twice as much time delivering supervision to others as receiving it. In addition, state licensees reported supervising others as much as being supervised. With concern over the apparent lack of state mandated supervision, Tent concluded that "all too often, supervision is nonexistent or a sham" p. 592. Seventy percent of mental health employers in White and Linquist's (1982) study of direct service public agencies in southern California considered the supervision of others a primary responsibility of masters psychologists within their organizations. Regarding training, Dimond et al. (1977) revealed in-service training had accounted for in the main duties expected of masters psychologists in the state of Illinois. Perlman reported APA affiliates who taught in institutions of higher learning spent approximately 20% of each workweek engaged in this professional activity. Moreover, overall percentages of masters affiliates performing the activities of supervision, teaching, and research were 41%, 25%, and 17% respectively.

Masters psychologists have been assigned routinely to positions of responsibility and not occupied by mechanical or "menial" tasks (Colliver et al., 1985; Dimond, et al., 1977; Richert & Fulkerson, 1987; White & Linquist, 1982). In 1977, Dimond et al. established "important tasks" comprised the majority of work time for masters psychologists. White and Lindquist (1982) again noted that masters psychologists were not hired to perform unskilled tasks. Employers in their study expected considerable expertise in masters psychologists including practical experience with similar populations, diagnosis and assessment skills, therapeutic goal setting and evaluation, knowledge of community agencies and referral sources, crisis intervention, training in different treatment modalities, and knowledge of ethical and legal issues. Consistent with these findings, Trent affirmed many masters psychologists in Tennessee were "functioning independently, not as mere technicians or assistants." Some authors of note, such as Perlman and Lane, suggest the responsibilities, varieties, or types of roles assigned to masters psychologists may be sufficient alone to define their professional competency.



Often masters psychologists perform the responsibilities and roles of other, even more educated, mental health professionals (Colliver et al., 1985; Havens et al., 1982; Perlman, 1985; Soper & Smith, 1978). When comparing APA-affiliated clinicians with those of doctoral psychologists, Perlman noted considerable overlap in the traditional clinical activities of both groups. He found both masters and doctoral psychologists were heavily involved in "practice, psychotherapy, testing, and consultation." Supervision, crisis intervention, and administration were also reported as three other "widely-practiced" activities. Perlman revealed masters psychologists spending more time performing psychotherapy and assessment and diagnosis than their doctoral counterparts. In addition, a greater number of masters psychologists practiced individual psychotherapy.

Colliver et al. reported masters psychologists engaged in essentially the same activities of other mental health practitioners, as reported by directors of public mental health facilities across the country. Many years earlier Dimond et al. had stated the job description in the state of Illinois sounded, "highly similar to what doctoral-level clinical psychologists may be expected to contribute to a mental health agency." Havens et al. reestablished that masters psychologists essentially shared the same functions as other professionals within mental health agencies. In fact, several reviewers of empirical data note it appears many employers do not distinguish between masters psychologists and other mental health professionals by degree type or level (Colliver et al., 1985; Havens et al., 1982; Lowe, 1997).

Competency Evaluations

Employers consider the academic preparation of masters psychologists to be sufficient for professional service, despite the contention of some doctoral psychologists. For example, Havens et al. found masters psychologists receiving positive ratings overall for academic preparation from mental health directors across the US. Colliver et al. affirmed employers' satisfaction regarding the training of masters psychologists in a survey of 386 mental health agencies throughout the U.S.

Employers have been very pleased with the performance of masters psychologists on the job. Perceptions of professional competence have been consistently high (Annis, Tucker, & Baker, 1984; Havens et al., 1982; Colliver et al, 1985; Dimond et al., 1977; MacKain et al., 2002;

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638.

Smith & Soper, 1978; Stevens, Yock, & Perlman, 1979). Without fail psychologists with masters degrees receive positive ratings for professional competence in the field. On the topic of competency, MacKain et al. recently reported the vast majority of employers in North Carolina agreed or strongly agreed these professionals were competent (97.7%), valuable to the agency (97.7%), and "among the better-trained" masters-level clinicians (82%). Unfortunately, these researchers collected little or no current information about responsibilities or work activities and focused primarily on where practitioners worked.

The richness of competency data conflicts with the notion that economically-based considerations largely explain the high rates of employment and employer satisfaction. Advancement into positions of greater responsibility provides additional evidence of actual competence (Dimond et al., 1977; Richart & Fulkerson, 1987; LeUnes et al., 1982). For example, Richart and Fulkerson (1987) found graduates of masters programs in psychology reported roles of significant responsibility, including ever-increasing supervisory roles. These researchers suggest advancement into positions of greater responsibility and consistently positive performance evaluations provide hard evidence of professional competence. LeUnes et al. informally arrived at the same conclusion regarding the esteemed alumni of their masters program.

Richart and Fulkerson conclude cost savings are inadequate alone to explain the endorsement of masters psychologists in the field. These investigators validate that the widespread employment of these individuals is based also on genuine contributions. Consistently, employers view masters psychologists as making genuine contributions in the agencies they work (Colliver et al., 1985; Havens et al., 1982; Richert & Fulkerson, 1987). Furthermore, long have masters psychologists been considered necessary and vital for adequate service delivery in mental health organizations (Colliver et al., 1985; Dimond et al., 1977; Havens et al., 1982; Stevens et al., 1979; White & Linquist, 1982). Over a quarter of a century ago, Dimond et al. reported masters psychologists were considered essential for service delivery by mental health employers. White and Lindquist and Havens et al. reestablished their importance to the public in 1982. Colliver et al. reaffirmed it in 1985 and further indicated that the majority of U.S. employers believed discontinuing masters training "would have a negative impact on mental health service provision" p. 638.

Employment Barriers

Before summarizing the empirical findings, it seems important also to note special barriers to employment reported in the literature. An understanding of the obstacles in the field makes the occupational achievements of these professionals even more remarkable. A few researchers note problems of some employers in finding masters psychologists who remain within the profession. For example, MacKain and colleagues recently discovered many public-sector employers in North Carolina valued masters psychologists and wanted to hire them *if* they were readily available. Difficulty finding psychology applicants was reported by these agencies as the most significant barrier to employment. Reasons for the lack of applicants were not fully explored or explained in the study; however, the authors noted a variety of potential barriers including the impact of managed care, lack of independent practice, state licensing laws, and supervision requirements. Other authors have noted the difficulties of masters psychologists with restrictive licensing.

Another notable concern raised by employers is non-eligibility for third-party reimbursement. This obstacle seems particularly noteworthy today as more mental health services are being delivered to clients in this manner. Employers prefer to hire other mental health professionals, rather than masters psychologists, because of their reimbursement eligibility. For example, MacKain et al. reported difficulty with reimbursement as the second highest ranked concern reported by North Carolina employers. Although they did not consider it a pervasive issue, these researchers discovered reimbursement was a concern for about a third o employers who received funding through managed care organizations. I Tennessee, Trent reported mental health agencies preferred to hire othe masters practitioners, such as social workers, rather than masters psychologists because of their statutory eligibility to receive third-party reimbursement. Thus, to some degree, insurance regulations and state l censing laws are obstacles to a more full inclusion of these practitione in mental health delivery systems.

Arguments Against Masters Psychologists

Perlman and Lane (1981) outline common arguments for a against the training of masters psychologists. These authors list a variet

of issues ranging from "folklore" to "legitimate and realistic concerns" p. 73. Some arguments against masters psychologists pertain to their employment and professional competence. According to some doctoral psychologists, the important roles of professional psychologists (i.e., scientist, diagnostician, and psychotherapist) cannot be performed by anyone without a doctoral degree. Doctoral opponents further claim that competent professionals could not be educated in such a short period of time and that subdoctoral personnel were simply nothing more than skilled technicians. Apparently, these thoughts have been left unchecked despite the continuous and mounting evidence to the contrary. Hays-Thomas (2000) recently acknowledged an even stronger belief held by some doctoral psychologists that "a master's degree in psychology, even with supervised practical experience, is insufficient training for competent mental health delivery" p. 340. She characterizes the factual discrepancy as follows: "We are faced with an issue in which data and logic are secondary to subjective opinion and emotion" p. 341.

Underlying the arguments of opponents is the basic issue of whether someone trained at the master's level can function with professional competence in the field. Even many years ago, an affirmative answer to this largely empirical question was available in the literature. Perlman and Lane responded affirmatively with a qualified yes, if one defines competency within the context of professional roles and responsibilities. Over the years, a great deal of additional research has accumulated to reveal the fitness of masters psychologists.

Conclusion

The current evidence-based review attempts to provide a more factual understanding concerning the competence of masters psychologists. The literature confirms that, despite significant employment barriers, professionals with master's degrees are viewed as competent mental health providers in the field. Contrary to the statements of some doctoral psychologists (see for example Cantor, 1999, and Plante, Boccacini, & Andersen, 1998), masters psychologists demonstrate core skills "upon which to build for role diversification;" competency in the provision of mental health service in the eyes of employers; and are not merely trained technicians. According to research published in reputable journals, masters psychologists who work in the mental health field are

widely endorsed by high rates of employment, comparable to those in other professions; work in all types of positions in similar settings as other professionals; perform traditional clinical activities; work with the same client populations as other mental health professionals; engage in a variety of professional activities including research, training, and supervision; work with and without supervision; occupy positions of genuine responsibility; perform in roles similar to other, even more educated, mental health professionals; share comparable functions as other professionals in health service agencies; demonstrate sufficient academic preparation in the eyes of employers; reliably receive positive ratings for professional competence from their employers without fail; advance into positions of greater responsibility; make real contributions within the organizations they work; are considered a vital asset for service provision in mental health systems; and often work unrecognized by other professionals, third party payers, and the states in which they live. In sum, masters psychologists appear to have established professional competency in service delivery and are widely held in high regard by mental health employers.

The current review reveals little or no evidence of psychologists with masters degrees harming or confusing the public, assuming they represented their credentials accurately and their employers were able to identify the appropriate personnel. However, a gross discrepancy exists between the public statements of some doctoral psychologists and the findings of empirical research. Regardless of the cause, professional approaches should be used to rectify the apparent contradiction. When speaking publicly and advocating special interests, doctoral psychologists must keep in mind the ethical principles of beneficence, nonmalfecience, integrity, justice, and respect for people's rights. These aspirational ideals mandate a demonstration of care for those who psychologists train and supervise as well as truthfulness and honor in professional advocacy whether for or against masters psychologists. A special ethical exemption for the statements of some doctoral psychologists against another group of esteemed professionals is neither warranted nor appropriate.

A brief excerpt from one of the early empirical studies is offered for additional consideration below. Approximately twenty years ago Colliver and colleagues struggled admirably with some empirical facts and public statements. They reasoned as follows:

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> ...Regardless, over [half] of the agencies directors in both surveys indicated that they believed discontinuation of all terminal MA-level training would have a detrimental effect on their agency's ability to provide adequate services. Given their consistently positive ratings on all dimensions of competence, it would seem inappropriate and even irresponsible to propose the abolition or disenfranchisement of subdoctoral-level clinical psychologists and clinical training programs for either of the reasons mentioned above. To do so would be a disservice to the public mental health system, to the patients they serve, and to the students who choose terminal clinical training programs because they are unable or unwilling to enter doctoral-level programs.

Interestingly, the results reported here appear to leave the critics of the subdoctoral clinician with only one objectively defensible reason for the abolition of MA clinicians, and that is to protect the status and third-party reimbursements of doctoral-level private practitioners (cf. Havens, 1979). Although this may be a reasonable, pragmatic consideration, it hardly seems to be a morally or professionally responsible reason to undermine the public mental health system or to question the professional legitimacy of the large and growing number of subdoctoral clinical psychologists who supervisors consistently view them as competent, valuable members of their staff (p. 639).

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Note 1: Masters psychologists refers to the group of psychologically-trained practitioners who hold a master's degree and provide professional services to clients. This is the term endorsed by the Council of Applied Master's Programs in Psychology and the Northamerican Association of Masters in psychology at the Third National Conference of Applied Master's Training in June 2000.

EXHIBIT 14

Why North Carolina needs more psychologists

Article originally printed 10/17/2014.

By Sandra Wartski

Gov. Pat McCrory has been traveling the state on a "Listening Tour" of 1,000 businesses aimed at promoting business growth, reducing unemployment and increasing opportunities for worker training. As an impediment to such growth, McCrory has cited worker shortages in the areas of transportation, agriculture, information technology, accounting and finance.

In a speech taped by television news crews on Sept. 25, McCrory also said our state has "enough psychologists" and workers in several other white collar fields. Soon after this gaffe, McCrory realized – or was convinced – the comment was a mistake and acknowledged it as such that same day.

It was an unfortunate misstep. However, it at least presents an opportunity for McCrory and North Carolina residents to "listen and learn" that there are not nearly enough psychologists and other behavioral health professionals to meet the demand for services in our state.

As of June 30, there were 2,662 licensed doctoral level psychologists in North Carolina. According to the U.S. Census Bureau, North Carolina's population in 2013 was 9,848,060. This means that, statewide, there was one psychologist for every 3,700 residents – or 27.3 psychologists for every 100,000. The national average is 32.77 per 100,000.

Startlingly, psychologists are not evenly distributed throughout the state, so many residents in rural areas do not have ready access to psychological treatment. Sixty-two of North Carolina's 100 counties are designated as Health Professional Shortage Areas.

Although the number of licensed psychologists continues to grow at about 4.5 percent per year, several factors were identified by the N.C. Department of Health and Human Services in a 2013 report to the General Assembly as contributors to the shortage of behavioral health professionals:

- The aging population of behavioral health providers.
- Limited training opportunities.
- The loss of public sector positions because of changes in the state mental health system.
- The lack of competitive salaries for behavioral health providers.

In fact, reimbursement for mental health services has been decreasing during the past decade. The major points of the 2013

DHHS report were the need to increase the number of behavioral health providers and to provide adequate funding for public mental health services, which has been significantly cut in recent years.

Psychologists are exceedingly well-suited to help meet the shortage of mental health providers in North Carolina. Psychologists are experts in the human experience. They are in a unique position to help people improve the quality of their lives and their ability to function on he job, with their families and in their communities. Psychologists help people live happier, healthier and more productive lives.

They apply research-based techniques to help people develop more effective habits, reduce distress and improve functioning.

McCrory's comments about the number of psychologists in North Carolina would be accurate if the mental health needs in all 100 counties were currently met. We would have enough psychologists if the needs of all schoolchildren with learning disabilities were addressed, if emergency rooms weren't packed with people suffering from emotional distress and if our jails and prisons were not crowded with individuals with serious psychological problems.

Yes, we would have enough psychologists if families were not torn apart by drug and alcohol abuse and domestic violence, if suicide and homicide did not end the lives of so many of our neighbors, if returning military veterans did not experience Post Traumatic Stress and if those affected by disasters such as hurricanes and tornadoes did not experience significant trauma

We're glad McCrory admitted his mistake and acknowledged the shortage of psychologists and other behavioral health professionals. We're ready to partner with him and his administration to rectify this problem so we can improve the behavioral health of North Carolina residents.

Together, we can build an economically prosperous, technologically advanced and psychologically healthy future.

Dr. Sandra Wartski of Raleigh is president of the North Carolina Psychological Association.