Meet the Past President: Dr. Fernelle Warren

1) What do you see as the biggest issue facing psychologists today? The biggest issue facing psychologists today is staying focused and involved in policy development relevant to psychologists. The Alabama Psychological Association (aPA) has been working with Democrats and Republicans to help oversee the health and well-being of all Americans in the pursuit of health care reform. The mission of aPA, the voices of psychology in Alabama, is to represent and enhance psychology as a science and profession and a means of promoting human welfare. As past president, I will continue to develop relationships with legislators on issues facing current and future health care.

2) Looking back on your training and career to date, who has been your most influential mentor and why? My graduate professor and mentor, Dr. Michelle Thomas, at Tennessee State University. She has been instrumental in my development as a psychologist and pushing me into the private sector as an entrepreneur.

3) What is one thing you wish you had known as a graduate student studying psychology? As a graduate student in college I wish is was more cognizant of how policy changes affect mental health in the state. I would have attended more psychology conferences and seminars to aid in policy changes in the state of Tennessee.

4) What was your favorite comfort food dish? My favorite comfort food dish is turnip greens and Jiffy cornbread.

5) Did you always know you wanted to be a psychologist? If not, what career did you think you would have? I always knew that I wanted to work in the health care field. During my early college years, I was majoring in biology with plans on attending medical school. When I enrolled in a couple of psychology courses, this help me to really focus on what I wanted to do as a career. I have no regrets.

6) If you could pick anyone in time (past or present) to have dinner with who would it be and why? I would have dinner with President Donald Trump. I would remind him of the millions of Americans who are in need of psychological services and how beneficial it would be in the long run (a healthy and productivity workforce).
### Alabama Psychologists in the News

**Schwebel honored by APA for discoveries in applied psychology**
Psychology Professor David Schwebel, Ph.D., whose research focuses on child injury-prevention, is the 2019 recipient of the Award for Distinguished Professional Contributions to Applied Research. It is presented by the American Psychological Association to those whose work has led to important discoveries or developments in the field of applied psychology.

**Donna Fleitas, Ph.D., Dan Marullo, Ph.D., & Heather Austin, Ph.D.** have been appointed as liaisons to the American Psychological Association (APA) Deep Poverty Initiative. APA President Rosie Phillips Davis, Ph.D., ABPP, has made examining psychology’s role in ending deep poverty a key initiative of her presidential year. This initiative will establish ongoing collaboration between psychological science and the public and private sectors through advocacy efforts, user-friendly science-based resources and partnerships to effect population-level change. The American Psychological Association proposes moving beyond understanding causes and consequences of poverty towards using psychological science as a catalyst to address and help solve deep poverty. Please visit the [American Psychological Association website](https://www.uab.edu/medicine/diversity/news/89-transforming-success-sessions) for more details.

**Heather Austin, Ph.D.**, has been invited to participate in the American Psychological Association (APA) Leadership Institute for Women in Psychology (LIWP). The APA Committee on Women in Psychology established the APA LIWP in 2008 to prepare, support, and empower women psychologists as leaders to promote positive changes in institutional and organizational life and to increase the diversity, number, and effectiveness of women psychologists.

**Eliza M. Belle, Ph.D.** participated as an invited speaker on a panel of experts about disaster related stress for first responder communities in Huntsville, Alabama at the National Weather Association’s Annual Meeting.

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Articles should be submitted to the Newsletter Editor via email. Email articles to: execdir08@bellsouth.net. Submissions are subject to editing for length and clarity. Article length should be a maximum of 800 words.

Publication of an article does not necessarily imply either the position or policy of aPA, the aPA Executive Council, or the Editors or Staff of The Alabama Psychologist. Opinions expressed are deemed to be the sole responsibility and position of the author. As a service, the aPA and/or The Alabama Psychologist provides a listing of groups, meetings and activities. The aPA has no way of determining the quality or substance thereof and therefore accepts no responsibility for them. Likewise, acceptance of an advertisement does not apply endorsement by the aPA, the Executive Council, the Staff or the Editors of this publication.

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This issue of the Alabama Psychologist offers readers an opportunity to earn 1 (one) CE Credit. By reading the articles provided, taking the CE quiz based on the articles, and completing the program evaluation, a 1 (one) hour CE credit will be sent to you. The following are the learning objectives for this edition of The Alabama Psychologist’s CE program:

At the Completion of this self study, the participants will be able to:

1) Identify when cannabis was first mentioned as a potential treatment and when cannabis vanished from pharmacopoeia.
2) Describe how cannabis containing substances have been used.
3) List four pathways toward approaching legal situations that clinicians are often brought into.
4) Describe the outcome of the Writ of Mandamus that is now considered case law regarding privileged information for child clients

The CE Quiz is on page 9. The Program Evaluation is on page 10.
You must score at least 80% on the quiz and submit the Evaluation Form to be awarded CE’s.

The Alabama Psychological Association is approved by the American Psychological Association to sponsor continuing education for psychologists. The Alabama Psychological Association maintains responsibility for this program and its content.

aPA Nomination/Elections

Nominations for the following positions were submitted to the Alabama Psychological Association:

Secretary: Jan 2020 through Dec 2021
Jennifer Adams, Ph.D. was nominated and will serve as the aPA Secretary beginning January 1, 2020

Alabama Board of Examiners: Practitioner (two positions):
5 year term (Jan 2020-Dec 2024)
Nancy Berland, Ph.D., Terasa Davis, Psy.D. & Robert DeFrancisco, Ph.D. were nominated. These names will be submitted to Governor Kay Ivey. The Governor will choose two to serve on the Alabama Board of Examiners in Psychology.

Licensed Psychological Technician (one position):
5 year term (Jan 2020-Dec 2024)
Lilah Aita, M.S., LPT
Only one nomination was received and will be submitted to the Governor.
Long before governments got into the business of regulating how people get high, cannabis was recognized as a potent medicinal and psychotropic agent. The written record dates back several millennia to China, where herbalists and surgeons described its beneficial effects as an anesthetic and anxiolytic, but its use as an intoxicant and medicine undoubtedly stretch well into prehistory. Because harvesting cannabis, opium, or coca leaves does not involve the type of collective planful action needed to produce alcohol (it literally does take a village to brew a beer, and some have speculated that humans transitioned from hunter-gatherer to agrarian societies primarily to be able to transform grain into alcohol), it is quite likely that plants or fungi containing psychoactive compounds (of which there are many, including not only cannabis, opium, and coca, but ayahuasca, kava kava, kratom, betel, ephedra, nightshades, psilocin-containing mushrooms, and many more) were for millennia what humans turned to in order to induce altered states of consciousness. Some of these plants had a principally ritualistic role (drug-induced religious experiences, or the so-called ecstatic visionary shamanism, meant to provide divine guidance or inspiration), others had medicinal uses, but probably more often than not they also were used for what we quaintly call today “recreational” purposes. The use of opium can be traced to prehistoric times in what is now modern Iraq. Homer referenced it in the *Iliad*. That its use was for nonmedicinal purposes can be divined from its Sumerian name *haul-gul*, which literally meant “plant of joy.”

Often mixed with alcohol or other sedatives, cannabis also has a long history in Western medicine. Extracts of hemp were mentioned in Robert Burton’s 17th century *Anatomy of Melancholy* as a potential treatment for depression; it was highly prescribed in psychiatry and medicine in the U.S. throughout the 19th and early 20th century. In combination with metallic salts like potassium bromide, alcohols like chloral hydrate, or other sedative substances, numerous cannabis-containing preparations were used as nonspecific sedatives, anxiolytics, and pain relievers, and these were a significant component of the pharmacopoeia until 1930 when a Treasury Department official named Harry Anslinger, perhaps sensing the end of Prohibition and seeking renewed job security, launched the first American “war on drugs.” By the mid-1930s, cannabis had largely vanished from the U.S. pharmacopoeia, and in 1937 it was listed by the U.S. Internal Revenue Service (then the government overseer of dangerous drugs) as a “narcotic.” By the time the first edition of Goodman and Gilman’s classic text *The Pharmacological Basis of Therapeutics* was published in 1941, cannabis, although still clinging to a listing in the official U.S. Pharmacopoeia as a therapeutic agent, was dismissed by Goodman and Gilman: “Cannabis has no rational or indispensable uses in modern medicine. While it was formerly employed empirically in migraine, insomnia, neuralgia, and many other syndromes, it is now no longer prescribed.” (p. 185 of the 1941 edition).

So there you have it. The arbiters of therapeutic drug use in the 1940s had nixed the use of cannabis as a useful drug in medicine or psychiatry, ironically for the same clinical syndromes that cannabis in the guise of “medical marijuana” is frequently used today. That is, as a nonspecific pain reliever, anxiolytic, or antidepressant. The Drug Enforcement Agency (a part of the U.S. Department of Justice) continues to list cannabis as a Schedule I drug (one that has no medical value and has a high potential for abuse). Because the U.S. government is impervious to irony, this listing persisted even though the FDA has long approved dronabinol, a synthetic version of the psychoactive compound in cannabis, delta-9-tetrahydrocannabinol, as a prescribed agent for treating AIDS-related weight loss and chemotherapy-induced nausea and vomiting. The drug, marketed as Marinol, continues to be available today, as a Schedule III drug (one that has potential for abuse but has recognized therapeutic benefit).

Cultivation of hemp, the major source of CBD, was made legal by the 2018 Farm Bill, and this has led to an explosion in the availability of CBD in multiple formulations (CBD-containing cocktails? Order one up from your friendly neighborhood bartender). This in spite of the fact that it is technically still illegal to put CBD in food for humans or animals. Former FDA commissioner Scott Gottlieb has called for a timeout, warning that CBD remains relatively poorly studied, particularly in humans, and for most commercial claims an evidentiary base is simply not there.

But rather than focusing on legal constraints, let’s look at some more practical aspects of CBD usage. In general, CBD use is probably unwise at present, simply because there are no regulatory mechanisms in place to ensure that what you consume is actually CBD (which it very well may not be) and if it is, how much of it you’re getting. Like most herbal or alternative medicines, regulatory processes are sketchy, and many if not the majority of herbal agents do not contain what the label says they do. Absent government oversight, the ability to detect adulterants or contaminants in the manufacturing process simply doesn’t exist. Readers are likely familiar with a well-known DNA analysis—found even in well-established commercial venues in the U.S. and Canada less than 50% of the supplements for sale contained the authentic product, over 60% had incorrect labels, and substitutions, contaminants, and undeclared fillers were common. Since the publication of that study, herbal marketing groups have promised to improve.

Continued on page 6
their practices, and perhaps they did, but without effective regulatory control there is no way of verifying this.

Perhaps more importantly, at the present time we really don’t have a clear picture of what CBD actually does, in part because the government’s classification of cannabis as a dangerous substance with no therapeutic value has severely limited our ability to research its actions and effects. In a nutshell, though, CBD has been claimed to lack the psychotropic effects of THC, but is said to be useful as an anxiolytic, potential antidepressant, antiseizure, and anti-inflammatory agent. (As a not-too-technical aside, please note that while CBD has been claimed to lack psychotropic properties, if it is an anxiolytic/antidepressant it is by definition a psychotropic agent. It may not be psychogenic, but that is a discussion for another time.)

Bear with me, because to understand all this a little bit of science is needed: Humans, like many if not most living creatures, have endogenous cannabinoid receptors (even invertebrates as basic as sea squirts possess some type of cannabinoid receptor). Since endogenous cannabinoid receptors are so highly evolutionarily conserved, it makes sense that they play some kind of role in regulating essential but incompletely understood homeostatic processes. Humans possess two known cannabinoid receptors, CB1 and CB2 receptors. CB1 receptors seem to be where THC binds and exerts most of its activity. CB2 receptors, like CBD, are less well understood (for a great, if technical review of endocannabinoid receptors see Bow & Rimoldi, 2016, who noted that CB2 has been called a “receptor with an identity crisis”).

**CBD does appear to have lesser affinity for CB1 receptor binding, and its action at CB2 receptors may suggest an anti-inflammatory action, among others.** While its mechanism of action is incompletely understood, CBD may serve as a competitive antagonist at CB1 receptor binding sites, and its role in epilepsy has been ascribed to a down-regulation of excitatory neural activity.

CBD in prescription form exists. Epidiolex was approved 2018 to treat Lennox-Gastaut or Dravet syndrome—two very rare seizure disorders that appear in infancy or early childhood. Dravet syndrome is generally marked by febrile seizures and is associated with hyperactivity and deficits in motor, speech, and social functioning. It may progress to status epilepticus. Likewise, cognitive, motor, and social difficulties are often present in Lennox-Gastaut syndrome, which generally begins ages 3–5 and is associated with tonic (muscle contraction) seizures.

So if you have read this far, you can see that our story is full of ironies (an undeclared filler in this column). Adding to the ironic quotient, if someone wants to consume a cannabinoid, rather than using nonprescription CBD they are far better off seeking out plain old cannabis in a state that has legalized the use of medical or recreational marijuana, because those states have regulatory mechanisms to determine things like total THC content and growing and sales of cannabis have some degree of oversight. Of course there are plenty of good reasons to use cannabinoids that are free of the psychoactive or intoxicant actions of THC. But until we have a better understanding of exactly what CBD does, it’s likely better to use it only for the purposes that have been best studied. And like all herbal substances, unless we really know what we (and the substance itself) are doing, it’s probably best that we recommend patients don’t use them.
As some of you know, I have been practicing as a psychologist for about 50 years and as a practicing attorney at law for 17 years. My law practice consumes about 10-20 percent of my time. My areas of practice in the law are elder law (wills, trusts, conservatorships, guardianships, etc.) and representing psychologists in legal forums and for Board complaints, which is the bulk of what I do as an attorney.

I was contacted by a psychologist in Birmingham, who was ordered by the Circuit Court in Shelby County Alabama, in the matter of V.C. v. B.C., to appear for deposition/hearing/trial and to produce to the defendant, a copy of all of her records pertaining to her treatment of one of the divorced parents’ minor child, who was 8 years old at the time. The psychologist is and was the treating Psychologist for the minor child only. This, of course, was a domestic case dispute regarding child custody/visititation.

The psychologist consulted with me, as her attorney, for assistance in this matter. As attorney for the psychologist, I filed a Motion to Quash the subpoena for testimony at deposition/hearing/trial and production of records on the basis that those records are privileged and not subject to discovery, as the child was not a party to the action and his records were protected from discovery by statute and case law; although, there has never been a definitive ruling in Alabama about the age at which a child has privilege and whether a parent, legal guardian, or Guardian ad Litem could waive such privilege. In Alabama, as with every other state jurisdiction, law is defined by statutes (laws) and the Appellate Courts’ interpretation of those statutes, which forms case law, which along with statutes, are considered binding law.

The Circuit Court Judge for Shelby County denied the Motion to Quash on June 29, 2016 and ordered the psychologist to submit to deposition/hearing/trial and to produce her records for the patient child to the defendant, Mr. C. On behalf of the psychologist, I then filed for a Writ of Mandamus with the Alabama Court of Civil Appeals on July 13, 2016, asking the Appellate Court to vacate the Circuit Court Order and to render an opinion on the privilege of children for their psychological records. Writs of Mandamus in Alabama are considered extraordinary and are rarely granted.

On September 12, the Alabama Court of Civil Appeals, in a unanimous decision, vacated the Shelby County Court Order and issued the Writ, directing the Circuit Court that the psychologist’s records for the minor child were indeed privileged, that the child had the privilege solely and had not waived said privilege and that the psychologist was not to produce any of the child’s records or appear at any deposition/hearing/trial on this matter. Those who wish to review the decision in its entirety may find it at Alabama Court of Civil Appeals entitled Ex parte Dr. Barbara Johnson, In re: V.C.R. v. B.C. No. 2150835 September 9, 2016. Since the decision of the Court of Civil Appeals was not appealed to the Alabama Supreme Court, it is now case law in Alabama.

This is an extraordinary outcome for this case and for the definition of the parameters of privileged communication between psychologists and their child patients. This case establishes case law in Alabama that protects all children from having their psychological records discovered by any third party, including parents, guardians, GALs, etc. at least from age 8. Currently, it should be interpreted that all children, regardless of age, retain the privilege in their communications with psychologists. The interpretation of this case law is that the privilege a child has with his/her psychologist may not be waived by a parent and a parent is not entitled to the child’s psychological records or test results without waiving that privilege at any age. Please be advised that when providing psychological services to children, a preservice agreement should be crafted and explained to the child-patient and his/her signature be obtained regarding the extent to which psychological information will be provided to the parent(s) or any other parties. While not controlling in other states, this landmark case also may be used persuasively by any other jurisdiction in the United States to protect psychological records of children from discovery.

Glen D. King, J.D., Ph.D., ABPP
Clinical and Forensic Psychologist
Attorney at Law
In the course of their ordinary activities, clinical psychologists are infrequently drawn into legal and courtroom issues. This relatively rare occurrence does not dissipate the widespread fear, anxiety, and concern that clinicians experience about legal involvement.

In some of my earlier work I have written about and researched the fear of litigation among mental health professionals. In a decade of hyperbole, I labeled these fears litophobia, although I later backed off, largely because the fears did not approach the intensity and pathology associated with real phobias. Still, therapists worry about getting sued, they worry about their clients dragging them into court as part of civil suits, and often detest the idea of testifying about the parenting competencies of their clients in custody disputes. In this present paper, I present four pathways toward approaching legal psychological situations into which therapists are brought, with the therapists often silently screaming in protest. Wait a second: I take back the word silently.

**Boundaries of Knowledge**

When therapists are subpoenaed to testify in depositions or court, there is a temptation to answer the legal psychological questions at hand. In most cases therapists will not have conducted a formal forensic assessment of the issues at hand, including emotional impairments and other consequences of personal injury and whether a person has adequate parenting skills. Both of these kinds of assessments call for explicit and detailed training and knowledge. Yet, I often see treating mental health professionals opining about whether a therapy client is impaired as a direct result of a trauma or accident, or whether the client is adept at parenting.

My advice is to be attentive to the exact questions being posed. Then look with some depth at whether you really do have the answer to such questions. For the mental health professional with a conventional and mainstream therapy and assessment practice, the best answer – indeed, the only answer – to questions about proximate causes of psychological disorders and about custody-decisions related parenting skills, is “I don’t know.” That answer is best accompanied by the explanation that no such explicit evaluation was undertaken. Furthermore, saying this initially when plaintiff or defendant’s attorneys have approached you will often keep you out of the whole courtroom brouhaha.

**Relinquishing Records**

Because therapists are committed ethically and legally to guarding privacy of clients and their records, therapists often resist giving up the full records of their clients when legally demanded. Such resistance is somewhat like offensive linemen on football teams, backing up and presenting a muscular barrier to the other side getting to the quarterback. In many instances, the clients will have signed releases or waivers. Without releases, when a court order to release records comes our way, a discussion with the attorney or court is often useful. By the way there is a big difference between a subpoena and a court order. Most attorneys can get a subpoena issued for records without much scrutiny. However, it is the court order issued by the judge that is the true legal demand for records. The APA Specialty Guidelines for Forensic Psychology offer some guidance. Guideline 8.01 reads, Forensic practitioners are encouraged to recognize the importance of complying with properly noticed and served subpoenas or court orders directing release of information, or other legally proper consent from duly authorized persons, unless there is a legally valid reason to offer an objection.

Now suppose there is content that you think offers a legally valid reason to be harmful if released. One possible action is to talk with the judge of that possible harm. Sometimes the judge will retract the order. The more common action is for the court to agree to seal the records at the request of the psychologist, or sometimes to disregard altogether the psychologist’s concerns. Think of it this way; once it comes to court procedures, it is not just about therapists or their practices anymore.

**Test Materials**

Now and then attorneys subpoena actual test materials, such as in the WAIS or MMPI or other tests. Yielding test results is okay. However, once you make copies of the stimulus materials in your WAIS-IV kit or of your MMPI or PAI items, it is a different matter. This issue is an intermittent topic of discussion on the psych-law listserve. A colleague of mine who was recently presented with just such a court order checked with the risk manager expert from the Trust liability insurance. In that situation the risk manager expert advised copying the protocol with the responses, and then blacking out the items so only the examinee’s responses remain. Here is my reading of the issue presented in terms of subpoenaing of test kit contents and items.

The preferred responses to this request, in order of desirability, are:

1. The requesting attorney should retain a psychologist to go over the results and your report and that person should already have the kit and questions available.
2. Inform the requesting attorney that professional terms of agreement with the test distributor do not permit sharing of test materials with individuals who do not meet the terms of use, and that operating copyright regulations support their position.
3. If the attorney persists, state that a court order is required for release of test materials and items and that order should include sealing of the items.
4. Some psychologists get the attorneys for the test publishers to join in the discussion. I never do.
5. If a court order comes along (remember, a subpoena is less compelling than a court order) and sealing of items is denied, then the general rule is that court order takes priority and one gives in. That is, attorneys who really care about getting the test items usually win in the end. For that reason, some psychologists just relent at the start. Relinquishing copies of test materials in a WAIS kit is another story, and may be worth digging in your heels.
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The Alabama Psychologist Quiz, Fall 2019:
1. Cannabis has a long history in Western medicine and was mentioned as a potential treatment for depression as early as the:
   A. 17th Century
   B. 19th Century
   C. 20th Century
   D. Never
2. Cannabis containing substances have been used as which of the following:
   A. Anxiolytics
   B. Pain relievers
   C. Sedatives
   D. All of the above
3. When did Cannabis essentially vanish from the U.S. pharmacopoeia?
   A. 1900s
   B. 1800s
   C. 1930s
   D. 1940s
4. According to the author why is it unwise to recommend using CBD?
   A. There is no regulatory mechanism in place to ensure that what you consume is actually CBD
   B. It is against the law
   C. CBT is the preferred treatment for depression
   D. There are too many formulations of CBD to know which is best to use

5. Based on the case discussed by Dr. King in “A child’s right to privilege,” records are discoverable for children older than 8 in the state of Alabama:
   A. By the parents
   B. By the Legal Guardian
   C. By the GAL
   D. All of the above
   E. None of the above
6. Dr. King also recommends that:
   A. Psychologists have children sign release forms to their parents so that records can be released.
   B. Psychologists never release information to parents about services provided to their child.
   C. Psychologists prepare a preservice agreement and explain to the child-patient and obtain his/her signature regarding the extent to which psychological information will be provided to the parent(s) or any other parties.
   D. None of the above
7. According to Dr. Brodsky and Dr. Parrott, a true legal demand for records is:
   A. a subpoena
   B. a court order
   C. unacceptable
   D. not a reason to release confidential information
8. A recommended first step in handling an attorney’s request for test materials is to:
   A. Call Pearson to ask for permission
   B. Have your patient sign a release, allowing you to share the test materials.
   C. Refuse to release any records without a court order.
   D. Suggest that the attorney retain a psychologist to go over the results and your report (This person should already have the kit and questions available.)
9. Dr. King initially filed a Motion to Quash on what basis?
   1. Only a guardian is allowed to see a child’s records
   2. That the records should be considered privileged as the child was not a party to the action and their records were protected from discovery by statute and case law.
   3. Privilege should not be waived in domestic violence cases
   4. The Guardian Ad Litem had not given consent
10. According to Dr. Brodsky and Dr. Parrott, the typical pathways psychologists should approach level matters are:
   A. Boundaries of Knowledge; Relinquishing Records; Test Materials, & Consultation
   B. Boundaries of Knowledge; Knowing what a Subpoena is; Not providing raw data
   C. Knowing when to say “I don’t know”; Guarding privacy no matter what; Testifying to only what you know
   D. Relinquishing Records; Contacting the Board of Examiners for Consultation
PROGRAM EVALUATION

Please indicate your agreement/disagreement with the following statements
(you must complete evaluation to receive CE’s)

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<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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<tr>
<td>Program Description was accurate</td>
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<td>4</td>
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<td>I acquired new knowledge or skills</td>
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<td>Teaching format/length was suitable to content</td>
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<td>Learning Objectives met as stated (as stated on page 4 of Newsletter)</td>
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<td>How much did you learn as a result of this CE program? Please rank 1-5 (1 being very little, 5 being a great deal)</td>
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<td>What topics would you like to see in the future?</td>
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PROGRAM TOPIC: ADHD UPDATE: Who Outgrows ADHD?

FORMAT: 1 hour lecture
CE CREDITS AVAILABLE: 1
Presenter: Dale Wisely, Ph.D.

PROGRAM TOPIC: Sleep Deprivation in Teens: Burning More than the Midnight Oil (3 CE Hours)

FORMAT: Video (90 minutes), independent reading (90 minutes)
CE CREDITS AVAILABLE: 3
Presenter: Mary Halsey Maddox, M.D. (Video)
Reading: PEDIATRICS Volume 134, Number 3, September 2014.

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