The Pennsylvania
Psychologist
MAY 2023
VOLUME 83, NUMBER 4

MENTAL HEALTH TREATMENT OF MINORS IN PENNSYLVANIA: Current and Future Considerations

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VOLUME 83, NUMBER 4 MAY 2023

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MENTAL HEALTH TREATMENT OF MINORS IN PENNSYLVANIA: CURRENT AND FUTURE CONSIDERATIONS

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The voluntary outpatient mental health examination and treatment of minors in Pennsylvania involves a combination of legal and clinical considerations. One of the issues related to the voluntary outpatient mental health examination and treatment of minors concerns the informed consent required to examine or treat a minor child.

This article reviews the Pennsylvania law associated with the informed consent necessary for the voluntary outpatient mental health examination and treatment of a minor, as well as the clinical issues associated with such interventions. This article also reviews a recent discussion by the Pennsylvania State Board of Psychology regarding this informed consent requirement, along with recent amendments to the Minors' Consent to Medical Care statute.

CURRENT LEGAL AND CLINICAL CONSIDERATIONS

In Pennsylvania, the age of majority is 18 (23 P.S. §5101). Prior to age 18, there are limitations concerning a minor's ability to make binding legal decisions.

The question arises, therefore, as to whose consent is required for the voluntary outpatient mental health examination or treatment of the less than 18-year-old minor. This issue generally is dependent upon the legal custody and the age of the minor.

Presently, there are a myriad of family constellations that include a minor child. For the purposes of this article, we will consider a family consisting of a mother, a father, and a minor child.

NON-CUSTODY ORDER SITUATIONS

In 1970, the Pennsylvania legislature adopted the Minors' Consent to Medical Care statute (35 P.S. §10101). This statute held that other than in a number of limited situations, such as if the minor is married, a high school graduate, or emancipated, parental or guardian consent is necessary to provide medical treatment to the less than 18-year-old minor. The statute was silent, however, as to the consent necessary to provide nonmedical mental health treatment to a minor.

In January 2005, the Minors' Consent to Medical Care statute was amended to address the voluntary outpatient mental health examination or treatment of a minor (35 P.S. §10101.1). On July 23, 2020, a number of additional amendments were made to the statute.

Pursuant to the Minors' Consent to Medical Care statute, *mental health treatment* is defined as follows:

> A course of treatment, including evaluation, diagnosis, therapy and rehabilitation designed and administered to alleviate an individual's pain and distress and to maximize the probability of recovery from mental illness. This term includes care and other services whichsupplement treatment and aid or promote recovery (35 P.S. §10101.l(a)(lO)(b)).

This definition, in essence, encompasses what psychologists generally refer to as a *psychological evaluation* or *ongoing psychotherapy*.

This Minors' Consent to Medical Care statute distinguishes between minors less than 14 years of age, and minors 14 to 17 years of age.

For minors less than 14 years of age, the consent of a parent is required prior to instituting the voluntary outpatient mental health examination or treatment of the less than 14-year-old minor (35 P.S. §10101.l(a)(l)). It should be noted that this statute does not state that such examination or treatment shall be instituted in these situations. Rather, the statute states that such examination or treatment of the less than 14-year-old minor may be instituted with the consent of a parent.

For minors 14 to 17 years of age, there are two possible avenues of consent.

First, if the minor is capable of making mental health treatment decisions, the 14- to 17- year-old minor may consent to their own examination or treatment, absent any parental consent or permission (35 P.S. §10101.l(a)(2)). Second, a parent can consent to the examination or treatment of the 14- to 17- year-old minor, absent the consent of the minor

(35 P.S. §10101.l(a)(l)).

On July 23, 2020, a number of additional amendments were made to the Minors' Consent to Medical Care statute. One of these more recent 2020 amendments reads as follows:

> A minor or another parent or legal guardian may not abrogate consent provided by a parent or legal guardian on the minor's behalf to voluntary... outpatient treatment... (35 P.S. §10101.l(a)(3)).

The exact meaning of this particular 2020 amendment is unclear. That is, under the prior 2005 version of the statute, the consent of only one parent was required to consent to the voluntary outpatient mental health treatment of the minor child. It was the working assumption that the nonconsenting parent could not abrogate the consent of the consenting parent. Under the 2020 version of the statute, this assumption has been codified by more specific language.

Presently, the legislative intent underlying this particular amendment is unclear. More specifically, it is unclear whether this particular amendment was added to clarify the existing rule, or whether this particular amendment was added to grant more substantive rights to the consenting parent.

The more recent amendments to the Minors' Consent to Medical Care statute, however, do not state that mental health examination or treatment of the minor child shall be instituted following the consent of a parent. Rather, the statute continues to state that mental health examination or treatment of the minor child may be rendered following the consent of a parent.

For this reason, in addition to obtaining the requisite informed consent, the potential treatment provider, prior to instituting any clinical intervention, also must consider and balance the clinical issues associated with the case at hand.

That is, when providing mental health examination and treatment to minors of any age, it often is helpful to have the permission, involvement, and input of both parents, even with the older adolescent. Such commitment and input by both parents may be necessary to effectuate a positive clinical outcome in the case. In addition, it is necessary for the treatment provider to remain a neutral party and maintain professional boundaries, especially in cases that involve more contentious or high-conflict families.

It is for these reasons, therefore, that the legal ability to institute mental health examination or treatment of a minor child by the consent of a parent does not answer the clinical question as to whether examination or treatment should be instituted. Rather, this clinical question must be answered on a case-by-case basis.

CUSTODY ORDER SITUATIONS

Custody involves the physical custody and the legal custody of the minor child. The physical custody and legal custody of the minor child can be sole or shared between the parents.

The provisions of the physical custody and the legal custody of the minor child are contained in the written custody agreement or the custody court order. For this reason, it is vital to obtain and review the custody agreement or the custody court order prior to instituting any type of mental health examination or treatment of a minor child.

In Pennsylvania, there is a statutory definition of legal custody. *Legal custody* is defined as the right to make major decisions on behalf of the child, including, but not limited to, medical, religious, and educational decisions (23 Pa. C.S. §5322(a)).

Under 23 Pa.C.S. §5322(a), there is no further statutory definition as to what constitutes a major decision in a shared legal custody situation. The question arises, therefore, as to whether under 23 Pa.C.S. §5322(a), the decision to seek voluntary outpatient mental health examination or treatment of a minor child constitutes making a major decision concerning the child.

In February 2000, a Pennsylvania psychologist underwent a Pennsylvania State Board of Psychology licensing proceeding related to the issue of establishing a professional relationship with and providing psychological services to a minor child in a shared legal custody situation.

The proceeding involved interpretations of prior Board decisions, American Psychological Association Standards and Guidelines, Pennsylvania custody law, and Pennsylvania case law.

Following a Board finding that was adverse to the psychologist, the case was appealed to the Commonwealth Court of Pennsylvania, the Pennsylvania appeals court that reviews licensing board determinations. The Commonwealth Court appeal was decided on June 2, 2003 *(Jan C. Grossman v. State Board of Psychology, 825 A.2d 748).*

In *Grossman*, the psychologist was retained by a mother's attorney in a 1996 custody matter in which the mother and father shared legal custody of their minor child. The referral questions included, in part, a request to determine whether the minor child could verbally assess her needs, a request to determine whether the minor child could communicate realistically, a request to determine whether the minor child could describe her two home environments, and a request to evaluate a prior determination by another psychologist that the minor child was not a reliable witness.

The psychologist reviewed background materials, met with the mother and the stepfather, and met individually with the minor child on two separate occasions. At the time of the two meetings with the minor child, the psychologist had obtained consent from the mother to meet with the minor child. At the time of the two meetings with the minor child, the psychologist had not obtained consent from the father to meet with the minor child.

The psychologist did not render a written report. The psychologist subsequently testified at a custody trial regarding his clinical findings.

In February 2000, a formal complaint was filed against the psychologist. Following an adverse finding against the psychologist, the case was appealed to the Commonwealth Court of Pennsylvania.

In its 2003 opinion, the Commonwealth Court found that the psychologist had conducted a psychological evaluation of a minor child in a shared legal custody situation without first obtaining the consent of the child's two legal custodians. The Commonwealth Court held that this professional psychological activity was in violation of the American Psychological Association standards and guidelines that are incorporated into the Pennsylvania Psychologists Practice Act.

In reaching this finding, the Commonwealth Court also based its opinion on Pennsylvania shared legal custody law and related Pennsylvania appellate decisions involving shared legal custody.

One of the bases of appeal in *Grossman* concerned the question as to whether a request that a minor child undergo a psychological evaluation, within the context of a shared legal custody situation, constitutes a major decision, thereby requiring the consent of both legal custodians. The Commonwealth Court answered this question in the affirmative. More specifically, the Commonwealth Court found that a decision to obtain a psychological evaluation of a minor child is a major decision that is encompassed within the statutory definition of legal custody.

The Commonwealth Court held, therefore, that the consent of all legal custodians is necessary prior to conducting a psychological evaluation of a minor child in a shared legal custody situation.

To date, there has been no Commonwealth Court case that has overturned this decision. Rather, this decision has been cited in subsequent cases in which psychologists have been found to have transgressed this rule (see, for example, *Laurie S. Pittman, Ph.D. v. Bureau of Professional and Occupational Affairs, State Board of Psychology*, unreported Commonwealth Court opinion, No. 1007 C.D. 2018, filed June 12, 2019).

In addition, since 2003, this decision has been interpreted and applied in situations involving the mental health treatment of a minor child.

As outlined above, on January 24, 2005, 2 years following the 2003 *Grossman* Commonwealth Court decision, the Pennsylvania state legislature amended the Minors, Consent to Medical Care statute. For the first time, the Pennsylvania legislature addressed what type of parental consent is necessary for the voluntary outpatient mental health examination or treatment of a minor child. On July 23, 2020, the Pennsylvania state legislature passed additional amendments to the Minors' Consent to Medical Care statute.

This Minors' Consent to Medical Care

statute raises a confounding legal question. That is, pursuant to the 2003 *Grossman* Commonwealth Court opinion, if a custody order contains a provision of shared legal custody, the consent of both parents is required prior

to conducting voluntary outpatient mental health examination or treatment of the minor child.

Pursuant to the Minors' Consent to Medical Care statute, however, the consent of only a parent is required prior to conducting voluntary outpatient mental health examination or treatment of a minor child. And, to confound things further, under the statute, no parental consent is necessary to conduct voluntary outpatient examination or treatment of the greater than 14-year-old minor child who is capable of providing their own informed consent to treatment.

In this regard, which rule applies: The court order containing a shared legal custody provision, or the Minors' Consent to Medical Care statute?

From 2003 through the current time, the prevailing rule has been that a court order that provides for shared legal custody of a minor takes precedence over the Minors' Consent to Medical Care statute.

This interpretation has been relied upon by the state attorneys who prosecute licensing board complaints, as well as by the Pennsylvania State Board of Psychology who have followed the principles contained in the *Grossman* Commonwealth Court decision in imposing discipline on psychologists. This interpretation has been applied to a psychological evaluation of a minor child in a shared custody situation, as well as to psychological treatment of a minor child in a shared custody situation.

DECEMBER 2, 2019 MEETING OF THE PENNSYLVANIA STATE BOARD OF PSYCHOLOGY

This issue of whether a court order containing a shared legal custody provision prevails over the Minors' Consent to Medical Care statute was discussed during the executive session portion of the Pennsylvania State Board of Psychology's December 2, 2019, meeting. Such executive session discussions are held outside the presence of the public.

The Board discussed this issue further during the public portion of their meeting. This public discussion is contained in the Final Minutes of the Board's December 2, 2019, meeting (p 26-28). The Final Minutes of the Board's December 2, 2019, meeting can be found on the Pennsylvania State Board of Psychology website.

In the Final Minutes of the Board's December 2, 2019, meeting, there is a discussion as to whether the original 2005 amendments to the Minors' Consent to Medical Care statute abrogated the *Grossman* opinion as it applies to voluntary outpatient mental health examination and treatment of a minor child. This discussion included a comment that the *Grossman* decision was a decision based on policy that was inconsistent with existing law.

In the Final Minutes of its December 2, 2019, meeting, there is discussion that there is no expressed language within the American Psychological Ethics Code requiring both parents' consent for a child to receive treatment. The discussion noted that for this reason, the reliance on the American Psychological Association ethics code in terms of informed consent was misplaced in that there is no requirement within the American Psychological Association Ethics Code for both parents' consent for the treatment of minors.

The discussion noted further that the American Psychological Specialty Guidelines on Child Custody evaluations do not require both parents' consent,

although it would be below the standard of care to perform a child custody evaluation without obtaining both parents' consent, which is different than assessment and treatment.

The Board also discussed the fact that the Board does not provide advisory opinions. The Board discussed whether regulatory changes were in order to clarify the Board's scope of authority and discretion, as well as clarifying that the Board's authority is consistent with the scope of the Minors' Consent to Medical Care statute.

It was commented that the Board adjudicates facts, and thus further clarification would be an adjudication of law. It was commented further that there was no need to change the regulations, and if it were litigated, ultimately a court would decide.

It should be noted that when discussing the Minor's Consent to Medical Care statute during the course of its December 2, 2019, meeting, the Board did not reference the Pennsylvania legal custody statute or the Pennsylvania appellate shared legal custody cases that were relied on in the 2003 Commonwealth Court *Grossman* opinion.

In addition, this December 2, 2019, Board discussion occurred prior to the more recent July 23, 2020, amendments to the Minors' Consent to Medical Care statute.

FUTURE CONSIDERATIONS

In light of the December 2, 2019, discussion held by the Pennsylvania State Board of Psychology, coupled with the July 23, 2020 amendments to the Minors' Consent to Medical Care statute, the question arises as to whether there has been a change in the type of consent necessary to institute voluntary mental health examination or treatment of a minor child in a shared custody situation.

In general, the rules governing the practice of Pennsylvania psychologists emanate from Pennsylvania statutes, Pennsylvania State Board of Psychology Regulations, Pennsylvania State Board of Psychology decisions, and Pennsylvania caselaw. The minutes of a Board meeting are public in nature and they contain discussions regarding issues or questions that are being considered by the Board. Such discussions, however, generally do not constitute the type of legal authority required to alter an existing rule or requirement.

There also is the legal doctrine of *stare decisis*. This doctrine is a legal principle by which judges are expected to respect precedent that has been established by prior court decisions. As outlined above, there presently is no Pennsylvania appellate case that has overturned *Grossman*.

Based upon the discussion contained in the Final Minutes of the Board's December 2, 2019, meeting, it is appears that the State Board of Psychology is exploring the type of parental consent that is necessary to conduct a psychological evaluation of a minor child or to provide psychological treatment of a minor child in a shared legal custody situation. Presently, however, there have been no formal changes to the existing rules.

The July 23, 2020, amendments to the Minors' Consent to Medical Care statute state in more specific language that consent of a parent for the voluntary outpatient mental health examination or treatment of a minor child may not be abrogated by another parent. Since this rule was implicit in the prior version of the statute, it is unclear whether it was the intent of the Pennsylvania state legislature to clarify the existing rule, or whether it was the intent of the Pennsylvania state legislature to overrule the *Grossman*

decision that requires joint consent in a shared custody situation.

In this regard, how should a Pennsylvania psychologist proceed?

For example, one parent in a shared legal custody situation requests and provides consent for a minor child to undergo a psychoeducational evaluation. Can (or should) the psychologist proceed with the evaluation?

One parent in a shared legal custody situation requests and provides consent for a minor child to undergo a psychological evaluation to address concerns regarding attention, concentration, and acting out behavior. Can (or should) the psychologist proceed with the evaluation?

One parent in a shared legal custody situation requests and provides consent for the minor child to undergo a psychological evaluation to explore a recent regression in social functioning? Can (or should) the psychologist proceed with the evaluation?

One parent in a shared legal custody situation requests and provides consent for the minor child to enter into treatment to help navigate the disruption of the family constellation. Can (or should) the psychologist proceed with the treatment?

One parent in a shared legal custody situation requests and provides consent for the minor child to enter into treatment to cope better with the demands of the physical custody arrangement. Can (or should) the psychologist proceed with treatment?

Once again, all of these situations involve what type of informed consent is required to proceed with the clinical intervention, as well as the clinical propriety of proceeding with the intervention absent the involvement and input of both parents.

In addition to these informed consent and clinical concerns, there is a question as to what, if any, legal jeopardy the psychologist may be placed when conducting an examination or treatment of a minor child pursuant to the consent of one parent in a shared legal custody situation. That is, will the Pennsylvania prosecuting attorneys who review and file licensing board complaints continue to file complaints based on the 2003 *Grossman* decision or will they alter their decisions based on the Minors' Consent to Medical Care statute and the Board's December 2, 2019 discussion?

If a formal board complaint is filed against a psychologist for conducting an assessment or instituting treatment of a minor child with the consent of only one parent in a shared legal custody situation, will the psychologist be able to present a successful defense to a *Grossman* violation based on the Minors' Consent to Medical Care statute and the Board's December 2, 2019, discussion?

If a malpractice action is filed against a psychologist that is predicated on a violation of Pennsylvania shared legal custody law and related shared custody case law, will the psychologist be able to present a successful defense based on the Minors' Consent to Medical Care statute and the Board's December 2, 2019, discussion and thereby shield themselves from civil liability and monetary damages?

Unfortunately, these questions remained unanswered. Each psychologist, therefore, will need to proceed in their own manner until there are more definitive answers to these outstanding issues.

More specifically, even in a situation where a psychologist determines that it would be clinically appropriate to conduct an assessment or institute treatment of a minor child with the consent of only one parent in a shared legal custody situation, the potential legal jeopardy of the psychologist remains unclear. As discussed by the Board during the course of its December 2, 2019, meeting, if such a case were litigated, ultimately a court would decide.

In this regard, one or more legal test cases may be necessary to answer these outstanding questions.

The practice of psychology should not be conducted in a defensive manner. The practice of psychology should not be conducted merely in a risk management fashion. Rather, the practice of psychology should strike a judicious balance between the mandated rules and the clinical needs of the case at hand.

Nonetheless, pending further legal clarification, guidance, and a possible test case, it may be prudent for psychologists to consider adhering to the joint consent requirements contained in the *Grossman* decision prior to instituting voluntary outpatient mental health examination and treatment of a minor child in a shared legal custody situation.

CLASSIFIEDS

"I KNOW YOU HAVE BEEN SUFFERING, BUT I THINK THAT I CAN HELP YOU"[1]

SAMUEL KNAPP, EdD, ABPP

Eighteen-year-old Rebecca sat at the edge of her bed and waited for her parents to fall asleep. It was not hard for her to stay awake, she had trouble sleeping anyway. Rebecca went slowly and quietly down the steps and went into the kitchen where the knives were. She had cut herself before, but this time was different. She wanted to die. She could not stop the thoughts. She hated herself, She was a real fuck-up. People would be better off if she were dead.[2] As she entered the kitchen, her dog Michael wagged his tail and jumped up on her. Rebecca petted Michael, turned around, and went back upstairs.[3]

The next morning Rebecca talked to her mother. Later that day they entered a psychologist's office. Dr. Jane said, "Rebecca, tell me in your own words how it came that you wanted to kill yourself." Rebecca was quiet and appeared to be struggling to find her words. Dr. Jane said, "Take your time, start anywhere you want."[4] When Rebecca finished, Dr. Jane said, "I know that you have been suffering for a long time, but I think I can help. Together we will find solutions."[5]

One hour later, Rebecca left Dr. Jane's office with an appointment card and a safety plan that she developed with Dr. Jane.[6]

When she got home, Rebecca sat on the couch and petted her dog. Her mother put her arms around her and cried.[7]

ENDNOTES

[1] This is a composite and is not based on the experiences of any one person.

[2] People often feel intense emotional pain before a suicide attempt. They may feel hyperarousal (agitation or insomnia) and have ruminations and tunnel vision. Rebecca may feel self-hatred, entrapment, or a belief that her pain is unbearable and there is no escape (Galynker, 2017; O'Connor, 2021), or perceived burdensomeness, or a belief that others would be better off if she were dead (Joiner et al., 2009). Effective treatment would help her to develop cognitive flexibility and less rigidity and help her to better regulate her emotions.

[3] There are many anecdotes of persons having their suicidal attempts interrupted by an incidental or casual event, such as a kind word or a friendly smile from a stranger (O'Connor, 2021).

[4] Dr. Jane is starting a narrative assessment in which patients are encouraged to tell their own stories, in their own words, at their own pace (e.g., Bryan & Rudd, 2018).

[5] Dr. Jane is offering realistic hope because she is using interventions that have been proven to be effective with many suicidal patients when delivered with care and compassion. Her attitude is consistent with good patient care that emphasizes listening carefully to patients, explaining treatment procedures clearly, involving patients in decisions throughout treatment, and asking patients about their perceptions of the process and progress in treatment (Knapp, in press; Michel & Jobes, 2011). Dr. Jane also stated that she has faith in Rebecca's ability to find solutions for herself. This is what is similar to what Jobes tells patients as part of the Collaborative Assessment and Management of Suicide protocol ("The answers to your struggles exist within you—we will find those answers together as treatment partners, helping you to learn to cope differently and endeavoring to help you find a life that you actually want to live, one that is defined by purpose and meaning," 2016, p. 54).

[6] Collaboratively developed safety plans reduce suicide attempts by an average of 43% (Nuij et al., 2020). Unlike no-suicide contracts that only tell patients what they cannot do, safety plans offer patients options that they can use to reduce their distress.

[7] Social support is an integral factor in well-being. Persons with strong social support are less likely to have thoughts of suicide. Many, but not all, patients benefit from some kind of family involvement in treatment. The death of a child by suicide would have been catastrophic for Rebecca's mother who would have to live with the loss of her daughter as well as the guilt that she should have done things differently and the social stigma of having lost a daughter by suicide. For every person who dies from suicide, several people will have their lives profoundly harmed; more will experience a deep impact and dozens will have some kind of noticeable impact.

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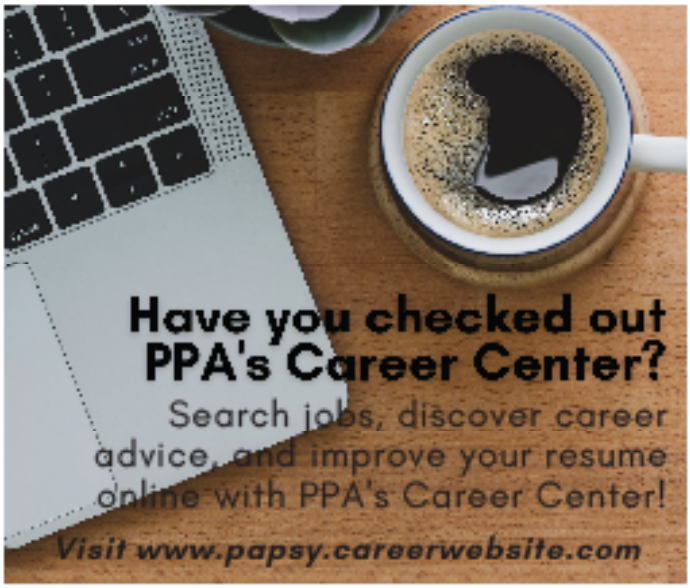

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