Treating Lesbian, Gay, Bisexual, and Transgender (LGBT) Veterans in the VA

When Examiners Must Look for Evidence of Competency
Floyd L. Jennings, J.D., Ph.D., ABPP

From Conversations to Action
Bonny Gardner, Ph.D.

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www.linkedin.com Texas Psychological Association
In the past I shared with you the challenges I experience when lobbying on your behalf. You might find it hard to believe, but I often still have Texas legislators ask me “What is a psychologist?” and “What type of practice do they have?” They understand you are mental health professionals, but in comparison to all mental health providers, I do not believe they understand the specific role you play in providing mental health services. Let me explain.

Last year during the 83rd legislative session, House Bill 1023 was passed, which charged the State to research and analyze the mental health workforce shortage and make recommendations on how to deal with these shortages. This mandate was given to the Commissioner of Health and Human Services, who designated the Department of State Health Services (DSHS) to fulfill HB 1023 requirements.

DSHS conducted a literature review, sought out information from stakeholders to include mental health professionals, and ultimately came up with five recommendations. The literature review revealed several statistics (most of which all of us already knew).

According to MentalHealth.gov:
- One in five American adults experiences a mental health issue.
- One in 10 young people experiences a period of major depression.
- One in 20 Americans lives with a serious mental illness, such as schizophrenia, bipolar disorder, or major depression.
- Suicide is the 10th leading cause of death in the United States. It accounts for the loss of more than 38,000 American lives each year, more than double the number of lives lost to homicide.

According to a 2011 study conducted by the Hogg Foundation:
- It is estimated that nearly 46.4% of all adults will experience a mental illness in their lifetime with 26% of these individuals experiencing mental illness annually.
- Only 36% of those persons with mental illness will actually seek mental health treatment.

In children, the facts are even more alarming. According to the Agency for Healthcare Research and Quality:
- For those under 18 years of age, the top five medical conditions were mental disorders, asthma, trauma-related disorders, acute bronchitis and upper respiratory infections and otitis media, with mental disorder being number one.
- Mental disorders were the most expensive condition costing over $13.8 billion.
- Nearly half of the expenditures for mental disorders in children were paid by Medicaid.

And finally, according to the Center for Studying Health System Change:
- Sixty-five percent of primary care physicians were unable to refer their patients to quality mental health practitioners.

We understand the problem, but do we have the mental health providers to meet the demand? According to DSHS, as of September 2013, there were 566 actively licensed psychologists in Texas with a clinical specialty. This leaves us with a ratio of 47,111 Texans per psychologist in our state. An even more alarming statistic is that 21% of Texas clinical psychologists were 65 years or older. Additionally, another 27% were between 55 and 64 years old. This combined population indicates that over 48% will be retirement age by the year 2023. That is only nine years away!
So, how does this measure up to the other mental health professions’ numbers? Our 566 clinical psychologists compare to 1,933 psychiatrists offering direct patient care; 6,316 clinical social workers; 3,062 marriage and family therapists; and an unbelievable 18,641 licensed professional counselors. Additionally, there are even more specific niche mental health providers among these numbers: 8,743 chemical dependency counselors were reported. So in 2013 there were a total of 39,261 mental health providers of which ONLY 1% were psychologists!

The federal Health Resources and Service Administration (HRSA) calculates that a Health Professional Shortage Area (HPSA) is defined by a population of 9,000:1 (Core Mental Health Providers (CMHP)).

So, with 566 clinical psychologists, our ratio within the state breaks down as such:

<table>
<thead>
<tr>
<th>Geographical Designation</th>
<th>Population per Clinical Psychologist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan, Non-Border</td>
<td>40,031</td>
</tr>
<tr>
<td>Metropolitan, Border</td>
<td>159,193</td>
</tr>
<tr>
<td>Non-Metropolitan, Non-Border</td>
<td>123,622</td>
</tr>
<tr>
<td>Non-Metropolitan, Border</td>
<td>20,024</td>
</tr>
<tr>
<td>TEXAS</td>
<td>47,111</td>
</tr>
</tbody>
</table>

While DSHS only counted clinical psychologists in the above calculations, their research also showed that clinical psychologists were only one subset of the total number of licensed psychologist in the state. In 2013, the number of psychologists in the state totaled 7,243, which included more than 4,000 licensed psychologists and more than 3,000 licensed specialists in school psychology. Taking these numbers into account, our ratios decrease to the following:

<table>
<thead>
<tr>
<th>Geographical Designation</th>
<th>Population per Clinical Psychologist</th>
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<tbody>
<tr>
<td>Metropolitan, Non-Border</td>
<td>3,190</td>
</tr>
<tr>
<td>Metropolitan, Border</td>
<td>10,428</td>
</tr>
<tr>
<td>Non-Metropolitan, Non-Border</td>
<td>7,618</td>
</tr>
<tr>
<td>Non-Metropolitan, Border</td>
<td>20,024</td>
</tr>
<tr>
<td>TEXAS</td>
<td>3,681</td>
</tr>
</tbody>
</table>

You can find the complete workforce shortage report on the DSHS website. However, the five key recommendations that will be submitted to the legislature are:

1. **Increase the size of the mental health workforce** – The shortage is driven by several factors, but the primary one is that the fee-for-service payment system fails to provide adequate reimbursement for providers.
2. **Improve the distribution of the mental health workforce** – Recruit rural mental health providers and expand the practice of telehealth services.
3. **Improving the diversity of the mental health workforce** – Increase the opportunity and encourage international medical graduates to practice in the state.
4. **Support innovative educational models** – The health education system will need to adapt its curriculum to train and produce providers who will practice in team-based care and patient-centered medical homes.
5. **Improving data collection and analysis** – There is a gap in the knowledge we know about mental health care. Additional data would help inform policymakers.

So, it is time once again to close this article with my same plea. **GET INVOLVED!** Contact your legislators. Call them and tell them about psychology. Your profession depends on you to keep it alive.
A Message from the

President

Marcy Laviage, Ph.D.

I have been told that this is the last Presidential letter required of me in my tenure as TPA President. When I received that bit of news, I sat back and reflected on the myriad of immediate feelings – surprise that the year has gone so quickly and my constant fascination with the concept of time; pensive about all that has occurred this year; amazed at all that has occurred this year; perplexed that many psychologists in Texas still do not join an association who has a primary duty to protect their careers; and I would not be honest if I did not add relief that we made it another year. It has been a month since I felt compelled to write a letter to all of you detailing the numerous activities that had occurred over the summer; therefore, I do not feel the need to recap and certainly do not want you to feel like you gained nothing from the few minutes you may take to read this article. Instead, I want to leave you with something new and hopefully useful.

A very wise and dear friend shared this story with me recently: Once at a conference, one of the speakers suggested that for an hour or perhaps a whole day, we wear our wristwatch on the other arm. He suggested we purposely drive to or from work in a different way than usual. He suggested we purposely drive to or from work in a different way than usual. He pointed us towards eating at a different restaurant than our normal dive, or painting if we believe we are terrible artists, or dancing if we are sure we have two left feet. The essence of his talk was not, however, a riff on Frost’s encouragement of “taking the road less traveled.” No, the difference, he taught us, wasn’t to be found on a different road at all. This may be because, according to the title of the latest book by Dr. Jon Kabat-Zinn, author and Director of the Center for Mindfulness in Medicine, Wherever you go, there you are (though many will say this is an old Buddhist concept, not a phrase he created). It turns out, there are rarely any meaningful answers on the other road – for we can only be on the road we are on.

A wrist watch that catches us off guard when we are looking for the time, or a way home that causes us to notice something we had never noticed before, or the way our taste buds reawaken when a new palate is presented—sometimes it is greatly worthwhile to engage in a common practice but from a different angle. How else can we know that we are truly on the right road if not but for the discernment that only challenging our status quo can bring? Or, to say it more simply, using another road metaphor, bumps in the road are helpful! They keep us alert and proceeding cautiously. More importantly, they keep us thinking and communicating, and they challenge us to pave new roads over the same old ones that have become too worn. Doing something different, while it may be uncomfortable at first, is often the best way to appreciate our path.

Allowing time to adjust to the new perspective then becomes a critical step. Just because it is new, awkward, and a bit disconcerting does not mean we abandon it. Time will take care of this discomfort if we let it.

And so I reflect back on this past year and relish at the smooth parts of the journey, but I also appreciate the bumpy ones. I encourage all of you to consider doing something different as it relates to TPA in your life. If you have been involved in only one capacity within TPA, get involved in another way. See it from a different angle! If you have never been involved, other than a critical dues paying member (not to be minimized!), get involved in some way. See it from a different angle! There are so many active committees, divisions and special interest groups. I promise you, life is way more interesting when we get our hands dirty and view things from a different perspective. I now have many perspectives on TPA. I believe it in more than I ever have – its mission; its leaders; its staff; and you, its members. You are vital to the continued development of TPA, and TPA is vital to the continued existence of psychology in Texas. If you are interested in becoming more involved, please do not hesitate to contact me at marcylaviage@gmail.com.

Thank you for allowing me this opportunity to lead TPA in 2014.
The APA Council of Representatives Meeting, held in Washington D.C. during the 2014 APA Annual Convention, continued to have a great deal of focus on the restructuring of APA governance. Much discussion centered on the issue of proportional vs. single entity representation, which resurfaced differences that many thought were resolved earlier with a vote to give each APA Division and each State, Provincial (Canadian), or Territorial association a single representative to Council.

The next step was supposed to have been working out the details of the function and authority of various governance elements and entities, but representatives of constituencies who opposed single member representation advocated for suspending the previous decision until function and authority were clear. The vote to implement single representatives per entity was approximately 60:40% in favor and a decision was made to extend the deliberation process through the February 2015 Council meeting in an effort to achieve greater consensus regarding the governance restructuring.

It should be noted that some of the models for consideration at the August meeting included Council representation for Ethnic Minority Associations, Regional Psychological Associations, and Members-at-Large elected by the general membership. Even with these additional representatives, the reduction of APA Divisions and of State, Provincial, and Territorial representation to a single representative still resulted in a reduction in the size of Council. This is all in efforts to have Council be a more nimble, responsive and transparent governance structure. The evolution of APA governance structure will continue into 2015.

In other action, the APA Council voted to review relevant Association rule changes in February 2015, which require at least one early career psychologist (ECP) on all boards and committees except for Publications and Communication Board, Finance Committee, and Teachers of Psychology in Secondary Schools and at Community Colleges. Council also approved a resolution focusing on the problem of false confessions and wrongful convictions resulting from interrogation procedures. A proposal by Division 42 representatives for a new APA journal focusing on practice innovation was not approved. Council also approved an Association rule change establishing a Committee on Associate and Baccalaureate Education to replace the Psychology Teachers at Community Colleges Committee.

Clinical Guidelines for Supervision in Health Service Psychology were approved. Also, extensions of recognition of Biofeedback: Applied Psychophysiology and of Psychoanalysis as specialties in professional psychology and renewal of Clinical Psychology as a specialty were approved.

Council approved allowing the Committee for the Advancement of Professional Practice (CAPP) to become a committee of the APA Practice Organization (APAPO). Thus, CAPP will no longer have a c(3) function, but will retain its c(6) functions. Nominations and elections to CAPP will be by members of the APAPO and a voting seat on CAPP will be created for an APAGS representative. Other resolutions approved included support of the United Nations Convention on the Rights and Dignity of Persons with Disabilities and a resolution supporting Gender and Sexual Orientation Diversity in Children and Adolescents in Schools.

APA President-Elect voting is now open online to all APA members.

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*Dr. McGraw was recently elected to APAs Board of Directors---ed.
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– Connie, Barnard Family Health Centers
Despite decades of efforts to “weed out” gay and lesbian service members, including a ban on openly identifying as gay in the military (“Don’t Ask, Don’t Tell”) (Cianni, 2012; Shilts, 1994), an estimated 1 million Veterans are lesbian, gay, or bisexual (LGB) (Gates, 2010; Gates & Newport, 2012). Approximately 65,000 LGB service members are on active duty. “Don’t Ask, Don’t Tell” was repealed in 2011, but repeal of this policy did not change the ban on transgender individuals from serving in the military. An estimated 134,000 Veterans are transgender, and an estimated 15,450 are presently serving in secret on active duty (Elders et al., 2014). It is not known how many lesbian, gay, bisexual, and transgender (LGBT) Veterans are enrolled in the VA. The VA medical record system does not track sexual orientation, gender identity or expression. However, the VA has recently made several advances toward more inclusive policies toward LGBT Veterans, including specific guidance about LGB and transgender treatment, and more inclusive definitions of family and visitation policies.

I use the acronym “LGBT” as a matter of convenience to refer to diverse groups of people who share a common experience of social stigma and discrimination based on their sexual and gender minority status. Even so, there are important differences within and between these groups. LGBT people have been found to experience several health disparities, including increased rates of depression, anxiety, interpersonal violence, smoking, drinking, and cardiovascular disease, to name a few (IOM, 2012).

Yet, we know little about the unique health needs of LGBT Veterans. A handful of studies suggest that people who are both LGBT and a Veteran may experience worse health outcomes than non-LGBT Veterans and worse than LGBT non-Veterans (see Mattocks et al., 2014). Although much more research needs to be done, a few clear and startling findings are evident. First, lesbian/bisexual female Veterans experience increased rates of childhood, military, and post-military sexual assaults compared to heterosexual female Veterans (Booth et al., 2011; Booth et al. 2012; Lehavot & Simpson, 2013; Lehavot & Simpson 2014; Mattocks et al., 2013). It is unclear why lesbian/bisexual female Veterans experience sexual assaults at higher rates. Second, compared with heterosexual female Veterans, lesbian/bisexual Veterans are more likely to smoke and have poorer health outcomes; and compared with LGB non-Veterans the lesbian/bisexual female Veterans have much poorer overall health (Blosnich, Foynes, & Shipherd, 2013). Third, gay male Veterans have an increased risk of smoking, depression, PTSD and substance abuse (Blosnich & Silenzio, 2013; Cochran et al., 2013).

Fourth, Veterans who receive VA healthcare and have a DSM-IV diagnosis of Gender Identity Disorder are 20 times more likely to engage in suicidal behaviors than Veterans in general (Blosnich et al., 2013). This is quite alarming.

One problem faced by the VA – and probably most healthcare organizations – is that relatively few clinical providers have specialized training and experience in LGBT healthcare. To address this deficit in the VA and expand clinical capacity, we have provided several national trainings in recent years to clinical (and non-clinical) staff on LGBT Veteran healthcare needs, sexual health issues of LGBT Veterans, and evaluation and treatment of transgender Veterans. In addition, we worked with VA program offices to establish nine postdoctoral psychology fellowships specializing in interdisciplinary LGBT care, including one at the Houston VA. In 2013, we released an LGBT awareness poster entitled, We Serve All Who Served, to the field for posting in clinic areas. A second poster designed to normalize the assessment of sexual health followed. In 2014, we launched a national training program on transgender healthcare employing videoconferencing to teach interdisciplinary clinical teams across the VA system about the unique treatment for transgender Veterans. In this program, an expert team (coordinated at Loma Linda, California) provides participating teams with brief didactics on transgender care and case-based consultation over a period of seven months. Five teams have already completed training, and 11 additional teams are currently participating and will complete the program in February 2015. A second national program on transgender care offers provider-to-provider E-consultation through the electronic medical record. Three expert teams (Loma Linda, California; Tucson, Arizona; Minneapolis, Minnesota) offer brief, non-urgent E-consultation on a variety of issues to providers at multiple VA facilities in broad regions. This program was launched in mid-2014. Finally, to coordinate these training and clinical support efforts, in 2012 Dr.
Jillian Shipherd, a clinical psychologist in Boston, and I were appointed LGBT Program Coordinators for the Office of Patient Care Services in VA. In an effort to help disseminate these many activities both within the VA and externally, Fact Sheets on LGBT initiatives have been developed and can be accessed by visiting the LGBT Program website: www.patientcare.va.gov/Lesbian_Gay_Bisexual_and_Transgender_LGBT_Veteran_Care.asp

Although the VA has undertaken a number of initiatives to train clinical providers on LGBT health issues and make the VA more welcoming to LGBT Veterans, we recognize that some LGBT Veterans may be unwilling to come to the VA because of negative experiences in the military (Sherman et al., 2014; Shipherd et al, 2012; Simpson et al, 2013). Of course, LGBT Veterans may also choose to go somewhere else for care for other reasons. Of the 22 million Veterans, about 40% are enrolled in VA. Some Veterans use both VA and non-VA services. Consequently, we want clinical providers in the community to be more aware of their patient’s sexual orientation or gender identity and their Veteran status. We urge community providers to assess this information and consider how social stigma related to LGBT status as well as events during military service contribute to the individual’s health behavior. Further, we urge community providers to work to create a welcoming environment for LGBT Veterans. What in your clinic would let LGBT people know that they are welcome and safe? A safe, supportive clinical environment will promote self-disclosure of sexual orientation or gender identity. A safe, supportive clinical environment also allows patients who aren’t certain about their sexual orientation or gender identity to explore these issues. We encourage community providers to discuss with patients what information about their sexual orientation and gender identity will be documented in the health record. Providers should acknowledge limits of confidentiality. As noted earlier, active duty military personnel and members of the National Guard or Reserves are prohibited from being transgender. What is more, the military can access service members’ medical records. So documentation of an individual’s transgender status may put them at risk of being discharged from service. Lastly, one of the most important ways that providers can create a welcoming environment, especially for transgender individuals, is to use the individual’s preferred name and gender pronouns. Doing this demonstrates respect for the individual.

For additional information about VA LGBT initiatives, follow this link: www.patientcare.va.gov/Lesbian_Gay_Bisexual_and_Transgender_LGBT_Veteran_Care.asp. Also, contact your nearest VA facility to find out what LGBT services are available. Many VA facilities have been designated as “leaders in LGBT Care” by the Human Rights Campaign in the Healthcare Equality Index survey. Review their website to see which VA and non-VA facilities near you have this designation www.hrc.org/hei. Thank you for caring for our nation’s Veterans, especially our LGBT Veterans.

Michael R. Kauth, PhD, is one of two LGBT Program Coordinators for the Office of Patient Care Services, Washington, D.C. He is located at the Michael E. DeBakey VA Medical Center, Houston, TX. Portions of this article were presented with Dr. Shipherd as a plenary address at the annual convention of the American Psychological Association, August 7-10, 2014 in Washington, D.C.

References:


Greetings from TPA’s Aging Division
We’re not getting any younger, and neither are our patients

Frank A. Fee, Ph.D.
Rafael Cuellar, Ph.D.
Aging Division Co-Chairs

The Aging Division has lost momentum and requires rejuvenation. The reasons for members’ lack of attendance at the past couple of Annual Convention meetings are not clear. We realize that there are competing meetings and sessions during the convention, often scheduled at the same time as the division meeting. This year will be no different. At a time when the older adult population is the fastest growing age group in the world, and 10,000 Americans turn age 65 every single day, there is little doubt that psychologists will provide services to aging Texans, even if they do not identify themselves as a Geropsychologists or Gerontologists; the Aging Division can help. The Aging Division is devoted to supporting TPA members who work with older adults in any capacity. Although there are APA divisions and other national organizations that focus on issues of national and international interest to psychologists working with older adults, TPA’s Division on Aging focuses on how this information impacts Texas and TPA members.

Please consider attending the annual division meeting in November. If you have an interest in the field of aging and cannot attend, please join the division and participate via the divisional listserv. We would like to invite clinicians, academicians, and students to attend the meeting and become active in the division. We are motivated to meet the needs of psychologists working in remote rural areas, as well as, urban centers. The goal is to be a resource and collegial group to those of us who work with older adults in Texas. Psychologists’ involvement in providing services to older adults is growing rapidly due to the changing demographic landscape. As the division is in the process of reinvigoration, the opportunity to participate and take on leadership roles is clearly present. Join us in meeting the needs of Aging Texans and supporting one another in the process.

Greetings from TPA’s Aging Division
We’re not getting any younger, and neither are our patients

Frank A. Fee, Ph.D.
Rafael Cuellar, Ph.D.
Aging Division Co-Chairs

Let’s Build Some Bridges Together!

Sydney Kroll, Psy.D.
TPA Membership Chair

As I’m sure you know, the 2014 Annual Convention is almost here, and GEEZ!, This is going to be an incredible year! I’m so excited about this convention. Maybe you could bring a guest with you to attend the conference.

As Membership Chair, I’ve heard a lot of y’all express concerns about the convention programming in the past, and the Convention Committee really took your ideas into consideration in their planning for this year. Following the vision of our President, Dr. Marcy Laviage, the theme is Building Bridges in Psychology: Collaborating in Tomorrow’s Healthcare Environment. We will have presentations led by psychologists partnered with other professionals, including attorneys, physicians, spiritual leaders, Veterans and others, all focused on the way psychology is uniquely positioned to inform the changing healthcare and community settings. Even the structure of the convention is different this year- there are distinct “tracks” to allow for specialty focus on areas such as forensic, neuropsychology, healthcare, military/Veterans, supervision/academic and child/family. They even made sure the presentations in these tracks weren’t all scheduled at the same time. I know how frustrating it can be to have two similar talks both scheduled at 10 a.m. on Friday. And of course, with the new PD requirements, they made sure you can get all your ethics and cultural diversity training.
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- **FREE, unlimited phone consultation with an attorney.**
- **FREE, copy of the TSBEP Acts and Rules book.**
- **Recognition in TPA publications and website.**

Those of you who know me know my passion for working with Veterans, and so I’m grateful for the focus on military psychology, both with the development of the military track and with the invited speaker, Dr. Barbara Van Dahlen, who will speak to the challenges of supporting Veterans returning from combat. There are also a lot of opportunities to support students. The Student Division and TPF are teaming up for Graduate Student Jeopardy: Battle of the Universities on Thursday evening. I’m sure the contestants would love you to come cheer for them, and I imagine it will be a hoot to watch! TPF is also offering awards for Undergraduate and Graduate Posters. Finally, if you’re like me and are using random iPhone picture on your website for your professional photo, TPF will have a photographer available to offer professional headshots at a great price. You can email her at tadcock44@sbcglobal.net to schedule a time.

More important even than the programming, I appreciate the convention as an opportunity to get to know my colleagues across the state. This year, I think it’s even more relevant for us to build those bridges not just amongst psychologists but in other professions as well. How cool would it be to network with social workers, clergy and physicians, while also showing off all that we in TPA have to offer? I challenge you to invite your friends and colleagues to join you in November. Let them see how proud we are of psychology and of our role as leaders and experts in behavioral/mental health. Let them see what a diverse and fun bunch we are! See you in Dallas!

P.S. If you can’t make it to the convention, you can still talk up TPA to your fellow psychologists. Take a new PhD or a newly licensed psychologist out to lunch and brag on the value that TPA brings to you and to the profession!
When Examiners Must Look for Evidence of Competency

Floyd L. Jennings, J.D., Ph.D., ABPP

Background:
Psychologists are often involved in assisting courts in criminal proceedings by offering an opinion (generally as independent experts upon court order, but sometimes as retained experts) as to whether a defendant is competent to stand trial. In Texas, as well as throughout the country, the standard for competency is whether the person has a rational and factual knowledge of the proceedings against him and/or whether the person is able to assist counsel in his own defense with a reasonable degree of rational understanding.1 (As an aside, the term “competency” is used in this narrowly defined sense. In the circumstance where a person might require a guardian for some purpose, he or she is regarded as “incapacitated.”) Competency in criminal matters is presumed. That is, it is presumed that the person charged with a crime has both a rational and factual knowledge of the proceedings against them, as well as being able to assist their attorneys with a reasonable degree of rational understanding. In fact, the party seeking to establish that a defendant is not competent has the burden to prove, to a preponderance of the evidence, that the person is unable to meet one or both of the foregoing prongs of competency – rational knowledge or ability to assist.

Consequently, competency examinations are designed to establish evidence of lack of competency (inability to meet the statutory standard). Thus, if asked, “When must examiners look for evidence of competency?”, most forensic psychologists would suspect that this is a trick question appearing only on some oral examination. However, it is not a trick question, and there is, in fact, a very specific circumstance in which examiners must diligently seek to establish that a defendant is competent. To a discussion of that circumstance we will turn after re-affirming specific aspects of the restoration determination and process.

Opinion on Likelihood of Restoration
Though not always addressed in competency evaluations, there is a statutory requirement for an examiner to opine, after a defendant has been opined not competent to stand trial, to several elements, among which are the following:

b) If in the opinion of an expert appointed under Article 46B.021 the defendant is incompetent to proceed, the expert shall state in the report:
   (1) the symptoms, exact nature, severity, and expected duration of the deficits resulting from the defendant's mental illness or mental retardation, if any, and the impact of the identified condition on the factors listed in Article 46B.024;
   (2) an estimate of the period needed to restore the defendant's competency, including whether the defendant is likely to be restored to competency in the foreseeable future; and
   (3) prospective treatment options, if any, appropriate for the defendant.

That is, the examiner must offer an opinion as to whether or not the defendant is likely to be restored in the foreseeable future. The reason for the inclusion of this requirement is seen in examination of Tex. Code Crim. art.46B.071(b) wherein it is stated that if a person is found incompetent (after being opined incompetent by the examiner) he may not yet be committed for restoration if he is unlikely to be restored in the foreseeable future. In fact, the court must proceed with either a dismissal of the case (with transfer to a court having mental health jurisdiction), or, if charges are yet pending, proceed with a civil commitment by the criminal court. This is under 46B.102/103 and is not for the purpose of restoration per se, and all proceedings are stayed. The defendant, however, will receive time credits for his hospitalizations just as if confined in jail.
Examiners frequently ask, “What does the ‘foreseeable future’ mean?” They may think, “I have no gifts of clairvoyance, and cannot predict the future well; so what do I say?” The answer given by the courts is more akin to “Too bad, that’s your job.” The court noted in *Graham v. State* (speaking about sanity, but applicable to competency as well, as both require expert witness testimony) that the issue is “not strictly medical. Were it otherwise, the issue would be tried in hospitals rather than in courts.” Courts may accept some of an expert’s opinion, all of it, or none of it. Richard Bonnie noted the “Even the best clinical testimony merely casts some light into a room that remains very dark.” Courts continue to hold that expert testimony, however unreliable, is useful if it helps the fact finder do its job.

**Foreseeability: A Modest Proposal**

There is neither case law nor statute that defines what “foreseeable” means in the context of a competency evaluation. However, implicit in 46B is an answer. Courts are permitted to order only one commitment for restoration in connection with a specific charge. As well, the period of time during which restoration must be achieved is the statutory time period of 60 days in the case of misdemeanor charges with a possible 60 day extension. Similarly, in the case where the person is charged with a felony, the court has 120 days from the beginning of treatment with a possible 60 day extension (at the request of the facility) in which to see restoration effected. Therefore, I would propose that examiners opining on the issue of foreseeability offer an opinion as to whether the defendant is likely to be restored “within the time frame available to the court.”

Illustration: Note that the issue is not what is “possible” in the best of all worlds, e.g., “If the defendant receives both treatment and training specifically geared for cognitively impaired persons, it is possible that within 1-2 years, he may be restored.” Rather, the issue is much more practical and simple, “Given that the court has available in this misdemeanor matter but 60 days of restoration treatment with a possible 60 day extension, it is unlikely that the defendant will be restored in this time frame.”

An Unvacated Adjudication of Incompetency

I began by noting that persons are presumed to be competent when charged with a crime. There is, however, an exception, which is quite significant in its implications. That exception is commonly referred to as “an unvacated adjudication of incompetency,” which is but to say that the person was opined incompetent, found incompetent, and not restored.

There are two such circumstances wherein a defendant may present “an unvacated adjudication of incompetency.” The first is as in the foregoing, where an examiner conducts an evaluation and opines that the person is not only not competent but is unlikely to be restored in the foreseeable future, i.e. in the time frame available to the court. If the court so finds, and the matter is disposed of by dismissal, or civil commitment, then upon the next arrest of the person, the previous adjudication of incompetency remains and the person goes into the court with a presumption – not of competency – but of incompetency. Note that this is precisely the opposite set of presumptions than would ordinarily exist. There is, accompanying the change of presumption, a burden shift. Now it is not the duty of the defense to show to the court that the person is incompetent but of incompetency. Note that the person is now competent.

Similarly, the circumstance of an “unvacated adjudication of incompetency” presents itself when a defendant is found incompetent, sent for restoration (but not restored), is ultimately released, but subsequently is charged in another matter. Whereas defendants are ordinarily presumed to be competent by Tex. Code Crim. Proc. art. 46B.003, in this case the defendant was found incompetent – not restored – and is now presumed to be incompetent. The logic of this presumption is that it directly links to the court’s last decision, which was that the defendant was not competent.

The burden shift described is of great moment because in *Manning v. State*, the Court of Criminal Appeals held, in these cases, not only that the state has the burden to prove the defendant is competent, but also to prove that claim “beyond a reasonable doubt.” The standard of evidence is not preponderance as in ordinary competency matters; not clear and convincing as in civil commitments; but beyond a reasonable doubt in criminal cases.

Consequently, though not frequently encountered, an unvacated adjudication of incompetency is, nonetheless, a significant issue – with implications for examiners.

**When Must Examiners Look for Evidence of Competency?**

As first stated, a competency evaluation is ordinarily one in which the examiner is providing to the court evidence that the person is incompetent, is lacking a rational and/or factual knowledge of the proceedings against him, or is unable to assist in his own defense with a reasonable degree of rational understanding. But in the circumstance described above, where an unvacated adjudication of incompetency exists, both the presumptions and burden are reversed, and so is an examiner’s task.

Commonly, it is the state that seeks an evaluation when the defendant is presumed incompetent. However, the examiner’s job is not to look for incompetence; incompetence is already present as a matter of law, and needs no establishment. On the other hand, what the examiner is seeking is evidence to support that a defendant is competent; however, the quantum of evidence necessary to offer an opinion is very great. It is insufficient, not to say
improper, to state (as might be stated in an ordinary circumstance) that “there is insufficient evidence to defeat the presumption of competency.” Rather, one might conclude there is “some” evidence of competency, perhaps even a great deal. The issue, however, is whether the weight of that evidence rises to the level of being “beyond a reasonable doubt.”

**Conclusions:**
The obvious conclusion to be drawn from this discussion is that examiners need to know the defendant’s immediate prior history. Was he or she found incompetent in their most recent prior case? If restoration was ordered, was the person restored? The answer to those questions will determine the standard for conducting a competency evaluation.

As well, I have made a modest proposal on the definition of “foreseeability”, i.e., the time frame available to the court in connection with the referenced matter, which is statutorily sound and may help to aid in reducing some confusion on that point.

**References:**
4 Tex. Code Crim. Proc. art. 46B.085
5 Op cit., 46B.073
7 Manning, at 748.
For several years running, the TPA Business of Practice Committee has provided a forum for identifying and discussing important issues impacting the practice of psychology at the state and national level. Our listserv allows for real time sharing of practical information and for problem solving regarding day-to-day business matters. Also exciting is that our listserv has been a springboard for action and advocacy through representation of TPA member interests in formal meetings and hearings, in communications with insurance companies and state agencies, and in communications with the APA Practice Directorate. Our committee is open to all interested TPA members. Our listserv membership extends further and currently includes: Drs. Dean Paret, Angela Cool, Rolland Fellows, Kyle Babick, Betty Clark, Carl Settles, Carol Grothues, Celeste Colon, Cythnia de la Fuentes, Danielle Young, Daphny Ainslie, Dan Roberts, Anne Morton, Steven Schneider, Glen McClure, Gregory Simonsen, James Bray, Jamie McNichol, Jenny Stadler, Kim Arredondo, Laura Baldwin, Lane Ogden, Leslie Rosenstein, Marcy Laviage, Marsha McCary, Miguel Ybarra, Michael Ratheal, Ollie Seay, Paul Andrews, Michael Pelfrey, Rico Ainslie, Ray Brown, Rob Mehl, Ron Cohorn, Rick McGraw, Ron Garber, Brian Stagner, Sydney Kroll, Tom Kremer, and Tom Van Hoose. Thanks to all my colleagues for being interested enough to contribute their perspectives on so many issues. Thanks also to Sherry Reisman and Lauren Witt who help maintain our listserv.

As psychologists we often work alone behind closed doors. While we may go to professional meetings and conferences and read monthly newsletters, it’s not easy to have that proverbial “hallway conversation” with a colleague on practice issues when we want to. Our listserv makes our colleagues’ judgment and expertise more available to us. In a way, our listserv is a virtual peer consultation group on practice issues. As Eric Marine, Vice President of American Professional Agency has noted, consulting with colleagues on a practice issues helps ensure that we are operating consistent with “community standards” for our profession. At the same time, very often our listserv underscores diversity of opinion and that there may not be one right answer or way to proceed.

The fact that many of us are solo practitioners or work only in small groups also leaves us at a disadvantage in dealing with the powerful megacorporations of the insurance industry. We are only loosely organized, and it is hard for us to have a collective voice. We can’t bargain collectively under federal antitrust laws and existing
labor laws in Texas. Any pooling and sharing of information that helps us deal more quickly and effectively with insurance companies or other large bureaucracies like Medicare or Medicaid saves time and emotional wear and tear.

Given the Affordable Care Act and other federal initiatives, we are confronting changes in the organization of health care delivery that will impact our profession in as yet unknown ways. There may be greater competition for every health care dollar and greater demands for accountability. The lobbies of corporate health care interests are well funded. To prevent our profession being marginalized in the new health care system, and to prevent the core values and functions of our profession from being eroded away as we integrate our services with those of other groups, we need to have platforms where we can strategize and develop plans for our roles in the new systems. I like to think that our TPA BOP listserv, or something like it, can help support us, as we transition to new roles.

The work of the TPA Business of Practice Committee has focused on: insurance company policies and practices that impact clinical practice and reimbursement; the implementation of the PQRS system; the challenges, benefits and difficulties of integration of behavioral health services into the larger health care system; psychologists’ participation in the Texas Medicaid program and reasonable requirements for their participation; ongoing cooperation with the APA Practice Directorate’s efforts to improve patient access to psychological services and to prevent exploitation of psychologists by insurance companies.

More details on the TPA BOP Committee’s accomplishments since November 2013 follow:

1. **Medicaid Rules.** The TPA BOP Committee reviewed the proposed new rules regarding waste, fraud and abuse for Texas Medicaid providers and gave input to Joy Sparks, Attorney for the Office of the Inspector General within the Texas Commission on Health and Human Services, both in writing and through testimony at a public hearing.

2. **Licensure and Title.** We discussed the actions taken by the Texas State Board of Examiners of Psychologists to remove our credential from our licensure renewals and provided feedback to the TSBEP on this issue as well as efforts to streamline licensure of military personnel from other states.

3. **Reimbursement for Testing.** We have discussed and taken action on difficulties with prior authorization of psychological testing for Medicaid patients with administrators of Centene, Cenpatico, and Superior Mental Health. A review of current testing guidelines was done and the CEO of Centene made modifications to make securing authorizations less problematic.

4. **Access to Care.** Every year, the TPA BOP Committee has been in communication with Medicaid program administrators and emphasized that ready access to psychological services is essential for maintaining the mental and physical health of Medicaid patients and that policies and procedures, as well as reimbursement, should be fair.

5. **PQRS Regulations.** We have discussed and clarified requirements and guidelines for use of the Medicare Physician Quality Reporting System codes. Adherence to the new PQRS standards will prevent Medicare fee reductions in 2016 and can also result in incentive payments.

6. **Psychologists’ Future Roles.** We have discussed the roles that we envision psychologists playing in a better integrated health care delivery system and given feedback to Rick McGraw, Ph.D., APA Council Representative, who requested support for an APA resolution on this issue. The potential advantages and risks to our profession of participation in a more formally integrated system were identified. Some believe that traditional private practice as we know it may become obsolete. There is deep concern that psychologists will lose autonomy over clinical decisions, forfeit control over their working conditions, and succumb to time constraints that will compromise quality of care. More purely medical models of care may eclipse what behavioral science research tells us about effective interventions. Others see an integrated system as ensuring earlier and better recognition of mental health problems and greater ease and effectiveness of treatment. This more optimistic view suggests that psychologists will be more firmly established in the system, ascending to full partnership.
in interdisciplinary teams, and receiving equitable reimbursement for their skills, as they demonstrate their competence to team members and through outcome data.

7. **Ghosts.** We have had ongoing discussions of insurance company “ghost panels,” a misleading practice whereby insurance companies market policies and claim that they have a large number of psychologists enrolled as providers when in fact they do not. They often list non-psychologists as psychologists in promotional materials to create an illusion of a diverse panel of providers. So far we have not been able to get either the TSBEP or the Texas Commission on Insurance interested in this issue. Kudos to Dr. Paul Andrews, who has spearheaded efforts on this issue.

8. **Fee Cuts.** We continue to work closely with Alan Nessman, APA Practice Directorate Senior Attorney, and Stacey Larson, also an APA attorney, on combating insurance company abuses. We participated in Alan Nessman’s survey of psychologists regarding problems with Humana, in particular. Alan Nessman has filed a formal complaint against Humana with the Center for Medicare Services within the U.S. Department of Health and Human Services and the U.S. Department of Labor. Humana cut fees drastically in January 2013 which drove large numbers of psychologists across the nation off of panels. The fee cuts limited access to care and disrupted continuity of care for many patients. The Texas Commission on Insurance did not respond to TPA’s requests that they investigate the impact of these cuts. However, now the U.S. Dept. of Health and Human Services is following up on the complaint APA has filed against Humana and TPA has signed on to this complaint. We are eagerly awaiting further progress on this front.

9. **Fee Negotiation.** While observing the constraints of antitrust law, we continue to discuss reimbursement trends and the process of fee negotiation.

10. **Accessing Decision Makers.** We are addressing some difficulties that psychologists report regarding reaching Blue Cross Blue Shield billing representatives when problems arise.

I’m grateful for all of the spirited discussion we’ve had on our listserv and for the diversity of opinion the listserv offers. In a time of challenges to our profession, the listserv has helped me maintain morale. From decision makers at the national level and insurance companies, there is greater-than-ever scrutiny of how psychologists work, and there are demands for change: we are asked to follow evidence-based practices and demonstrate outcomes in shorter segments of time. We are asked to adopt electronic record systems and engage in electronic billing. We have been asked to integrate our services better with those of other health care professionals and consider new models of care. These changes may have a positive and transformative impact on how we practice and serve the public. However, they require our time and attention, and the pace of these changes can be very stressful. They may pose serious drawbacks to privacy and have other consequences for our practices we haven’t yet considered. At the same time, we are experiencing an unrelenting downward pressure on our fees from insurance companies, which are less regulated than they should be. I believe that the TPA BOP Committee has allowed us to support each other in a difficult time. Also, I believe that our committee members have been able to formulate some well-considered recommendations that can benefit TPA and all Texas psychologists. Our voice on a number of issues has been heard at the national level through our linkage with the APA Practice Directorate. It has been my pleasure and privilege to serve as Chair of the TPA Business of Practice Committee. This experience has reinforced for me a belief in the value of group problem solving and the importance of collective wisdom.

The Business of Practice Committee will be meeting at the TPA Convention on Thursday, Nov. 13 from 1-2 p.m.
News From the TPA Disaster Response Network

New Training Opportunity at the convention!

Judith Andrews, Ph.D.
Rebecca Hamlin, Ph.D.
TPA DRN State Co-Coordinators

The TPA Disaster Response Network exists to promote psychologists responding when disaster strikes anywhere in the United States. Any member of TPA is eligible to join the TPA DRN through our link on the TPA website. As coordinators we are responsible for running this APA-driven program within our own state of Texas. We connect our DRN to that of APA and share information during disasters.

Disasters are, by definition, uncommon and unsettling events. There is a strong need for psychological expertise to help meet the challenges of disaster response, but the skill set required may lie outside our everyday experience. Therefore, all DRN members receive special training to be maximally effective. We recruit interested psychologists and guide them into training in the area of disaster mental health. Primarily through our partnership with The American Red Cross we help psychologists be prepared and poised to respond during disasters.

The required trainings for mental health professionals to respond with Red Cross will be offered at our upcoming convention: Disaster Mental Health Fundamentals and Psychological First Aid (Saturday, November 15: 8:00 a.m. - 3:00 p.m.). Once these courses are completed psychologists simply enroll with their local Red Cross as a Disaster Mental Health (DMH) volunteer. There is no obligation to respond during disasters, local or other, although this process is required in order to be eligible to respond should one choose to do so. As state coordinators we maintain a TPA DRN statewide committee to carry out these recruitment and training objectives. Currently, we are seeking interested psychologists to join our TPA DRN statewide committee. If you are interested in joining, please contact Judith Andrews at judithphdjudith@yahoo.com. We encourage all interested psychologists to join the TPA DRN!

NEW DIVISION AT TPA: NEUROPSYCHOLOGY

Alice Anne Holland, Ph.D.
Pete Stavinoha, Ph.D., ABPP
Neuropsychology Division Co-Chairs

In recognition of the important role of neuropsychology as a subspecialty in Texas, the Neuropsychology Division of TPA will officially be established upon ratification by the TPA membership at the upcoming Annual Convention in Dallas. The establishment of the Neuropsychology Division will not only benefit current members but also provide an additional incentive for new members to join TPA, thereby strengthening the organization as a whole. FREE membership in the Neuropsychology Division is open to any TPA member with an interest in neuropsychology or who simply wish to support this division, regardless of your clinical activities or training.

The objectives of the Neuropsychology Division are the following:
1. To provide a forum for communication and consultation among psychologists in the state of Texas who engage in the practice of neuropsychology.
2. To promote legislative initiatives that further the practice of neuropsychology both in Texas and nationwide.
3. To enhance the educational opportunities for those psychologists wishing to increase their skills and expertise in the area of neuropsychology.
4. To provide information to the public regarding the expertise and services offered by neuropsychologists.

COME AND MEET US! All TPA Convention attendees are invited to join us for the inaugural meeting of TPA’s Neuropsychology Division on Thursday, November 13 at 2 pm. This will be an informal meeting consisting of a brief introduction and discussion of the division’s objectives, with opportunity for questions, as well as casual mingling to meet others who share an interest in neuropsychology. Please stop by during this time if you are interested in learning more about and/or joining the Neuropsychology Division!
TPA TACKLES DIVERSITY ISSUES

Alfonso Mercado, Ph.D.
Gregory Simonsen, Ph.D.
Diversity Division Co-Chairs

Texas (and the nation) is witness to an unprecedented pace of demographic change, and the role of professional psychology must expand to respond to an increasingly complex world. The Diversity Division's goal is to promote and apply knowledge of psychology to issues relating to racial, ethnic, and cultural diversity. Specific objectives include:

1. Encourage research on traditionally marginalized groups and culturally effective and responsive treatment.
2. Promote standards of practice that are culturally and linguistically appropriate.
3. Promote legislative initiatives that further the training, research and practice of race and ethnic minority psychology and culturally competent care.
4. Provide a forum for communication and consultation in developing culturally and linguistically appropriate skills and practices.
5. Promote the highest standards of ethical and culturally competent practitioners consistent with those espoused by the Texas Psychological Association, the American Psychological Association, and Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists of the APA.

Division activities include promoting cultural diverse workshops at the convention, contributing articles to the TPA E-Newsletter, and providing a student diversity paper award. Our goal is to provide an environment that embraces and fosters cultural diversity in clinic, research, and community outreach settings. Please join our team and attend our Annual Meeting at the convention on Thursday, November 13, 2014 at 5:00 p.m. and workshop titled, "Multicultural Perspectives and Important Clinical Considerations in the Treatment of Culturally Diverse Groups" on Saturday, November 15, 2014 at 9:00 a.m. See you there!
Beginning October 1, 2014, all renewing licensees are now required to show completion of 20 hours of professional development (formerly continuing education). Of these 20 hours, three hours must be in the areas of ethics, Board's Rules of Conduct, or professional responsibility, and three hours must be in the area of cultural diversity. Furthermore, at least half of the required 20 hours of professional development must be obtained from or endorsed by national, regional, state, or local psychological associations, public school districts, regional service centers for public school districts, or psychology programs at regionally accredited institutions of higher education.

1. Continuing education is now termed Professional Development.
2. Any licenses renewals from here on out must earn at least 20 hours total of professional development. A. At least three of those 20 hours must be in the areas of ethics, the Board's Rules of Conduct, or professional responsibility. Examples include: confidentiality, patient rights, dual relationships, sexual harassment, billing fraud, HIPAA, risk management and duty to report.
3. If you are a provider who wishes to fit into 3(D) and wishes to be formally endorsed by Texas Psychological Association, please contact Sherry Reisman at tpa_sreisman@att.net. Staff can walk you through the details and the process to become an endorsed provider or provide a single endorsed workshop.

If you have any questions about these requirements, Sherry is happy to answer them for you. Call the central office at 888-872-3435 or email tpa_sreisman@att.net.
Become a Platinum Advocate today!

With monthly dues of just $50, TPA Platinum Advocate members receive the following benefits and services in addition to all traditional TPA professional resources:

~Discounted (50%) convention registration fee
~FREE 3 hours of online Professional Development
~FREE doctor finder subscription (referral service)
~FREE, unlimited phone consultation with an attorney
~FREE copy of the TSBEP Acts and Rules book
~FREE Professional Development at TPA’s Summer Get-Away
~Special badging at convention
~Reserved seating and special recognition at the convention awards luncheon
~Recognition in TPA publications and website

ADVOCATE: defender, protector, supporter, upholder, pleader, champion, ambassador, believer

Thank you to our 2014 Platinum Advocates for showing your commitment to being defenders of the profession of psychology.

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2014 Annual Convention
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