Integrated Training:  
The Interprofessional Training of Predoctoral Psychology Interns with Family Medicine Residents  
Kathryn Wertz, Ph.D.  
Robert B. Tompkins, M.D.

The Common Factors of Social Justice  
Jospeh H. McCoy, Ph.D.

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My most recent articles have focused on TPA as a legislative organization. Some psychologists are fine with this reality and accept it. Others, however, are not as comfortable with this concept. They ask, “Why would TPA want to be a legislative organization? Why would I want to be part of that?”

When I am asked these questions, I respond by reminding them that the profession has been regulated for over 65 years. Each psychologist chooses to enter a profession that is regulated by the state of Texas. Therefore, once licensure became law and once a mental health professional chooses to earn licensure, he/she also chooses the corresponding responsibility to participate in how that licensure continues to be shaped. Either psychologists shape their futures or they allow other providers to not only keep them from advancing, but chip away at their current opportunities to help the citizens of Texas.

Understandably, many psychologists feel that everything in their practice is fine. They are happy with reimbursements and not overly burdened by the bureaucratic requirements to get reimbursed by Medicaid, Medicare and managed care. However, if YOU do not feel this calm content and you wish things could be different, YOU MUST BE INVOLVED. Join a TPA Committee that interacts with state agencies and attends meetings; consider running for TPA’s Board of Trustees or chairing a TPA Division or Special Interest Group; consider participating in TPA’s Grassroots Network (legislative session is just around the corner). Contact Sherry Reisman (tpa_sreisman@att.net) or Lauren Witt (tpa_lwitt@att.net) to express interest and find the best fit(s).

Using this same model and working with the same understanding I’ve outlined above, I have chosen as my profession to represent an association whose members are regulated by the state of Texas. I, too, choose the corresponding responsibilities that result from that choice. In the last 30 days I have traveled to Houston, Gatesville, San Antonio and Corpus Christi to visit with legislators and their staff to share requested changes to your profession that your colleagues have expressed interest in modifying/updating. You have colleagues who are making similar contacts with their legislators. Do you have a relationship with your Representative or Senator? If so, let me know. We would love to include you in our efforts to continue to connect with legislators and tell psychology’s story. We must remain relevant and present in the eyes of those who regulate. The next 30 days looks a lot the same. I will visit Dallas, Fort Worth and Brownsville. You might be surprised where I have met legislators—restaurants, Starbucks, doctors’ offices, attorneys’ offices, and sometimes in the hallways of office buildings. It does not matter where I meet with them, just so I have the opportunity to visit with them and tell them about psychology.

Another question I am asked is “What does TPA do for me?” or “What has TPA done for me recently?” Besides all of the meetings I’ve listed above, we are conducting conference calls with the staff at the Department of State Health Services about the shortage of mental health providers, visiting with attorneys in preparation of an Amicus Brief dealing with proper test protocol, consulting with our attorney in preparing documents for the Texas Attorney General outlining the importance of doctoral training mental health professionals vs. master’s trained clinicians. These are the meetings and calls in which I or TPA staff are directly involved. This does not include all the Board of Trustees, Committee and Task Force volunteer hours that are expended to benefit the profession.

I aspire to have every Texas psychologist and student of psychology involved in the shaping of your profession and professional association in some meaningful way that goes beyond your day-to-day work responsibilities. Your involvement is critical to TPA - whether it’s joining/renewing your
TPA membership, having coffee with a legislator, coming to TPA’s Annual Convention, or better yet, getting involved with a committee or serving on the Board. If you already are involved, please continue! If you are not currently engaged, please GET involved.

I am very proud of my staff and the dedication they provide you and your association. Beginning with my Assistant Executive Director, Sherry Reisman; she has provided executive leadership to TPA members for over 17 years and helps make every aspect of TPA successful. Lauren Witt has made TPA’s website, publications and social media one of the best in the country. Brooke Nowak, who is my Legislative Assistant, keeps all of my legislative endeavors on track. Yes, TPA has a staff of three full-time and one part-time employees. All of the services, activities, meetings, conference calls, legislative visits and accomplishments that we provide you, our members, are achieved by a staff of 3FT, 1 PT and volunteers (like you?).

“Why would TPA want to be a legislative organization?” “Why would I want to be part of that?” Because it is our reality and because we need to be.

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Beginning October 1, 2014 PD requirements increase from 12 to 20 hours. Of the 20 hours, at least half (10 hours) are required to come from endorsed providers such as TPA.

TPA’s Annual Convention offers a multitude of Professional Development opportunities. Join us in Dallas and receive all your PD hours for the year.
ATTENTION TPA MEMBERS!
ATTENTION TPA MEMBERS!

Marcy Laviage, Ph.D.

I do not know exactly how to get your attention, but I need it. BADLY! Not because the sky is falling or there is some major crisis, but because SO much has occurred in the past eight weeks, I want desperately to update you and keep you informed. TPA has struggled to find the best medium to communicate with all of you. We send out email blasts, but I feel as many of you likely do, sometimes when too many are sent they become almost invisible. We send out newsletters like this one, but I feel as many of you likely do, who has time to read it? We send out letters in the mail, but I feel as many of you likely do, and it gets lost among the paper pile on my desk. I cannot seem to solve this problem that has plagued organizations for years, but I am eager to catch you up to speed and I will use any and all means to do so.

Trying to describe what the past few weeks have been like is difficult. I can’t seem to find the right metaphor. On one hand, I feel like a boxer using fancy feet work and dodging left and right at rapid pace, but this image may make it seem like I am having to dodge painful blows and that is not (necessarily) the case. But it’s the quickness of the movement of a boxer than resonates with me.

First, on May 2, I was contacted by a passionate attorney in East Texas asking for TPA to file an Amicus Brief for his case involving his client who has been on death row for 20 years. The case is scheduled to go before the Fifth Circuit Court in New Orleans in July. Your Board of Trustees responded to my request for an urgent, immediate conference call to discuss this unique matter. With their approval, I created a specialized and, I must say, brilliant Forensic Task Force to work directly with our attorney on this case. Led by TPA Board Member, Dr. Pete Stavinoha, the specialists include Dr. Mary Alice Conroy, Dr. Michael Ditsky, Dr. Floyd Jennings, and your President-Elect-Designate, Dr. Steven Schneider. Their willingness to take on this task – which fundamentally involves the use of assessment to ascertain MR status – demonstrates the core of Texas Psychologists. We are experts and if anyone is going to comment on the science of assessment in any forum, it should be no one but psychologists. They answered the call and I am very grateful. They are hard at work as we speak!

On June 3, TPA was made aware of a written request sent to the Attorney General by Representative Richard Pena Raymond, Chair of the Committee on Human Services, questioning the legality of LPCs, LMFTs, and LMSWs receiving 70% reimbursement of PhDs. This issue was viewed as another immediate need to address and for TPA to make a strong statement in response. Within a week, Dr. Brian Stagner, TPA Director of Professional Affairs, was already working on a draft, and we were on a conference call with attorneys from APA assisting us with strategy. The recommendation was made for TPA to hire an attorney. We will have an official response submitted very soon and before the posted deadline. On June 9, TPA was contacted by the Houston Chronicle to comment on the GOP Platform on Reparative Therapy. As most of you now know, their platform included endorsing the use of reparative therapy, as well as providing immunity to those who provide the intervention. We had a choice to not comment, but again, we are the experts and if anyone is going to comment on the science of empirically validated methods, it should be no one but psychologists! Again, we needed to act quickly (what is relevant one day is quickly old news the next day), and this time your Executive Committee drafted a statement that was careful to focus on what we know based on science. I congratulate TPA for taking a stand on this hot issue.

On June 20, I traveled to Dallas to meet with TPA Convention Chair, Dr. Greg Simonsen and TPA staff to plan out convention. You will hear me say this again and again (especially if you attend convention), but OH MY GOODNESS I am so proud of the proposals this year! Wow. Each of you answered the call to demonstrate the incredible breadth and depth of psychology. Even though I clearly know what we do, even I was overwhelmed by the incredible bridges that will be presented with attorneys, physicians, dieticians, religious leaders and other disciplines. THANK YOU for listening and responding. I love the field we all chose, and I love it even more when I consider how many aspects of life we touch.
– I cannot think of another profession that does it as much as psychologists do. My goal was to showcase what we offer to our communities and there is no doubt this will occur in Dallas at The Westin Galleria on November 13-15. I really hope you join us. If you have never attended TPA’s Annual Convention or it has been awhile, you will not want to miss this one.

And, on June 27, I traveled again to meet with our esteemed Finance Committee to do our annual duty of pulling apart the budget and piecing it back together to ensure that TPA is viable for many, many years to come. This budget will be presented for approval at the next board meeting in August and again at our update during convention.

These are just highlights. I have not even mentioned the constant work by Dr. Bonny Gardner and her very busy Business of Practice Committee who are constantly raising issues that must be confronted. Or our incredibly active and tireless Grassroots Committee who is making contacts left and right to implement our legislative agenda.

So, this boxer will continue to shuffle her feet and move from side to side as best as I can. But let me tell you, if I know that you are all waiting in my corner to pour water on my face and put pressure on my bruises (yes, I do get them every now and then), then I will continue to shuffle and dance as fast and best as I can. Thank you for all of your support and, as usual, if you have comments or questions about any of these issues, please do not hesitate to contact me at marcydivage@gmail.com.

This June the Texas Department of State Health Services (DSHS) launched a public awareness campaign on mental health entitled Speak Your Mind Texas with the objectives of providing support, promoting hope and fostering recovery for people experiencing mental illness. This campaign aims to increase dialogue about mental illness and break down the stigma of those who suffer from mental illnesses, while educating teens and young adults about the resources that are available to them.

DSHS, partnering with local organizations, will be hosting a series of town-hall community forums around the state focusing on mental health, substance abuse and the available resources for these issues.

It is important that as a profession, psychologists participate in these discussions – attending the forums and affirming the value of psychotherapy in treating mental illness. There are also numerous campaign resources available online that can be used to promote mental health and this initiative - including posters, brochures, shareable graphics, videos and PSAs.

Upcoming Community Conversations
August 12 – Waco/Temple
August 13 – San Antonio
August 18 – Lufkin
August 19 - Austin

Visit www.speakyourmindtexas.org for more information about the community forums and how to participate.
The integration of behavioral health into primary care is fast expanding. Embedding psychologists into primary care clinics has been an effective means of providing care to patients and is appreciated by patients, psychologists and physicians alike. It is the essence of the Patient Centered Medical Home (PCMH) (Rosenthal, 2008). It is also the prerogative of Centers for Medicare and Medicaid Services (CMS), as evidenced in the behavioral health component of the Delivery System Reform Incentive Payment (DSRIP) programs.

Dating back to the 1960s, family medicine is a specialization that has traditionally incorporated behavioral science into its faculty and curriculum (Fischetti and McCutchan, 2002). The curricular requirements for family medicine residencies to this day include skills in behavioral change, interpersonal communication and cultural awareness.

Of the medical specialties, family medicine is probably the most receptive to and compatible with psychology. Whereas psychiatry values some of the same traditions and focuses on the same clinical populations as clinical psychology, it is within family medicine that clinical psychology melds with health psychology. In this setting, the psychologist works with the medical team to assist with anxious, depressed, bipolar patients and psychiatric patients of all ages, as well as assists in health psychology concerns such as headaches, obesity, smoking cessation or overuse of pain and anxiolytic medications. Further, psychologists in family medicine help medical residents learn how to give bad news, and teach patients how to receive it. Last but not least, the psychologist helps the “gum out of the works” in a busy primary care clinic. When the physician is out of time with a depressed patient, the psychologist has more time to offer.

Although there are multiple roles of psychology, it is the traditional role of clinical psychology that is most valued. This is precisely because, in family medicine, traditional medicine comes into closest contact with traditional psychiatry. Since family medicine doctors constitute the “ad hoc psychiatric system,” treating more mental illness than all of psychology and psychiatry combined (Regier et al., 1993), they appreciate the knowledge of and practical assistance from psychologists. Psychologists help sort out anxiety from agitation, bipolar depression from major depression, offer treatment, and make recommendations.

In 2003, Blount described a continuum model for the integration of psychological services into primary care. The first level, “coordinated care,” is typified by an exchange of information (with patient consent) between psychologist and primary care physician about their mutual patients. The structure of the relationship is traditional, with physician and psychologist maintaining separate practices. The second, “co-located care,” involves practices that are now in the same workspace, but the referral system is the same as before. Third is the “integrated care” model, in which the psychologist and primary care doctor are part of a unified team treating the patient together with fluid, ongoing communication, shared decision-making, and ongoing input from the patient and the patient’s family. The focus is on overall health care, including not only mental health concerns, but also behavioral aspects of illness and wellness (Blount, 2003).

Making a true cultural shift in patient care ultimately requires shifting the training of both psychologists and physicians. The full integration of psychological care into primary care requires involving physicians and
psychologists in a collaborative relationship from the beginning of their careers. So-called “interprofessional training” is not new. Eastern Virginia Medical School (EVMS) has been doing it since 1976 (Cubic, 2009). However, interprofessional training is not commonplace either.

At the University of Texas Health Science Center at Tyler (UT Health Northeast), we have begun the process of interprofessional training. In our first year in training doctoral psychology interns, half of their experience is taking place within a family medicine residency training clinic. Across the country, as well as in Texas, more programs are training postdoctoral fellows alongside family medicine residents than doctoral interns. There are advantages and disadvantages to either doctoral or postdoctoral training. On the one hand, a postdoc is on a more equal footing with a resident, since each is called “doctor.” On the other hand, doctoral interns are still developing areas of interest for their future profession and still learning how to practice what they have been taught. Postdocs, on the other hand, may already have their minds set on their professional direction and have reached a much higher level of independence.

Trainees in the helping professions, regardless of discipline, go through similar experiences in their development as professionals (Hurley and Schoenberg, 1983). Within the current training paradigm, doctoral psychology interns and first-year family medicine residents (also called “interns”) are learning how to become professionals in their respective fields together. Each group has undergone their formal academic education. Each group has had extensive practicum experience. At the levels of doctoral psychology internship and first-year medical resident, the trainees in each profession are at similar stages of professional development. “The clinical psychology and medical education literatures provide evidence that clinical trainees act more independently as their training progresses (Kennedy et al., 2005).” It is at this first internship year that trainees in both professions most rapidly transition from dependence to independence. More importantly, at the same time, they are figuring out how to involve each other in order to promote the health of their mutual patients.

**Doctoral Psychology Interns**

Confidentiality. As Cubic (2009) notes, part of the training of psychology students in the family medicine setting means “psychology interns must unlearn aspects of what they have learned in graduate school” and other traditional clinical settings. In order to provide integrated care, strict confidentiality is traded for “practical confidentiality.” In the integrated setting, team interactions open communication in a way that may make psychology trainees initially uncomfortable. New parameters on communication are required. Patients are informed of and give consent to the disclosure of pertinent information to the team. Information that is relevant to integrated care is shared with team members (Vogel et al., 2012), but highly private, noncontributory information is withheld. This is true in both vocal interactions and within the written communication of a shared electronic medical record (EMR). Finding this balance requires discernment, guidance and practice on the part of the intern.

**Learning about the traditions/culture of medicine.** One of the initial hurdles for doctoral psychology interns is to understand that the profession of medicine has its own culture that is remarkably different from that of psychology. It may be difficult for young professionals to recognize that they have been indoctrinated into a professional culture, with its own way of problem solving and thinking, and its own distinct values. Faced with the new culture of medicine, it may be hard to accept that other ways of interacting with patients are equally valid (Vogel et al., 2012). The psychology intern must accept that her training is very different. Teaching to this difference promotes more positive interactions between psychology trainee and young physician. Since the dominant culture is the medical one, it is the psychology intern who must adapt her skills to blend in while maintaining the core values of her own professional culture. She must recognize that she is working in an environment that belongs primarily to medical doctors. This is a challenge to neophyte psychologists who have just started building confidence in their own skills and building their professional identity.

By comparison, the family medicine resident does not have to adjust to the psychology culture. She remains in the dominant medical culture. In fact, the first-year resident is learning her role as a physician and is still learning to negotiate medical culture in general, as well as learning to adapt to the nuances of the culture of other specialists. The family medicine resident rotates to other specialties (Ob/Gyn, Pediatrics, Surgery, and Trauma), making adjustments to schedule, content of practice, method of practice, and supervisor personalities every four weeks. Only in the family medicine clinic and inpatient service does she finally get to work with her “own kind.”

**Learning not to be intimidated by “real doctors.”** Family medicine residents have completed medical school and have earned their medical degrees. This may put the doctoral psychology trainee at a nominal, psychological and political disadvantage. Not being able to be called “doctor” when his level of training is essentially equivalent is hard on the psychology intern. Fortunately, in the climate at UT Health Northeast, the physicians are friendly and inviting. As a sign of their acceptance, they have occasionally called the interns “doctor,” which we have cordially had to discourage.

**Learning how to promote consultation.** Learning how to “build a practice” and promote consultation is a big part of the experience of working in family medicine for psychology trainees. Physicians do not automatically think of referring to psychology, nor are they aware of all the ways that psychology can
support them. The psychology interns learn to promote consultations in a variety of ways. One is their strategic positioning in clinic. They sit in the main room where residents and faculty congregate for precepting and teaching. Whenever a resident sits down with a preceptor for supervision, the intern listens in to see if there is some way she can interject some psychological knowledge or offer to see the patient. Although “jumping in” may make the intern a bit anxious at first, it establishes her presence and availability in the clinic. Similar to this strategy is wandering through the clinic, visiting with the nurses and physicians in their hallways and making herself visible and available.

Occasionally, the psychology intern shadows a resident throughout a half-day of clinic patients. This works particularly well with second- and third-year residents who are already fairly comfortable and confident about their clinic skills and are therefore more open to the intern’s presence. Some lovely, unexpected benefits have come out of this arrangement. First, the intern becomes more aware of the demands on the physician. Second, the resident becomes more aware of the intern’s skill set and utility in the clinic. Third, more referrals are made to psychology. Learning how to offer help and be useful to a physician oftentimes means offering to intervene not only with traditional psychological issues, but also with health psychology issues. Psychosocial aspects of illness, behaviorally influenced health care problems such as overeating, poor sleep hygiene, headaches, and self-management concerns of chronic conditions such as diabetes and COPD are areas of intervention where psychologists are not often considered. Stepping up and offering help is a part of promoting awareness of all that psychology can offer.

Saying “Yes” to the request. When our psychology interns are directly asked for their help, they are instructed to always say, “Yes.” Psychologists are taught to be contemplative and critical thinkers—to look for problems and barriers. This approach, in the medical world, may be interpreted as negative, recalcitrant and rejecting. Psychology interns in our setting are taught to say “Yes” first and ask questions second. They are instructed to find a way to help, even in the event of an inappropriate referral. Clarifying ways that they can be helpful is important in redirecting a “bad” referral while remaining engaged and not rejecting the physician’s request. Rejecting a request strongly discourages all future referrals.

**Learning how to collaborate.** The psychology intern has to learn, perhaps for the first time, how to work within the team environment. In the family medicine clinic, this includes not only the physicians, but also the nurses, dietitian, social worker, medical assistants and front desk clerks. Collaboration means providing assistance without stepping on toes, offering suggestions for care, and
ensuring plenty of communication. As the expert in communication, the intern must remember to offer this skill not only to patients, but to the treatment team as well. The psychology intern may be surprised to discover that the physician may need his assistance in clarifying a request. Not only is this clarification focused on diagnostic questions or treatment questions, but also on simple logistics: “Do you want me to see the patient in the exam room or the counseling room?” “How much time do I have?” “After I’ve visited with the patient, are they free to go or do you need to wrap up with them?” are examples of simple communications that offer support and reduce potential conflict.

Learning about medical case presentation. Physicians use specific scripts when describing a patient's condition. By attending case conferences, psychology interns learn the manner and the order in which information is delivered about a patient. When psychology interns are able to speak the language of the “locals,” they are seen as less foreign and more as a part of the medical team. They are also seen as more credible. Therefore, our psychology interns begin the year attending “Morning Report,” to ascertain how the physician presents a case. There is a secondary gain as well: Morning Report occurs at 7:15 a.m. Attending these meetings indicates to the residents that the psychology intern is a part of the team, even when it is uncomfortably early. Proving this point is a key piece of medical culture, wherein there is a certain, for lack of a better word, “bravado” in working long, uncomfortable shifts. Although psychology interns keep to an APA recommended 40 hour workweek, we don’t advertise that fact.

Learning to fit into a fast-paced environment. Family medicine values speed. No other medical specialty is under as intense a demand for brevity as this one. Seeing a patient every 15 minutes or less is the standard. In family medicine specifically, and in medicine in general, “thinking on one’s feet” and acting quickly is highly valued. Psychologists, on the other hand, are often trained to stop and evaluate—to make slower decisions. Psychology interns must retrain to become more immediately responsive—to meet the physician’s request the moment it arrives. Further, they must learn to present data in brief format, free of elaboration and contingencies. Physicians tend to operate from yes-no decision trees, and appreciate clear, concise answers, as opposed to the more elaborate, conceptual and situation-specific answers preferred in psychology.

Learning to flex and adjust. Working in this environment requires the psychology intern to become not only faster but more flexible. Interventions may be brief in time and brief in duration. The intern may offer a ten minute intervention and never see the patient again. Psychotherapy appointments may be interrupted for a “warm handoff” or “curbside consult.” We have encouraged physicians to introduce the patients they are about to refer to psychology. This “warm handoff” allows the patient to connect to the psychologist/psychology intern and spend a few minutes in brief counseling. It has greatly decreased the “no show” rate of new referrals. “Curbside consults” allow providers to quickly ask each other questions about a concern they are having about how to treat a patient.

Learning new boundaries. The psychology intern is in a tricky position of having information to offer, yet learning to defer to members of the team when appropriate. Interns need to know a little something about medicine, especially psychopharmacology and psychosomatic complaints, but they leave the practice of medicine to the experts. Occasionally they are asked to “recommend” medication, but we encourage them to defer to the physician, hitting the target behaviors to medicate without naming a particular drug.

Family Medicine Residents
At the same time that our psychology interns came on board in the family medicine clinic, we implemented a policy to deliver a depression assessment (PHQ-9, Spitzer et al., 1994) to every patient who walked through the door. This decision was made as part of a larger project of integrated behavioral and physical health. In order to make the burden less onerous to the physician, we scheduled a behavioral health provider to be in the clinic at all times. The deal the psychologist made with the MD’s was this: If the PHQ-9 revealed more psychological problems in your patients, the psychologist would offer more psychological support. The deal worked well. The physicians were no longer resistant to dealing with depression, as long as they had the backup support they needed. Further, the residents and faculty were delighted to be able to provide on-site psychological services to their underserved population. The fact that the services (with the psychology interns, at least) were free of charge made the deal even sweeter, since so many of our patients are impoverished.

Learning how to consult with on-site psychology. As it is in much of the country, there is a severe shortage of mental health care in Northeast Texas. As a result, this care typically falls to the primary care provider, at least in the initial stages of treatment. Unfortunately, typical training in both medical school and residency settings is limited in scope in the areas of psychiatry and psychology. Traditionally, virtually no interaction or training occurs with clinical psychologists.

Within the family medicine residency program, four steps have evolved in the interprofessional training of family medicine residents with psychology interns. The first of these was learning what a clinical psychologist actually does for patients, as well as the help she can offer medical providers. Since medical schools offer little contact with this profession, residents and medical faculty
alike had to orient to how to utilize, interact with and integrate psychology into medical practice. Second was learning how to identify psychological and psychiatric issues during clinic visits. These concerns are not readily apparent to physicians who are intensively trained to identify and treat physical illness. Conversely, these concerns are also often invisible to our patients. Oftentimes patients are focused on their physical complaints. The third step was helping residents learn both how and when to ask for help from the psychologist or psychiatrist. Fortunately, this has been made easier by the fact that access to these specialties is immediate because they are embedded. The fourth step is teaching residents to work as a team with the psychologist and psychiatrist so that the patient benefits the most.

Learning a few counseling skills. Mental health training in medical schools has typically revolved around DSM criteria for diagnosis and "medical" therapy with pharmacetics much more than psychological counseling. In many cases there is limited time for primary care providers to stop and take time to counsel patients even if the proper training had already been obtained.

In their family medicine residency training, residents learn basic counseling skills through both formal and informal means. Informally, residents learn from the clinical psychologist and psychology interns during everyday encounters with patients. When the medical resident identifies a psychological issue, the resident has immediate access to the psychology team and frequently does a “warm hand-off.” The warm hand-off is initiated by the resident and it helps “break the ice” between the patient and psychologist or psychology intern. By facilitating the initial interaction between the patient and mental health care provider, the primary care provider is also intending to reduce the “stigma” of being treated by a psychologist or psychiatrist. Further, during these team-with-patient interactions, the resident can directly observe the skills that the psychologist employs. Over time, the resident begins to use these same skills of her own accord. At the end of the warm handoff, the patient is then offered an appointment to meet back with the psychologist or psychology intern for further counseling, as well as the appointment to meet back with the physician.

In addition, residents develop counseling skills through shadowing by the psychologist faculty. The psychologist shadows residents during patient encounters and gives immediate feedback to the resident on his interviewing and counseling skills. Further, all residents receive multiple lectures in Motivational Interviewing techniques. Finally, many residents choose to spend elective time with the psychologist to improve their own interviewing and counseling skills.

Learning how to use brief measures. In clinical practice there are a number of screening tools available to medical practitioners to use for many different medical conditions. During medical school training, typically little more than a brief notation during a lecture is given to the use of screening tools such as the PHQ-9 (for depression), GAD-7 (for anxiety) (Spitzer et al., 1994), and Mood Disorder Questionnaire (for mania) (Hirschfeld, et al., 2000). In our residency, these mental health screening tools are discussed and the proper use is taught on a daily basis. In fact, all patients in the family medicine clinic receive and are encouraged to complete a PHQ-9 at each clinic visit. In this way, many patients are found to have symptoms of depression that were not readily apparent to either the patient or health care provider. The proper use of these measures during everyday practice has been eye-opening for our residents and faculty.

Increasing experience in using psychotropic medications. The appropriate use of psychotropic medications in our family medicine clinic has greatly improved as well. Residents and psychology interns have a basic understanding of psychotropic medications. However, when medication decisions become more complicated, residents, psychology interns and faculty have immediate access to competent and experienced psychiatrists for questions regarding the use of psychotrophic medications. A positive side effect of calling on the psychiatrist is typically a “mini-lecture” covering the current problem on a real-time basis, helping drive home the clinical teaching points.

Increasing awareness of psychosocial dynamics of health. The integration of psychology training has increased residents’ awareness of the effects that mental health disorders can have on the physical and overall well-being of patients. Interdisciplinary didactic sessions involving medical residents, clinical psychologists, psychology interns, pharmacists and psychiatrists deepen this awareness and further their knowledge and understanding. Family medicine residents are now much more alert to and “in-tune” with screening for and treating anxiety, mood disorders and other psychological disorders, as well as the impact of these conditions on medical and physical illness. Further, residents are better able to educate patients on the impact of mental health upon physical health, in general, and upon cardiovascular morbidity and mortality, hypertension, and diabetes, in particular.

Psychology Interns and Family medicine Residents
The benefits to both groups of learners have been multitudinous and often subtle. As the year has progressed, interactions and trust have built. Working together with a “teammate” enriches both sets of learners, and opportunities begin to blossom as a result. We did not anticipate the extent to which this might happen. For example, one of our psychology interns was having a slow day, with numerous “no show” appointments. With a little encouragement, she asked a third-year resident if she could “tag along” during his clinic. What they both discovered was that many patients who were there to see the doctor had underlying
psychological issues that the psychology intern could help identify. Her questions to the patients gave the physician an example he could follow. The intern also began to learn more about the wide variety of problems and the huge time demand that faces her counterpart. As a result, the resident asked if the psychology intern could accompany him on inpatient rounds as well. Both agree that if her questions begin to go into the direction of a counseling session, that due to his time constraints, the resident will move on to the next patient and the intern can catch up to him later. In this and other ways, our learners are creating new forms of collaboration, and all are enriched, including the patient. Hence, our learners are also one another’s educators.

**Patient benefits**

Our patients are benefitting tremendously. They are receiving high-quality integrated care. The combined package of primary care and psychology provides the patient with “one-stop-shopping” for their well-being. They leave our clinic feeling that they are being well cared for. For those who seek psychological care, they get to return to the comfort of their regular doctor’s office for that care. They also know their physician knows something about their progress in their psychological care, as well as the fact that their psychologist or psychology intern is following what is going on with their medical care. If there is a problem, the doctor can pop her head in to talk to the psychologist, and the psychologist can do the same.

**Conclusion**

“By combining training of family medicine physicians and psychology interns, both disciplines develop mutual trust, a practical understanding of one another’s skill sets, and the ability to communicate effectively about patient care issues (Hornyak, 2013).” The further along we have gone in the direction of integrating training and integrated care, the more we have asked ourselves why we hadn’t done this sooner, or better yet, why hasn’t it always been this way? The effect of interprofessional training is far reaching. Newly minted physicians and psychologists will take this experience into the community, better prepared to provide quality care to their patients, with tools of integrated care in their armamentarium. Psychology is a natural fit for family medicine, and family medicine is an equally natural fit for psychology.

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THE COMMON FACTORS OF SOCIAL JUSTICE

Joseph H. McCoy, Ph.D.

When I started my practice in the Rio Grande Valley 16 years ago I would not have identified one of my “in groups” as social justice. My concept of “those people” (I felt that the social justice advocates at TPA were my out group) was one of well-meaning do-gooders, at best. As you might expect, since I’m writing this article, I have undergone a transformation. Now check your reaction. Are you aware of your own relationship to social justice advocacy in your practice? In your personal life?

When families seeking my services began showing up to my office on a regular basis having allegedly been told that their child did not have one of a number of learning or developmental disorders, I began to feel like Shane in the movie of the same name. He rode into a new town and found himself drawn into an argument not of his making. (Dr. McCoy bears no physical resemblance to Alan Ladd—Ed.) The more I heard the less I could ignore systemic injustice. I metaphorically threw my cigarette down to the ground, squashed it out, and said, “that ain’t right,” but I had no gun and no holster (or so I thought). I began to understand that explosive children were not having their needs met properly, and in fact school and agency administrators were making decisions that made things worse. I sought training on how to assess and manage such behavior so I could offer helpful collaborative solutions. However, I found that offers of collaboration or new approaches were soundly rejected by all but one principal who was towards the end of his career and did not worry about lawyers or threats from the superintendent. He helped my client get through junior high school, but sadly he couldn’t be there for her in high school, nor were his or my advice followed at that level. She found her own solution to the school’s failure, pregnancy—not once but twice. To all of this I found myself doing my powerless impression of Shane all over again.

Eventually, I became aware of some organizations to which I could refer families and get some results, and not feel so powerless; oh, so I do have a gun (my referral pad), and my referrals/resources (a bullet to shoot), and my holster, of course, is an iphone. However, serving this population is not fast-tracking me to the country club life.

I digress. My bullets include often include Disability Rights Texas (f.k.a. Advocacy Inc.), NAMI, Mental Health of America, the ARC of Texas, MH/MR, the Mental Health Coalition of the Rio Grande Valley, the Lone Star Psychology Internship Consortium (formerly the Lone Star Psychology Residency Consortium), and fellow health care workers to name a few. Of the latter group this includes psychologists, LPCs, social workers, case workers, physicians, psychiatrists, occupation-speech-and-physical therapists, nurses and so on. Also, many people in various state agencies do right by the good people of Texas despite the reputation of their agency or some of their colleagues. Being armed with these bullets of various caliber, I began to say “that ain’t right” with a little more conviction.

In addition, seeing children and disadvantaged adults be mistreated by various members of agencies designed to be helpful has bothered me. Being in a community with limited resources I recognized early on that I may be the only person in the life of my clients capable of advocating for them. I decided that I either had to find ethical ways to accomplish this or I’d have to leave the area I was serving, because I couldn’t live with what it would do to me to ignore it, while making weak excuses like “it’s not my role” or “gee life’s not fair.” I would not sleep well.

My mind was persistently ringing with the things my father had constantly reminded me—things of which he led by example: that he did not promise me “fair”, that even in the face of enormous pressure, you do what you think is right and refuse to do wrong, and that you give to and help those who are worse off than yourself. Thanks to his mentoring, in both my professional and personal life, I have felt an inclination to use both the fair and unfair advantages that I have to assist others in their struggles against injustices, which grind them down. This is especially true when the struggle falls in my area of expertise.

Sometimes I find I am in a unique position to be helpful. For example, it may be a politely, but sternly, worded letter reminding special education directors or principals of TEA guidelines and federal statutes like 504, ADA, and IDEA and/or suggesting to them that certain simple solutions could solve the problem with little conflict. I find I have written a lot of letters. My psychologist role gives me a unique vantage point to understand both the experience of my clients and the requirements and regulations that are supposed to direct the agencies with whom the clients interact.
Do these examples mentioned so far have anything to do with ethics or social justice? Looking at the APA Ethics Code in the General Principles, Principle D begins with “Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists” (para. 5).

I find that my urge to be more helpful to those who are more disadvantaged or less knowledgeable about how psychological services can be used is on track with this aspirational guideline. In discussing the provision of services to the homeless, Liu, Stinson, Hernandez, Shepard, and Haag (2009) have a similar suggestion for psychologists to address:

As psychologists strive to include social justice into their work, the reports of the men in this study are a reminder of this population’s dire need for direct services and advocacy. For instance, psychologists not already employed in agencies that serve the homeless population might consider volunteer[ing or providing] other probono work within these settings. Psychologists working or volunteering in these settings need to learn about and understand the complexity of social services available for both men and women [and children] who are homeless. … Often, agencies may not have psychologists or access to psychologists who can navigate hospitals and health care agencies (e.g., a Department of Veterans Affairs). Furthermore, access to health care settings is sometimes contingent on accurate psychological assessments, which must be communicated to other health care specialists. Psychologists, with some additional training and experience, would be best suited for these settings. (pp. 131-148)

Frankly, this concept could be applied to nearly any population in your community at one time or another. My personal recommendation is that you consider serving a population a few hours a week or month that is on the top ten list of most disadvantaged in your community, which in every community would include the uninsured. At the same time we all have contact with the “underinsured” insured clients as well. Even with the rollout of the Affordable Care Act, this group still exists. I’m certain you’ve encountered those folks with “no mental health benefit” – that’s the current loophole around parity of care, which still has not been effectively closed. Also, because insurance companies were waiting to learn what the health care legislation was going to look like, they used that as an excuse to not act on the parity legislation deadline passed with TARP. As a consequence, we still have clients who have huge deductibles on their mental health benefit. For them it’s more affordable if my office negotiates a cash discount for that individual because, for the problems they are presenting us with, we know they are not going to reach that high deductible limit. Even though this issue falls into social justice, it is such a common problem with practicing health care that we all have to have mechanisms to accommodate this. So while it is a just thing to do, to advocate for your patients with third party payors, I believe we are better off as a profession if we all advocate in at least this way. However, it is my personal opinion that if this is the only form of justice you practice, then you really are not meeting the criteria of our ethical Principle D. We all need to help with the “fairness to access to and benefit from” our services to people who are less commonly getting seen by most us.

An option that is available is offering services at one of the many “free clinics” that are set up around the nation as non-profits, which are run completely on volunteer time from health care professionals of all disciplines. In my community, I recently gave a professional development presentation at such a clinic to help raise money for the center to operate. Due to the fact that this presentation was on ethics and included the latest information, it was well attended and the sponsoring agency was able to charge top dollar and keep all profits. There are many ways that you can capitalize on your areas of expertise. If you are excellent at something in our field, you have the power to donate your time providing seminars that can be used to raise money for organizations that provide services for those who normally cannot afford them. You can supervise trainees who are willing to serve in such agencies and clinics if it is for informal hours. You can also “Give an Hour” to one of the many vets returning to your community. (See www.giveanhour.org/)

Another way you can give that help both the profession and those in need of service is when you serve on regional or statewide committees that help direct service to be fair and effective. This includes the many committees you can volunteer for or be appointed to that advise Texas Health and Human Services, the Department of Health Services, the Department of Disability Services, and state regulatory boards of all kinds. Many of your peers in TPA do this, and it has led to policy changes that benefit all Texans. A recent example of this that helped the profession was when one psychologist mentioned that if LPAs are added as extenders for Medicaid services so should PLPs and LPs until they get their Medicaid number; otherwise, the system creates an inherent disruption in the continuity of care. Many of your peers have had a role in shaping how services are now delivered within many state agencies for the good of all. One of these was our past president Dr. Ollie Seay, who sat on a Behavioral Health Integration Advisory Committee that was appointed to help advise HHSC on improving these services. She still sits on another Behavioral Health Advisory Committee that continues to work on these issues after the form committee finished its task.

The final area of social justice I’m involved in, that is a passion of my life, is being involved with the wonderful people who formed the Lone Star
Psychology Internship Consortium. Many of your colleagues have been or are currently involved in this. One of its main purposes is to train future psychologists in underserved areas so that they may start their careers in those underserved areas and help make these areas less underserved. There are psychologists with other start up consortia throughout the state doing similar work. Additionally, we have a psychologist with the Hogg Foundation who is helping to direct projects aimed at improving the work shortage in psychological services in this state. That is social justice in action.

While this article may sound like self-aggrandizement, it is intended to provide examples of social justice involvement that we all can engage in, which may not fit the stereotypical forms of social justice. Similarly, involvement does not have to involve the stereotypical “social justice” issues, whatever you think those are. It does not have to involve protests or sit-ins (although I do find it personally enriching, for my own development, to hang out with those who fit these stereotypes).

In addition, I can easily think of 20-30 of my dear colleagues in TPA who could have written this using the examples of how they practice social justice. My hope is that this stimulates your mind on how you can apply this concept in your professional and/or personal life in any small or large manner – thus enriching your life and the life of your community. Finally, you might begin to consider that the “social justice” crowd could be one of your “in groups.” Perhaps you might feel welcome at a Social Justice Division Meeting at the next TPA Annual Convention and to participate in our activities throughout the year. The chair of the Social Justice Division is Dr. Rick McGraw (rmcgraw@wcc.net). I’m sure he’d welcome your interest, and I guarantee that whatever your efforts you will gain personally when you incorporate justice advocacy into your thinking.

Editor’s note: Dr. McCoy is Past Director of Training and a current Site Director of the Lone Star Psychology Internship Program, an active leader in the TPA Social Justice Division, and a Platinum Advocate Member of TPA. He operates a successful group practice in Edinburg, TX.

PROFESSIONAL DEVELOPMENT FOR TSBEP LICENSEES

License renewal changes are just around the corner - October 1, 2014

Let’s take a moment and clear up any confusion you might have about the updated TSBEP professional development requirements. Beginning October 1, 2014, all licensees renewing their license will be 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 rules, 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) The changes affect licensees renewing beginning in October 2014. (August 2014 and September 2014 are not required to adhere to the updated rule until your 2015 license renewal.)
3) For those renewing October 2014 forward, you 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.
   b. At least three of those 20 hours must be in the area of cultural diversity. Examples include: age, disability, ethnicity, gender, gender identity, language, national origin, race, religion, culture, sexual orientation and social economic status.
   c. 10 of those 20 hours MAY be earned from any of the sources from which you have earned qualifying CE before, as long as it is directly related to the practice of psychology.
   d. 10 of those 20 hours MUST be earned 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.
4) 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 would have happy to answer them for you.
Call the central office at 888-872-3435 or email tpa_sreisman@att.net.
Austin, Texas is known as “The Live Music Capital of the World” and boasts having more music venues per capita than any other city in the United States. Every year, tens of thousands of visitors flock to Austin for the Austin City Limits and South by Southwest music festivals, and locals enjoy listening to world-class musicians perform in historic clubs like Antone's, the Broken Spoke, the Continental Club and the Cactus Cafe. Austin is home to many award-winning artists and groups, including Willie Nelson, Asleep at the Wheel, Gary Clark, Jr., Spoon, Shawn Colvin, Explosions in the Sky, Patty Griffin, Grupo Fantasma, the Dixie Chicks and Jimmie Vaughn, as well as Rock and Roll Hall of Fame inductee Ian McLagan. Live music is not only integral to Austin's cultural identity, but also to its economy. The music industry generates almost two billion dollars in economic activity for Austin annually and provides over 18,000 jobs (TXP, Inc., 2012).

Austin musician since 1991, rues that “…you literally don’t make any more money playing a gig in Austin today than you did 23 years ago” (Curtin, 2013). Musician earnings in Austin average $23,371 annually, with $15,504 coming from creative work earnings and the remainder from side work (Austin Creative Alliance, 2013).

While musician pay has remained stagnant, the cost of living in Austin has soared due to real estate value growth rapidly outpacing regional income growth. The Austin Creative Alliance study suggests that for the average Austin musician to live exclusively from performing music, rent would need to be about $388 per month. The average monthly rent reported by musicians in this study was $749 (2013). Austin Chronicle reporter Kevin Curtin notes:

Austin stands burdened with a cultural conundrum: A largely impoverished class of musicians earns the city a hip reputation, in turn contributing to its spectacular population growth. Consequently, rent and real estate grow more and more expensive, making it difficult for musicians to afford living there... Put simply, musicians are being negatively impacted by the economic growth that they help stimulate. (2013)

Economic strain represents only one challenge Austin musicians face in plying their trade. Many people idealize the professional musician lifestyle as a care-free, bohemian existence. The following review of musician occupational stressors and psychological vulnerability, however, portrays a more unadorned reality.

Musician Occupational Stress and Mental Illness

Being a gigging musician is stressful. In a pioneering study, Willis and Cooper (1988) surveyed 246 British musicians working in rock, pop, jazz or commercial music genres and performing in live music venues, recording studios, and other settings to study their occupational stresses. Multiple concerns were identified, including performance-related anxieties and maintaining self-imposed...
standards of musicianship, alternating periods of high performance pressure and boredom, unpredictability of work, concerns about career development and relationships with other musicians, and the impact of unusual work hours and frequent travel on personal relationships (Willis, 2001). Similarly, Angel (2010), in a survey of over 1,300 North American musicians, identified five rank ordered factors associated with sources of musician stress: Musician Identity (including the highest loading survey item, “Feeling that your musical ability is not appreciated because of the public’s ignorance about music”), Work/Pay (lack of work and benefits, struggling to become better known or better paid, and having to play disliked music to earn a living), Artistic and Business Relationships, Performance Anxiety, and Travel and Work Environment.

Occupational stress is associated with increased risk of developing both medical and mental disorders (American Psychological Association, 2009), and working musicians are no exception. Of all musicians surveyed by Willis and Cooper (1988), gigging musicians, “the kind who work in clubs…and touring musical shows,” were the most highly stressed group (Willis, 2001, p. 27). They also demonstrated the poorest overall health and expressed the least satisfaction in their work as musicians.

In addition to work-related stress, musicians and other artists have long been considered more vulnerable to mental illness than the general population because of their creative temperament (Jamison, 1993). Much of this research is based on historiometric research methods that examine historical data through the lens of objective, quantitative analyses. Ludwig (1995), for example, investigated evidence of mental disorders in the published biographies of 1,005 eminent people in 16 professions reviewed in the New York Times Book Review from 1960 through 1990. Lifetime rates for any psychiatric disorder in musical performers were 68%, compared with 18-29% in less creative occupations, such as business, military, politics and physical sciences.

Simonton (2005), in a review of the research linking creativity and mental illness, estimates highly creative artists are twice as likely to experience some form of mental disorder compared to less creative individuals, with depression, alcohol dependence and suicide being the most common presentations. Although a number of these studies have been criticized due to selection and measurement bias (Schlesinger, 2012), a large epidemiological study examining suicide rates for 32 occupational groups based on data from 1990 national mortality files -including 9,499 suicides in 21 states - found musicians to be 3.6 times more likely to commit suicide than average (Stack, 2002). By comparison, physicians, a widely-recognized high stress occupation, were 1.9 times more likely to kill themselves than the general population.

Unfortunately, many musicians with mental health issues lack access to affordable health care. A recent national survey of 3,402 creative artists conducted by the Future of Music Coalition (Thompson & Cook, 2013) found 43% of musicians and other artists did not have health insurance, more than double the 18% national estimate. The vast majority of respondents (88%) cited lack of affordability as the primary reason for lack of coverage. Those respondents who spent more time or derive more income from being an artist were less likely to be insured. Texas artists were least likely to have health care coverage - less than one in four.

Many self-employed musicians stand to benefit from the Affordable Care Act expanding access to affordable health care coverage. Unfortunately, Texas’ decision to opt out of Medicaid expansion continues to leave many low-income musicians without an affordable health care option.

The SIMS Foundation: A Brief History
Research findings demonstrate that performing musicians present with economic and occupational stressors and psychological vulnerability that place them at significant risk of developing mental disorders, with more limited mental health treatment access than most. Austin musicians, however, are fortunate to have a unique resource to address their mental health concerns. The SIMS Foundation is a 501(c)(3) non-profit organization that has provided mental health services to thousands of uninsured and underserved Austin musicians and their families since 1995, including counseling, psychiatric medication management and substance abuse treatment.

The idea for the SIMS Foundation emerged in the wake of the tragic suicide of Sims Ellison, a popular Austin musician with a significant history of depression. In the months preceding his death in June, 1995, Sims Ellison experienced the loss of his band’s major-label record contract as well as the breakup of a serious long-time relationship (Corcoran, 2010).

Inspired by an Austin American Statesman article by Michael Corcoran, who proposed that Sims Ellison’s memory would be best served by creating a counseling program for musicians (Moser, 2010), Austin Rehearsal Complex (ARC) owners Don Harvey & Wayne Nagel, along with Sims’ father Don Ellison, answered the call. They conceptualized and created a unique organization where therapists would mitigate their fees, the organization would subsidize a portion, and musician clients would pay a small amount in order to be invested in their treatment. The original board of directors was then expanded to include attorney-songwriter Walter Taylor (who established the organization’s 501(c)(3) status) and recording artist Alejandro Escovedo (D. Harvey, personal communication, May 24, 2014). Then known as the S.I.M.S. Foundation (an acronym for “Services Invested in
Musician Support*), it has since come to be known affectionately as SIMS (Langer, 1996; Moser, 2000). According to co-founder Don Harvey,

It was truly a grassroots effort. We knew most musicians couldn’t afford proper mental health care and we didn’t want to see more tragedies occurring. Something had to be done, and no one was going to do it for us. We took it upon ourselves and the entire Austin music community rallied to the cause.

(personal communication, May 24, 2014)

SIMS struggled for a number of years initially to meet increasing musician requests for mental health services with limited personnel and financial resources (see Langer, 2002). A chief benefactor during the early years was radio station KGSR and its program director at the time, Jody Denberg, who beginning in 1997 donated annual proceeds from the popular KGSR Broadcast CD series to the SIMS Foundation. KGSR to date has donated over two million dollars to support the SIMS mission (KGSR, 2014).

The SIMS Foundation has through the years developed into a mature, financially sound non-profit organization with a 2014 operating budget of $869,000, fed by healthy, diversified funding sources (SIMS Foundation, 2014a). The current structure of SIMS includes a managing director and clinical director that co-lead the organization, four staff members, a board of directors, a clinical advisory board, a music advisory board, and a host of dedicated volunteers. SIMS participates in numerous community outreach events throughout the year, hosts an annual fundraising concert (in addition to quarterly musical events for funders), and partners with like-minded non-profit organizations like the Heath Alliance for Austin Musicians (HAAM), which provides access to affordable medical, dental and vision services for uninsured Austin musicians (HAAM, 2014).

**SIMS Clinical Services and Client Satisfaction**

In 2013, the SIMS Foundation provided mental health services to 620 Austin musicians and family members and, on average, added 20 new clients monthly (SIMS Foundation, 2014a). The majority of SIMS clients (84%) first learn of SIMS through word of mouth in the music community or referral by the Health Alliance for Austin Musicians (SIMS Foundation, 2014b).

In the latest 2014 SIMS client satisfaction survey, which included 158 completed responses for a response rate of 20%, 62% of respondents were male and 38% female. Twenty-four percent were in the 20-34 age range, 21% ages 35-55, 28% between 40-49 and 27% ages 50 and older. Seventy-eight percent were White, 7.6% Hispanic, 3.8% African American, 6.3% mixed ethnicity, 1.3% Native American, 1.3% Asian or Pacific Islander, and 5% other (SIMS Foundation, 2014b). This ethnic distribution is not representative of the Austin population, which includes 35% Hispanics and 8% African Americans (U.S. Census Bureau, 2010), and indicates a need for stronger outreach efforts to minority members in the Austin music community.

The household income for 67% of current SIMS clients is at or below 133% of the federal poverty level (SIMS Foundation, 2014a), which disqualifies fully two-thirds of SIMS clients from participating in the Health Insurance Marketplace and leaves them without affordable health care options due to Texas’ refusal to expand Medicaid eligibility. Only 10.7% of SIMS-serviced households make more than 200% of the federal poverty level, which is $23,340 for an individual and $47,700 for a family of four (SIMS Foundation, 2014a; FamiliesUSA, 2014).

To access services, musicians call the SIMS confidential client line (512-494-1007) and speak with a licensed clinical specialist who conducts a targeted clinical assessment to determine appropriate referrals, as well as eligibility for services. Given performing musicians’ unconventional work schedules, a priority of SIMS is to be available to musicians in distress when they need help. The phones are staffed after hours with operators generously provided by Alliance Work Partners, an employee assistance program, who take messages for the intake counselors to return the next business day.

After the initial phone intake, new SIMS clients are referred to counseling, psychiatric medication management or addiction recovery services based on their presenting need. SIMS intake counselors also provide brief telephone counseling and case management services, including routinely contacting clients within two to four weeks of starting services to insure a goodness of fit with their clinical provider to minimize premature dropout. The SIMS Foundation currently partners with over 50 licensed professional counselors and clinical social workers, two psychologists, 16 psychiatry residents and four psychiatry faculty with the Seton Mind Institute (which also provides intensive outpatient program groups), five community psychiatrists, the Austin Recovery Center for detox and residential treatment, four sober living homes, and a pharmacy assistance program. Approximately 90% of SIMS clients are engaged in counseling services, 30% receive psychiatric medication management and 8% are involved in addiction recovery treatment (SIMS Foundation, 2014b).

SIMS clients routinely express high satisfaction with the clinical services they receive. In the 2014 client satisfaction survey, 97% of respondents rated SIMS staff and counselors as good or excellent, as well as 91% of psychiatrists and 82% of addiction specialists (SIMS Foundation, 2014b). Ninety percent of respondents also endorsed symptom reduction and improved functional status since beginning services.
A Musician's SIMS Story
SIMS client satisfaction survey responses capture only one facet of the impact these clinical services have on musicians and their families. Many musicians insist that “SIMS saved my life” and share their experiences like the one below to pay it forward.

There were a lot of moving parts to my own recovery. For a long time, I didn't know I needed help – being isolated, even in a large crowd, is so much part of the life that I didn't notice that I was slipping away. When I started to understand that I needed to do something, I had no idea what that might be – apartness had become so ingrained in me that it didn't occur to me that treatments available to “civilians” might also work for me.

But I was lucky enough to have a longtime friend who is a therapist, and when I finally talked to her, it wasn't five minutes before she said, ‘Okay, here's what you're going to do.' It turned out she did most of it – I really was in a bad place – and what she did was put me together with SIMS.

That first phone call I made could've gone badly – musicians are so sensitive to tone that a wrong note would've driven me away. Instead, I immediately felt accepted – both as a musician and a human being.

I got help. The help helped. And I learned there were things I could do to feel better, and if I practiced those things – a process with which I'm very well acquainted – my recovery could be hastened.

All this seems so obvious to me now. None of it did, then. All those moving parts – realizing I needed help, finding out what form that help might take, being able to access that help even though I was nearly penniless, at every step of the way met with caring and compassionate people – all revolved around SIMS. I honestly don't know what would've happened to me without that organization, and I count myself incredibly lucky to live in a town where such services are available. (J. Jordan, personal communication, May 23, 2014)

Summary
Austin, Texas has a strong tradition of community activism to preserve the natural and cultural resources that make Austin unique. The Save Our Springs Alliance, for example, began as a grassroots movement to protect the quality of water flowing into Barton Springs, one of Austin's “crown jewels.” Austin's unofficial slogan, “Keep Austin Weird,” was coined by a local librarian and adopted by the Austin Independent Business Alliance to promote local business and the preservation of Austin's distinctive countercultural heritage.

In the same tradition, the SIMS Foundation began as a small grassroots collaboration of dedicated Austin music and mental health community members to support another vital and vulnerable Austin resource – its musicians. In 2015, the SIMS Foundation will observe its 20th year of providing interdisciplinary mental health services to Austin musicians and their families. The skyline of downtown Austin and national landscape of the mental health delivery system have changed in ways unimaginable 20 years ago. SIMS, too, has evolved and now serves as a model for providing specialty mental health services to musicians for other communities to emulate. Looking to the future, the SIMS Foundation continues to strategically adjust to changes in health care delivery with the implementation of the Affordable Care Act, while still providing a safety net for those Austin musicians and families who do not otherwise qualify for affordable mental health care.

But in other ways, nothing has changed at SIMS. SIMS providers, who recognize the unique economic and occupational stresses and psychological vulnerabilities so often inherent in being a performing musician, use these insights to bridge theory and practice with their SIMS clients’ presenting concerns to develop strong working alliances and effective therapeutic interventions. Within this “creative space” (Mitchell, 2012), SIMS clinicians work collaboratively with musicians and their families to decrease emotional distress, promote overall health, and help keep Austin musicians “in tune.”
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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
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- FREE doctor finder subscription (referral service)
- FREE, unlimited phone consultation with an attorney
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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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TPA Online Groups - How to Participate

So, TPA has a snazzy new website platform – with a lot of cool, innovative features – but how do you use them?! One of the features we are most excited about is the social interaction capability of our site. TPA Divisions and Special Interest Groups now have their own homepages, forums and directories under the new “Group” function. It is our hope that this will continue to stimulate interaction and discussion among colleagues and provide meaningful networking opportunities.

1. Login to TPA profile.
2. Click on “Groups” under “My Profile” on the right side of the screen.
3. All groups that you are currently active in will show up on the screen.
4. Click the group that you wish to interact with.
5. You will be brought to the group’s homepage screen:

   6. All of the group’s functions will be listed on the right of the Group Feed.
   7. The two main features Groups use are:
      i. Group Directory: see who is in your Division, SIG or Committee.
      ii. Forum: this function will serve as the group listserv for discussion topics.

**How to Use the Forum Function**

1. Click on “Forums”
2. Click on “General Discussion”
3. All of the group’s discussion topics will show up under this section.
4. On the gray bar above the list of topics, select “Forum Activities.” Select “Subscribe to Instant Updates.” By selecting this option, you will receive an email notification when there is an activity on this forum – for instance, when a new topic is created.
5. When a new topic is posted – you will need to follow the same process and subscribe to the topic as well. View these topics as different Subjects in listserv emails. To subscribe to Topic Notifications:
   - Go to the group homepage of the Division
   - Click “Forums” on the right rail of the group menu
   - Click “General Discussion”
   - Click the topic you want to subscribe to
   - Under “Thread Actions” select “Subscribe to Instant Updates”

Please note that the Group Forums will be replacing the Division Listservs. If you still want to receive relevant Division information, please be sure to subscribe to both the Forum and all Topics within the Forum that are of interest to you.

If you have any questions, we will be more than happy to help walk you through this process. Contact Lauren Witt at 888-872-3435 or tpa_lwitt@att.net.
Does she need more than just medicine?

When she needs help getting medical equipment, refer her for case management services, a Medicaid benefit for children birth through age 20 and high-risk pregnant women. Case Managers help patients navigate the health system by providing access to medical, dental, behavioral health, educational, and social services related to their health conditions.

Anyone can make a referral.
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