Awards Issue

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A Note From the Editor of the
Texas Psychologist

Brian H. Stagner, Ph.D.
Editor

We are putting this issue of the Texas Psychologist together in late December and still buzzing from the annual convention in Houston last November. Were you there? We had a great time and folks are already making plans for next year, November 13-15 in Dallas, so mark your calendars! In addition to attending, a number of informative presentations, those in attendance shared in recognizing the hard work of psychologists and others in promoting the interests of psychology around the state. Each of them exemplifies the power individuals can have in promoting change. You’ll find their pictures and an all-too-brief summary of each person’s good works later in this issue.

The convention always reminds us of the power and limits of our knowledge. We have a chance to celebrate the new knowledge our colleagues have brought to the world, and opportunity to hone our professional awareness in our own work. This issue includes a refresher on the basic points of determining legal competency, an update of concerns from the TSBEP, and a detailed review of emerging knowledge about concussions in children.

The issue of competency brings psychologists into both criminal and civil jurisprudence. Law and Order fans will be familiar with the question of competence to stand trial. It is likely that it is as close as many of us will get to that side of the problem. Civil competence is another matter. As the population ages and society faces the need of growing population of individuals with varying age-related impairments: Psychologists will be asked to assist the courts and caregiver agencies in making defensible determinations about competency. Dr. Floyd Jennings has provided a succinct yet thorough primer on the legal procedures involved in competency and determination. Keep it handy; you never know when you’ll need them.

Unless you are a specialist you hope never to need the information in the article by Stavinhoa, Castillo, Holland, and Hernandez on pediatric concussion. As parents, we would all probably prefer that kids and concussions don’t share the same universe, but unless we keep our children encased in cotton batting and Styrofoam packing peanuts there will be head injuries.

With all the publicity about concussion syndromes in professional sports, there is a lot of misinformation about the impact of concussion on the developing brain. Thankfully, our understanding about concussion has clarified what variables we should be monitoring and how we should support the concussion patient during recovery. Psychologists (and parents) may be surprised at the extent of what has been learned. Check it out!

Finally, there is a short discussion of concerns from the licensure board. The TSBEP Executive Director, Mr. Darrel Spinks, and TSBEP Chair Dr. Tim Branaman were kind enough to attend the TPA Board meeting and to make a presentation to the convention in a public session. We persuaded Mr. Spinks to share some of his slides and the high points are presented here.

TPA comes off of a big year in 2013, with some major triumphs in the legislature. Let’s keep the momentum up in 2014! There are many challenges to our profession and many opportunities for individuals to get involved. Each of us can chip in one or two hours a month to help TPA. Start by finding an early career psychologist and taking her to lunch. Bring a membership form with you….

REMEMBER: TPA is YOU!

Turn to page 10 of this issue of the Texas Psychologist to view a list of the 2013 TPA Distinguished Professional Contribution Award winners.

Editor’s Note
I don’t know about all of you, but I am still very much in new year’s mode. Still reflecting on 2013 in awe of what transpired; still looking ahead at 2014 in awe of all that lies ahead; still writing and re-writing my new year’s resolutions with devout commitment to take them seriously... Personally, I love this time of year as it calls for quiet time and space to consider all that surrounds us and decide what is important and what, quite frankly, is not. As a parent, I try to instill this differentiation in my children: Family and friends – important; Xbox and iPhones – not important; Good health – important; McDonald’s – not important and so on.

If I look at what falls on the “important” list, what I want to teach my children, and try to summarize the basic underlying concept, it all seems to boil down to this; helping others, being kind to others, and giving back to the communities in which we live - IMPORTANT. Or, if I may so indulge and say it another way, being a psychologist - IMPORTANT. Is this not what we do on a daily basis? Our patients come to us with high expectations and we must do our best to help them, be kind to them, and ensure that they, too, can continue to function within the communities in which we live. What we do is important and while many agree with us, I think that many do not realize or understand what we do. Or, perhaps, they have a minimal understanding and more certainly, more often than not, confuse what we do with what others in the mental health field do as well (i.e., “you prescribe medicine, right?”).

In this issue, David White, CAE outlines TPA’s legislative agenda for the 2015 legislative session. This is one avenue to educate a significant and influential group of individuals on what we do and why it is important. At the TPA convention in Houston this past November, I laid out my hopes for connecting with other groups in hopes to do the same. At convention, Dr. Ray Brown cleverly chose the theme “Honoring Our Traditions, Expanding Our Horizons” which depicts our need to figure out how to unite with other treatment providers to establish best care practices for the people we serve. While no crystal ball exists, this practice is expected to be the new norm for health care; but until we assert ourselves as relevant providers, co-mingling with other treatment providers will be difficult.

On the topic of this past annual convention, I want to stop and give thanks to Dr. Brown and his incredibly hard-working convention committee; including Chairperson, Dr. Betty Clark, Dr. Greg Simonsen, Dr. Bob McGlaughlin, Dr. Kelly Arneumann, Dr. Robbie Sharp, and of course, our assistant Executive Director, Sherry Resiman. Talk about giving back! These individuals completely volunteered to put this convention together and with out them we would not have had the experience of the engaging Dr. David Eagleman, the distinguished Dr. Nadine Kaslow, and the many other speakers who enlightened and educated us on the varied topics of which we find relevant to our field. Dr. Greg Simonsen has agreed to be the Chairperson for our next TPA convention which will occur November 13-15, 2014 in Dallas. We are already hard at work considering themes, relevant speakers, and other new and innovative ideas to not only build the bridges I identified at this past convention, but actually walk over these bridges and meet others on the other side. If you have feedback, requests, and/or ideas for TPA’s Annual Convention in Dallas this year, please feel free to contact me: marcylaviage@gmail.com. In the meantime, be sure to mark your calendars now!

It's a new year. I am excited to look ahead at 2014 and see what it will bring for TPA. As psychologists, we must continue to look even further ahead – 2015 Legislative Session, 2017 Sunset Legislation, and the Affordable Care Act, overall healthcare reform, and where we, as psychologists, fit into this evolving picture. We must never stop reflecting where we have been and looking ahead at where we are going. As individuals, we may not do that often enough, but TPA is here to do that for you. We just need your help in order to continue to best serve you. We need you and we need your colleagues. TPA will be there for you during these upcoming significant legislative events, but we need you to be involved and more importantly, to get others involved. As your colleagues who volunteered their time to assemble convention, I ask you to volunteer your time to spread the word about the importance of TPA membership. If I could travel to each and every city, academic institution, hospital, and VA in Texas to reach every psychologist, I would do it in a heartbeat. But, the more efficient way of spreading the message is through you. If you need materials to hand out to your students and/or colleagues or other types of summaries of TPA activities (PowerPoint presentation is available as well!), again please feel free to contact me. As we differentiate what is and is not important in 2014, let me be clear: Your involvement in TPA – IMPORTANT.

Happy New Year Everyone!
TPA supports legislation and regulations that improve communication among providers and healthcare systems through the use of information technology and electronic health records that contribute to enhanced treatment outcomes, reductions in healthcare costs, while protecting the privacy and confidentiality of patients.

Quality of Care and Payment Reform: Improving the quality of behavioral, psychological and mental health care in Texas demands improved access to psychologists who are properly trained and reimbursed for their services. It is essential that regulatory agencies recognize and support psychologists to practice within the full scope of their training and expertise and to be reimbursed for services consistent with other doctorally trained health care providers.

TPA’s 2014/2015 Legislative Agenda

The Texas Psychological Association is dedicated to improving the lives of all Texans; with an emphasis on behavioral, psychological and mental health contributions to health and well being. In the 2015 legislative year TPA will focus on: Improving access to care; Improving continuity of care across inpatient, residential and outpatient settings; Improving quality of care; and payment reform.

Access to Care: TPA will work to improve access to behavioral, mental health and substance abuse services and to insure that mental and behavioral health parity is fully implemented for all Texans. TPA will work to insure care for those who are at risk and most vulnerable, including children and economically disadvantaged individuals and families. Access to care translates to increased Medicaid and state funding along with increased staffing in both inpatient and outpatient private and public facilities throughout Texas.

Continuity of Care: There continues to be problems in coordinating care across inpatient, residential and outpatient settings, with providers in each domain having limited access to critical information about patients and the nature of care provided. The lack of continuity of care is a critical barrier to high quality care and improved patient outcomes that reduce unnecessary healthcare costs.

Executive Director’s Message

Our Next Effort at the Capitol

David White, CAE
Executive Director

Coming off a very successful legislative session in 2013: It is time to start planning for the future. Every year your Board of Trustees discuss where the profession is in Texas and how TPA can advance the profession with new or modified laws. The outcome of this discussion is a legislative agenda that gives the Board, Committees, and staff a directive on what we will focus. This agenda sets the tone for what we want to accomplish for the next 12 months. Even though the legislative session in Texas takes place every 2 years bringing the next session to be held in 2015: TPA’s legislative work is in full swing. Our legislative and grassroots committees are currently meeting and developing a strategy on how to get new laws passed. This is your profession and association and we need your help in order to continue to be a key player in the health care arena.

TPA supports legislation and regulation changes that enable psychologists to utilize telephone consultations and telehealth services with their clients and be reimbursement for those services.

TPA supports legislation that enables supervised psychology interns to be reimbursed for providing behavioral, psychological and mental health services.

TPA supports legislation that provides immunity from prosecution for psychologists who are providing psychological services on a volunteer basis.

TPA supports legislation that enables properly trained psychologists to provide cognitive-linguistic or neurocognitive assessments to students who compete in extracurricular athletic events sanctioned by the UIL.

TPA supports legislation that allows psychologists to provide the necessary examination for determination of wards and proposed wards in certain guardianship matters.

TPA supports legislation to exempt licensed psychologists from any requirement to obtain an additional certification/license to deal with sex offender.

TPA plans to collaborate and partner with legislators, staff, professional organizations and patient advocacy groups to enact these legislative changes for the public good of the citizens of the State of Texas.
Pediatric Concussion: What Psychologists Need to Know

Peter L. Stavinoha, Ph.D., ABPP, Christine Castillo, Ph.D., ABPP, Alice Ann Holland, Ph.D., & Ana Hernandez, MA, CBIS

The frequency with which concussions and mild traumatic brain injuries (mTBI) are topics of media reports has exploded in recent years. Accounts of former professional athletes exhibiting uncontrolled anger, depression, cognitive decline and early dementia, and even suicide seem to have become the “face” of concussion. Parents of children who have experienced concussion are often aware of these reports, and this may impact the nature and level of concern they have for their child as well parental expectations for symptom presentation, appropriate management, and eventual recovery.

Increased awareness has lead to vast amounts of sometimes conflicting and unfounded information for the general public to consume and interpret, leaving parents with more questions than answers. Is a concussion bad? Is more than one concussion worse? What should I do if my child has a concussion? Should my child stay out of school following a concussion? What is mTBI and is it the same as concussion? What about long-term problems from concussion? What treatments are there for concussion? Science has not yet provided clear answers to all of these questions, so parents and even professionals are often left to fill in the blanks. This void raises significant risk for misinformation and misattribution, and it is important for psychologists to potentiate neither.

In addition to increasingly fielding queries about concussion from parents, identification and management of concussion are potential practice growth areas for psychologists working with children and adolescents. Even if a psychologist’s practice is not one that specializes in concussion, it is important to stay aware of progress in concussion identification and management to help prevent misinformation and misattribution. For psychologists who include concussion management as part of their practice, it is particularly important to stay abreast of emerging research into the identification and clinical management of concussion. Roles for psychologists are not limited solely to clinical management of individual patients, as psychologists are well-positioned to inform, consult with, and educate primary and specialist physicians caring for children and adolescents with concussion. Definition and Pathophysiology. The term “concussion” is sometimes used interchangeably with mTBI, and there is no consensus on the use of terms either in clinical definition or research criteria. Some authors suggest that including the adjective mild gives mTBI an inappropriately benign connotation, while others believe that using the term mTBI is appropriate because it separates these injuries from more severe TBI diagnoses, which may evoke thoughts of significant structural damage to the brain and prolonged or permanent neurologic dysfunction. It has also been suggested that the use of one term over the other is a product of how the clinician wants to project the seriousness of the injury. For example, if assurance wants to be communicated, then the term concussion is emphasized, while the term mTBI is used to stress the need to take injury seriously (DeMatteo et al., 2010). Even authoritative texts on the topic do not reach a clear conclusion regarding the use of these terms (Holland & Stavinoha, 2010). For the purpose of this article, the terms will be considered synonymous.

Although there is no overall consensus definition for concussion, the International Conferences on Concussion in Sport held in Prague (McCrory et al., 2005) and Zurich (McCrory et al., 2009; McCrory et al., 2013) have moved toward a consensus definition of concussion in sport. The consensus definition provided in Zurich, which has been adopted by organizations such as the American Academy of Pediatrics and the Centers for Disease Control (CDC), is that concussion is a brain injury and is defined as a complex pathophysiological process affecting the brain, induced by biomechanical forces. These guidelines further describe common features that incorporate clinical, pathologic, and biomechanical injury constructs that may be utilized in defining the nature of a concussive head injury, including that concussion: (a) is caused by an impulsive force transmitted to the head, (b) results in rapid onset of short-lived impairment of neurological function that resolves spontaneously, (c) includes clinical symptoms reflect functional disturbance rather than structural injury, (d) may or may not involve loss of consciousness, and (e) recovery is usually sequential.

The pathophysiology of concussion, as described from animal models, begins with a disruption of the neuronal membranes, resulting in an efflux of potassium into the extracellular space with a subsequent release of glutamate (Babikian, DiFiori, & Giza, 2012). Sodium-potassium ion pumps increase activity to restore balance. A brain energy crisis develops because of the increased need for glucose coupled with diminished blood flow. Calcium enters the cell as a manifestation of both nerve cell and axonal disruption. Calcium can be toxic to the nerve cell by triggering various inflammatory responses and even cell death. Within 24 hours, the brain enters a hypometabolic state that can persist as long as 10 days in experimental models, often correlating with clinical symptomatology.
Signs and Symptoms

Because there are no clearly defined biomarkers or medical tests that can definitively identify a concussion, it is important for clinicians to be familiar with the various clinical symptom manifestations of concussion. As with most injuries, symptoms tend to be more prominent nearer the injury, with complete symptom resolution occurring over a period of 7 to 10 days in most cases. According to the CDC (“What are the Signs and Symptoms of Concussion”, 2013), the signs and symptoms of concussion fall into four categories: physical, cognitive, emotional, and sleep.

### Table 1 Signs and Symptoms of a Concussion

<table>
<thead>
<tr>
<th>Physical</th>
<th>Cognitive</th>
<th>Emotional</th>
<th>Sleep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>Feeling mentally “foggy”</td>
<td>Irritability</td>
<td>Drowsiness</td>
</tr>
<tr>
<td>Nausea</td>
<td>Feeling slowed down</td>
<td>Sadness</td>
<td>Sleeping less than usual</td>
</tr>
<tr>
<td>Vomiting</td>
<td>Difficulty concentrating</td>
<td>More emotional</td>
<td>Sleeping more than usual</td>
</tr>
<tr>
<td>Balance problems</td>
<td>Difficulty remembering</td>
<td>Nervousness</td>
<td>Trouble falling asleep</td>
</tr>
<tr>
<td>Visual problems</td>
<td>Forgetful of recent information or conversations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td>Confused about recent events</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensitivity to light</td>
<td>Answers questions slowly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness</td>
<td>Repeats questions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sensitivity to noise</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Numbness/Tingling</td>
<td></td>
<td></td>
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<tr>
<td>Dazed or stunned</td>
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</table>

**Acute and Post-Acute Assessment**

Guidance for acute management of concussion tends to center around appropriate participation in sports. However, when professionals are not present at the time of injury and concussion is suspected, which is more likely to be the case in non-sports related concussions, the child should always be seen for urgent medical evaluation. Acute assessment of sports concussion first involves an on-field physical exam for urgent medical evaluation of vital signs and consciousness, including assessment of any suspected spinal injury. If medical personnel determine that the child does not require emergent transportation to a hospital, the child should be taken to the sideline or locker room for further assessment of balance, reported symptoms, and cognitive functioning. It is important to recognize that some children may be motivated to under-report symptoms in order to return to play. If a concussion is suspected, even if unconfirmed, the child should not be allowed to return to play (“when in doubt, sit them out”). Acute, subtle “tells” that may indicate concussion include dazed appearance, confusion about one’s role in the game, forgetfulness, poor coordination, difficulty remembering events, changes in behavior or personality, and slowness in responding to questions. Thus, immediately following a suspected concussion, the child should remain under constant observation for these and other, more serious symptoms—such as deteriorating mental status, which would indicate a need for hospitalization.

Neuroimaging typically is normal following concussion and most often is only indicated in instances of lingering or worsening neurological deficits, worsening physical symptoms, or repeated concussion. Post-acute assessment (within days of injury) should address the same triad of domains that is the focus of acute assessment: balance, reported symptoms, and cognitive functioning. No consistent relationships have been detected between these three domains, and thus it is important to assess all three rather than relying on just one. For example, a child may not demonstrate difficulties with balance or cognitive functioning but may exhibit symptoms such as headaches and sleep disturbance that can be indicative of incomplete recovery. One measure commonly used by physicians that assesses all three domains in this triad is the Sport Concussion Assessment Tool, Third Edition (SCAT3), which is normed for ages 10 and up and available free online. The SCAT3 provides a brief assessment of orientation, verbal memory, working memory, reported symptoms, balance, and coordination.
The “gold standard” for balance assessment is the Balance-Error Scoring System (BESS), which involves having the child stand in three different positions (straight stance, one-leg stance, and diagonal stance) for 20 seconds each, with eyes closed, at first on a flat and stable surface and then on a foam pad that creates a less stable surface. A healthy individual typically makes about 10 errors over the course of the BESS, whereas a concussed individual typically makes about 17 errors (Bell, Guskiewicz, Clark, & Padua, 2011). However, it is important to note that fatigued individuals also commit more errors than non-fatigued individuals (Bell et al., 2011). Additionally, significant practice effects have been detected (Brogio, Zhu, Sopiarz, & Park, 2009) that must be taken into consideration when assessing a child at multiple time points in a short interval. Other options for balance assessment include computerized force-plate systems such as the Sensory Organization Test, although studies have not shown any advantage for these expensive systems over the BESS.

Acute and post-acute assessment also should include an investigation of reported symptoms including physical (e.g., headache, dizziness, visual problems), alertness (e.g., sleeping more or less than usual, daytime drowsiness), cognitive (e.g., difficulty concentrating, confusion, feelings of mental “fogginess”), and emotional symptoms. Of note, reports of mental “fogginess” have been shown to correlate with slower reactions times, reduced memory performance, and slower processing speed on computerized cognitive testing one week post-injury (Iverson, Brooks, Lovell, & Collins, 2006). However, the method of assessing such reported symptoms is clearly subjective and may be influenced by the format of reporting. When working with children, it is important to obtain reports from both parent and child, as parents often detect symptoms that a child may not notice, and vice-versa—which explains the general finding of low-to-moderate correlations of parent and child reports on identical checklists. Gender should also be taken into consideration, as most concussion symptom checklists are developed with predominantly male populations given the higher frequency of concussion in males.

In general, there is significant “value added” of formal cognitive assessment (e.g., neuropsychological assessment) in the acute and post-acute assessment of concussion, as the administration of formal measures increases diagnostic accuracy through enhanced sensitivity (Van Kampen, Lovell, Pardini, Collins, & Fu, 2006). Specific domains of cognitive functioning most commonly affected by concussion include processing speed, attention, memory, and emotional/behavioral functioning. It is often challenging to determine whether a child has returned to baseline functioning, particularly if the child has not completed a baseline neuropsychological assessment. Comparisons to normative data should be made as part of the effort to determine return to cognitive baseline, and reported history of prior academic functioning may clarify whether the child might have previously met, exceeded, or fell short of normative means on various neuropsychological measures. Collection of collateral information such as academic records (e.g., report cards, standardized testing results) and reports from teachers also may be helpful in this regard.

For example, slow processing speed following concussion might be the norm for a child who has historically been a slow worker, or a child with ADHD may have significant pre-existing attention problems. Pre-existing learning difficulties may cloud interpretation of cognitive findings. These situations and others make interpretation of a child’s return to baseline difficult. Flexible decision-making and sound clinical judgment are essential to cognitive assessment following concussion. Simply giving a test and interpreting the score in isolation of other factors may not be adequate, as this may over- or underrepresent new onset difficulties related to concussion.

Computerized testing is one method of assessing cognitive functioning after suspected concussion that has become increasingly popular in recent years. The most widely used computerized measure is ImPACT (Immediate Post-Concussion Assessment and Cognitive Testing; Lovell, Collins, Podell, Powell, & Maroon, 2000), which provides composite scores of verbal memory, visual memory, reaction time, processing speed, and impulse control. ImPACT is normed for children ages 10 and up, is available in 20 languages, can be completed in approximately 45 minutes, and can be administered by physicians, coaches, and athletic trainers. However, the relatively lax qualifications required to administer ImPACT also represent a downside to this method of assessment, particularly given the nature of the printout of ImPACT results. For example, it is possible for an individual to respond with 100% accuracy to all measures of verbal memory yet not receive a high score on the Verbal Memory composite due to the inclusion of the “Symbol Match” subtest—which involves only numbers and symbols—in the calculation of the Verbal Memory composite. A child with 100% accuracy will receive a high score on the Verbal Memory composite, whereas a concussed individual typically makes about 17 errors on the test.

In general, computerized cognitive testing typically involves an inflexible battery that does not allow for adjustments specific to concerns reported by the parent or observations that might be made during traditional neurocognitive assessment by a doctoral-level clinician. Additionally, the non-interactive nature of computerized assessment creates questions regarding motivation and effort. Much research promoting the validity of computerized cognitive testing such as ImPACT focuses on its ability to detect presence of concussion (e.g., Schatz, Pardini, Lovell, Collins, & Podell, 2006) rather than its ability to assess cognitive functioning. It is concerning to note that the test-retest reliability of most indices on ImPACT is poor to minimally acceptable (Bolvik & Shay, 2012), the verbal and visual memory composites are vulnerable to practice effects (Resch et al., 2013), and none of the four alternate forms of ImPACT demonstrate satisfactory equivalence to the primary form (Resch, Macciocchi, & Ferrara, 2013).

Thus, a joint statement issued by the American Academy of Clinical Neuropsychology and the National Academy of Neuropsychology in 2012 acknowledged the potential advantages of computerized cognitive testing but issued a number of cautions and guidelines for software developers, including a call for enhanced built-in validity checks, more detailed descriptions of the normative sample, validity/reliability data, and honest marketing of the software’s capabilities and limitations (Bauer et al., 2012). A consensus statement developed at the fourth annual International Conference on Concussion in Sport states unequivocally that “brief computerized cognitive evaluation tools […] are not substitutes for formal neuropsychological assessment” (McCrory et al., 2013). In general, traditional neuropsychological measures demonstrate stronger reliability and validity, offer opportunities for direct observations of the child’s work strategies and behaviors, and ideally benefit from the clinical judgment of doctoral-level psychologists conducting such assessments.
Predictors of Long-Term Outcome

As noted above, the vast majority of concussions appear to resolve without persistent symptoms or long term complications. However, there are times when problems persist and even increase following concussion, and it may not be until months later that a child or adolescent who previously experienced a concussion comes to clinical attention. In the literature to date, there are numerous factors that have been identified that increase vulnerability to experiencing prolonged issues following concussion. Loss of consciousness and/or a score less than 15 on the Glasgow Coma Scale (GCS; Zemek, Farion, Sampson, & McGahern, 2013), disorientation at the time of concussion, associated pain or somatic symptoms (Zemek, Farion, Sampson, & McGahern, 2013), and associated body injury (e.g., fractures, sprains; McNally et al., 2013) are associated with increased likelihood of persistent problems following concussion. Long-term complications are also further impacted by cognitive dysfunction, emotional lability or dampening, behavioral disturbance, and other physical symptoms secondary to the injury itself (McNally et al., 2013).

Additional factors that are correlated with extended recovery periods include female gender (Broshek et al., 2005; McNally et al., 2013), lower cognitive abilities (McNally et al., 2013), and genetic liabilities (including the APOE gene and others; Jordan, 2007), all of which impact postconcussive symptoms. Additional research suggests that a personal psychiatric history (Zemek, Farion, Sampson, & McGahern, 2013), as well as a family history of psychiatric difficulty, have been found to occur more frequently in children exhibiting symptoms for an extended period of time after concussion (Gioia, 2012). Age is another a factor that seems correlated with long-term issues in concussion, with much of the literature indicating that the younger the child at the time of concussion, the more likely it is that problems to not fully remit as expected in the first seven to 10 days following injury (McNally et al., 2013). Again, prolonged, persistent symptoms from concussion is not typical.

Another important issue to consider following concussion is the degree to which the concussion and its related factors create a significant family burden and/or increase parent stress, which in turn may complicate recovery. This is especially common with parents who themselves experience high anxiety and/or have extremely high expectations for their children in school, which results in a significant discrepancy between expectation and current ability, and often between previous performance and current ability. Family burden and distress also seems erroneously high when the number of postconcussive symptoms seems to be greater than that expected based on the injury severity (Ganesalingam et al., 2008) although it is not known which factor precedes the other.

Management-related risks are not to be diminished or overlooked. For example, being isolated from peers, falling behind in school, and being extremely limited in activities secondary to prescribed physical and cognitive rest may unintentionally cause greater difficulty in children and adolescents recovering from concussion. Although the prescription for rest is sometimes over-interpreted by well meaning parents and professionals (e.g., causing a child to be isolated and out of school for weeks on end), even a relatively brief (i.e., a week) period of isolation from academic and social activities may prolong a child’s recovery in some cases. Additionally, parents’ over-interpretation of the child’s symptoms and resultant over-protection may cause the child to experience or express even more difficulties as a result of falling into the “sick role,” potentially leading to issues involving secondary gain (e.g., avoidance of school work). Finally, the communication from healthcare professionals, educators, coaches, and parents to the child that over-emphasizes the seriousness of their concussion may cause significant hesitancy in returning to any activity, including beloed athletic activities, for fear of experiencing another “debilitating” concussion.

Experiencing more than a single concussion creates greater risk for complications. The literature varies widely regarding the level of concern noted for repeated concussions. Some data suggest that individuals who experience concussion with loss of consciousness are four to six times more likely to have another concussion (Delaney, Lacroix, Leclerc, & Johnston, 2000), which may be caused by a lesser impact than experienced with the first concussion. Other issues that seem to play a factor in concussion recurrence include individual susceptibility (e.g., genetic factors) and activity level. Furthermore, it has been found that children experience slower symptom recovery after a second or third concussion than they experienced first with the first concussion.

Management of Concussion

As with practically any issue with which psychologists help patients and families cope, a cornerstone of concussion management is early and balanced education and support. Because public awareness of concussion prior to just a few years ago was scant, and because information disseminated through media outlets is often sensational, psychologists should never assume that parents or patients know the nature and natural course of concussion. While some parents may be quite dismissive of concussion, others may view concussion as a devastating and lifelong brain injury. Providing accurate and balanced education in a supportive manner may help guide parent and child attribution of concussion symptoms and promote healthy resolution of symptoms. For instance, in our clinical experience, some parents are hyper-vigilant for symptoms to associate with concussion (even symptoms that pre-dated concussion), so every headache or every episode of distractibility is interpreted as supporting the seriousness and potential permanence of the injury. As with any physical injury, it is to be expected that there will be symptoms for a period of time after the injury; following concussion, it is expected that symptoms will largely resolve to baseline within one to three weeks in the vast majority of cases.

The use of analogies when educating parents and patients about concussion recovery may be helpful. For example, if a child has a broken arm, it is expected that there will be arm pain for a period of time, and that the arm pain will dissipate as the fracture heals. It is also expected that temporary reduction of function will be associated with the healing period, and as the arm heals functional capacity will eventually return to baseline. During the healing process, exertion is limited (e.g., no weightlifting with the broken arm). There are not expectations for complications, as with proper treatment the arm is expected to fully heal. The same basic message should be communicated during the early stage of recovery from concussion – it is an injury that has expected symptoms, and symptoms will resolve as the injury heals. For any concussion patient, the initial recommendation is usually activity restriction/physical rest and cognitive rest (Halstead et al., 2013; Master, Gioia, Leddy & Grady, 2012; Moser, Glatts, & Schatz, 2012; Moser & Schatz, 2012).
However, it is unlikely that prolonged or overly isolating rest will be useful, and in this fact may be detrimental (as noted above). Seemingly contrary to the idea of rest is recent research investigating the potential benefits of modest exercise for concussion in animal studies (for a review, see Iverson, Gagnon, & Griesbach, 2012), though this clearly needs to be further investigated before making recommendations for clinical practice.

As noted above, supportive and education-focused consultation soon after concussion can provide reassurance to families who are often distraught over their child's injury and extremely concerned about possible deleterious outcomes (Iverson, Gagnon, Griesbach, 2012), especially considering the impact of the media on parent perceptions of concussion-related disability factors. Education can also help parents understand the impact of the concussion on their child's recovery status, versus the impact of premorbid psychiatric or learning difficulties that may simply become more pronounced or magnified in the acute stages of recovery.

Most children and adolescents with concussion will be able to return to school within a couple of days of their concussion without significant impact upon their learning or school-related needs. However, for those who may experience more prolonged recovery, it is essential for school personnel to receive education about how to provide appropriate accommodations for the student and foster reintegration into a normal school day as much as possible, and numerous resources exist to provide information to schools regarding appropriate re-integration and accommodations (Gioia, 2012; Halstead et al., 2013; Kirkwood et al., 2008; Kirkwood, Yeates, & Wilson, 2006). Because school personnel are just as likely to be impacted by the fear-inducing media reports, it is important to provide consultation to school teams so they understand the nature of a student's concussion and how it is currently impacting performance. Conversely, there are also school personnel who may be unfamiliar with concussion and unlikely to accommodate a student who does not appear “disabled.”

Physical symptoms arising from concussion can become a significant stressor. Headaches and migraines, visual difficulties, auditory sensitivity, balance problems, and sleep disturbances may require a medical professional's assessment (Halstead et al., 2013). At the same time, psychologists can provide coping and relaxation training to support better pain management and sleep hygiene. Physical symptoms can be as much a manifestation of the physical injury as they are symptomatic of poor emotional coping and adaptation following concussion.

Similarly, general emotional dysregulation (i.e., irritability), mood dampening, increased anxiety, or even behavioral dysregulation may become more prominent following concussion and warrant psychological education and intervention, both with the parent and child. There are some situations that may also require involvement of a psychiatrist for medication management. Sometimes frustration over lack of physical or cognitive recovery can lead to poorer family adjustment. Therefore, some research suggests that moving toward conceptualizing postconcussive symptoms in a rehabilitation framework, rather than moving toward a “cure,” can be helpful in alleviating some of the distress that may be experienced by older children and adolescents, as well as their families (Kirkwood et al., 2008).

For some children and adolescents with a prolonged recovery from concussion, they also experience apparent neuropsychological difficulties. With this in mind, focused neuropsychological evaluation may be warranted. In many cases, evaluation does not reveal any significant issues, which therefore helps reassure parents. In other cases, increased difficulty with attention, processing speed, or memory may truly be present and require accommodation or intervention, at least on a temporary basis. It is important to note that problems with chronic pain and poor general emotional coping may significantly impact neuropsychological performance, and these issues are important to discuss with families in light of the potential for cognitive functioning to improve once emotional issues are resolved. Additionally, psychologists should keep in mind that some students may be more likely to feign increased difficulty to achieve some secondary gain (e.g., avoidance of a sport they were never truly invested in, avoidance of school work). Therefore, symptom validity testing is recommended in post-concussion evaluation cases (Kirkwood & Kirk, 2010; Kirkwood et al., 2008).

**Conclusion**

Concussions in children and adolescents are injuries that have potential for a number of difficulties that, while largely temporary, can lead to longer term complications and unnecessarily prolonged recovery periods. While every concussion should be taken seriously, most concussions resolve completely and without complication. Psychologists are well-positioned to provide appropriate, scientifically sound, and balanced information and education regarding concussion to children and families and to help support adjustment during recovery. Further, psychologists can help guide expectations and attributions during recovery to lessen the likelihood of prolonged recovery or complications. Concussion management represents not only a practice opportunity for psychologists, but also an opportunity to positively impact public education and knowledge of this injury.

References for this article are located at: http://texaspsyc.org/associations/246/files/Pediatric%20Concussion%20References.pdf
Beginning October 1, 2014, all licensees renewing their license will be required to show completion of 3 hours in the area of cultural diversity.

I hope many of you were able to attend the TPA 2013 Annual Convention as there were many great multicultural and diverse continuing education opportunities for all members to attend!! This was a great improvement from previous conventions.

The Student Diversity Award for the best student diversity paper was presented at the annual TPA Diversity Division meeting at the Convention as well. The winner this year was student member, Danielle Young from Baylor University. Her paper was titled, “Associations between Family Religious Practices, Internalizing/Externalizing Behaviors, and Body Mass Index in Obese Pediatric Patients”. Danielle was able to attend the meeting to receive the award and gave a wonderful overview of her study.

During the business meeting, we also discussed the possibility of helping a non-profit counseling center in Reynosa Mexico, Patronato del Centro de Atencion a la Juventud de Cd. Reynosa A.C. and collaborating with existing divisions at TPA with similar interests.

The TPA Diversity Division's goal is to promote and apply knowledge of psychology to issues relating to racial, ethnic, and cultural diversity. Specific objectives include:

- Encourage research on traditionally marginalized groups and culturally effective and responsive treatment.
- Promoting standards of practice that are culturally and linguistically appropriate.
- Promoting legislative initiatives that further the training, research and practice of race and ethnic minority psychology and culturally competent care.
- Provide a forum for communication and consultation in developing culturally and linguistically appropriate skills and practices.

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.

Our Diversity Plan also includes increasing minority membership in TPA, including student members. Please indicate your interest to join our Diversity Division upon membership renewal to be part of our exciting projects this upcoming year!
Legislator of the Year

Representative John Zerwas, M.D. is serving in his 8th year as a Representative of House District 28 which encompasses Fort Bend County in the Houston area.

Representative Zerwas serves on the Human Services Committee, the House Appropriations Committee and as part of this committee serves as Chair of the Health and Human Services subcommittee. He was also honored to serve as Chairman of the House Committee on General Investigating and Ethics and has twice served on the Conference Committee for Senate Bill 1, the state budget for the biennium.

A physician for more than 30 years, Representative Zerwas is one of three doctors in the Texas House of Representatives at a time when Health and Human Services is one of the fastest-growing areas of spending. Dr. Zerwas is the immediate Past President of the American Society of Anesthesiologists. He previously served as the President of the Memorial Hermann Health Network Providers and Chief Medical Officer of the Memorial Hermann Hospital System.

Representative Zerwas has earned numerous accolades for his dedication to public service including being named one of the “Ten Best Legislators” by Texas Monthly for his work during the 81st and 82nd legislative sessions. However, we are honored Representative Zerwas as TPA Legislator of the Year as he was the orchestrator of the passage of HB 807 and HB 808 for TPA. His leadership was the key to the passage of these two bills for us. We thank him for his dedication of working with many groups who had questions about these bills and for persevering through the long process of getting these bills passed.

Representative Zerwas and his late wife, Cindy, graduated from Bellaire High School in 1973 and were married in 1978. After graduating from the University of Houston, Representative Zerwas earned his Doctorate in Medicine at Baylor College of Medicine in 1980 and started a full-time private practice in 1985. He and Cindy have four children; John Jr., Joseph, Brandon, daughter-in-law Monica, Sherry, son-in-law Matthew, and two grandchildren, Isabella and Matthew.

Outstanding Contribution to Education Award

Dr. McCoy has long been involved in education and training of future psychologists. He was, in fact, nominated by one of his current students. He has been involved in training, leadership, and mentorship in the Rio Grande Valley, and has inspired many future psychologists along the way. He is known for his commitment to providing culturally competent psychological services and educating his future students to do so as well. Recently, Dr. McCoy has been intensely involved in the Lone Star Consortium doctoral training initiative and pursuing APA accreditation for a site in South Texas. He is revered by his students and admired by his colleagues for his dedication and hard work.
Dr. Paul Andrews is in private practice in Tyler. He has generously given his time and energy to many TPA projects, including traveling to Austin to monitor the TSBEP meetings on behalf of TPA. He has received several of the honors that TPA awards, therefore, how do we honor someone like Dr. Andrews who is essentially eligible for honors every year? The clear solution was the notion of naming an award for him and making him the initial recipient of such. Remember that Dr. Paul Andrews is among the inaugural TPA Platinum Advocate members. He was previously the recipient of two presidential awards and recipient of the legislative contribution award. He chairs the TSBEP Committee which is actively working on rewriting supervision regulations. He is on multiple other TPA committees and is particularly active on the legislative committee.

The Paul Andrews Advocacy Award commemorates the passion for the profession of psychology as well as for the dedication and service to the profession through tireless efforts in working with the Texas State Board of Examiners of Psychologists. We recognize the commitment to advance the profession at the state regulatory level and celebrate for improving the lives of all members of the psychology community as well as the populations it serves. This award goes to a persuasive defender of all that is good in TPA and the profession.
TPA Past Presidents Reception

Every year TPA recognizes the dedicated members who have given countless hours of their time to the Association. At TPAs 2013 Annual Convention in November, a reception was held in honor of the Past Presidents of TPA thanking them for the hard work and efforts put in every year to keep the advancement of psychology top priority. Thank you for your continued dedication to the profession of psychology in the state of Texas. The individuals pictured below have all helped in leading the way to TPA’s success in promoting the profession of Psychology.

Left to Right: Ollie J. Seay, Ph.D., Rick McGraw, Ph.D., Robert Anderson, Ph.D., Laurence Abrams, Ph.D., Lane Ogden, Ph.D., Robert McPherson, Ph.D., Robbie Sharp, Ph.D., Brian Stagner, Ph.D., Ron Cohorn, Ph.D., Ray Brown, Ph.D., Tom Lowry, Ph.D.

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Ten Issues viz. Competency for Non-Lawyers

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

Preface: Let’s deal with nomenclature. The term “competency” or “competent” is used in the legal sense only to refer to competency to stand trial in criminal proceedings, or to refer to the narrow issue of the competence of a witness to testify. Whereas, the term “capacity” refers to the functional abilities of persons that may or may not rise to the level of warranting a guardianship in the civil context.

As to competency, lawyers are commonly told that “If you have any reason to believe your client may be incompetent, raise the issue.” The reason is that the standard for competency is quite low; namely, whether a person has a rational and factual knowledge of the proceedings against him and is able to assist their attorney with a reasonable degree of rational understanding. Tex. Code Crim. Proc. art. 46B.003.

There are three standards about which we are speaking:

- The standard to raise the issue with the court – prompting an informal inquiry.
- The standard required for the court to order an examination.
- The standard for a finding of incompetency.

Let’s talk about raising the issue: How much evidence does it take? The answer is “not much.” Any evidence suggesting the defendant may be incompetent is sufficient.

Note that the standard to raise the issue in a court of law changed as of September 1, 2011. The prior standard was whether, in the mind of the trier of fact, there was a bona fide doubt as to the competency of the defendant; if so, this triggered an informal inquiry by the court as to whether to order a competency examination. See Mata v. State, 632 S.W.2d 355 (Tex. Crim. App. 1982); McDaniel v. State, 98 S.W.3d 704, 710 (Tex. Crim. App. 2003). The Legislature intentionally and specifically lowered this standard in 2011. In fact, the Legislature had endeavored to change the standard as early as 2003. However, a number of courts of appeal continued to apply the former standard, and the “bona fide doubt” approach was upheld by the Court of Criminal Appeals in Montoya v. State, 291 S.W.3d 420, 425 (Tex. Crim. App. 2009). In direct response to Montoya, the Legislature added Tex. Crim. Proc. art. 46B.004(c-1) in 2011.

The present quantum of evidence necessary to raise an issue of competency is “a suggestion of incompetency,” and upon “some evidence from any source that would support a finding that the defendant may be incompetent to stand trial,” and “may consist solely of a representation from any credible source that the defendant may be incompetent.” The court shall then stay other proceedings and order a competency appraisal. Tex. Crim. Proc. art. 46B.004. In fact, the test from Mata, McDaniel, and Montoya was specifically repudiated in the 2011 statutory language, which states that “[a] further evidentiary showing is not required to initiate the inquiry, and the court is not required to have a bona fide doubt about the competency of the defendant.” Id. at 46B.004(c-1). The court, on its own motion, or either party may raise the issue. Id., 46B.004(a).

We tell attorneys that there is no virtue in waiting for any significant period before conducting an informal inquiry, and if some credible evidence exists to suggest incompetency, order a competency examination. Waiting for any appreciable period is to invite unnecessary delay, inasmuch as obtaining a competency report will, by statute, require as much as thirty days, with a possible extension for good cause. Tex. Crim. Proc. art. 46B.026. If the person is mentally ill they may be on a special unit, may pose some risks to themselves or others, and there is no reason for delay.
The caveat to this suggestion has to do with the availability of jail psychiatric services. That is, if the county jail is providing jail psychiatric services and aggressively both screening inmates and prescribing psychoactive agents, then it may be desirable for counsel simply to seek a 14-21 day reset if the defendant has been seen and medication prescribed, but there has been insufficient time to stabilize the person. Note that only a handful of the larger jail provide such services.

The implication for psychologists who conduct such examinations is that in many smaller communities, you may well see a person who is floridly psychotic, because there is neither means, nor has there been time, to effectuate stability not to say restoration.

A finding of incompetency, however, requires a preponderance of the evidence – not clear and convincing, and not beyond a reasonable doubt (with one exception to be discussed).

Examiner qualifications: Who can conduct examinations?

Examiner qualifications, as described in Tex. Crim. Proc. art. 46B.022, were clarified and narrowed somewhat in 2011 to include either psychologists or psychiatrists, who are: Board certified in forensics, or have had 24 hours of specialized training in conducting competency or sanity evaluations (and at least eight hours of such continuing education in the 12 months preceding the appointment).

Further, the examiner must not have been involved with treatment of the defendant. The goals of forensic examinations are quite different from clinical treatment and involve inevitable conflicts of interest. See Id. at 46B.021. Thus, it is improper to rely upon the opinion of a person treating a defendant to offer testimony on the issue of competency.

Too often, persons with a long history of ties to the court will conduct such examinations, and their qualifications are, all too often, not scrutinized. It may be in the interest of the court to determine whether the appointed examiner is statutorily qualified to perform the task. To be sure, in exigent circumstances, the court may appoint a person with special qualifications; id. at 46B.022, but in most urban settings – or those contiguous to urban settings – qualified examiners are readily available. Additionally, although the court may appoint the same expert to examine the defendant for both competency and sanity, if the expert determines that the defendant is not competent, the expert may not issue an opinion on the defendant’s sanity. Id. at art. 46B.025(c).

Implications for Psychologists

Despite the fact that these instructions are routinely given attorneys, there is confusion about the role of psychiatrists and psychologists – either because the role’s are not distinguished, or because there is sometimes the belief among attorneys that “I need to find a psychiatrist”, when the speaker is not aware that psychologists routinely conduct competency evaluations and are statutorily permitted so to do. While not all psychologists conduct forensic evaluations, many do so.

And, you may conduct both a competency evaluation as well as a sanity evaluation; the statute contemplates such though attorneys may wish for them to be separate. Note, however, that if the order is for a sanity evaluation alone, the examiner must first conduct a competency evaluation as a predicate for conducting a sanity evaluation; that is, you cannot opine on the issue of sanity unless assured that that the defendant is competent.

Contents of reports: What should be in a report, or not? Who gets a copy?

It goes without saying that if the order is for an independent evaluation, the report will go to the court, but as well as to counsel. By statute, art. 46B.026, the examiner shall provide a copy to the court and counsel for both parties. On some occasions, the order will be an ex parte order wherein the results go only to the movant, though the order authorizes access to the defendant. Some examiners will agree to be retained by one party, sans any order whatsoever. This is troublesome, particularly if the defendant is in custody, inasmuch as access to the defendant may well be restricted unless the order specifically authorizes such.

With regard to content, studies conducted by Vernon State Hospital staff some years ago of some 103 reports revealed that there were major difficulties with a significant percentage of the competency reports that accompanied defendants committed to the state hospitals for restoration. Many of the reports contained bare, unsupported opinions and were simply devoid of any information describing the basis upon which the examiner offered his/her conclusions. Less than half (47%) reported the nature of the deficits impacting the defendant’s trial competency or how the deficits were related to competency. Prospective treatment options were identified in only two-thirds of the cases reviewed. Examiners did not document having made required warnings to defendants in roughly half of the cases. These issues, however, were a major factor in the 2003 revision of art. 46B, which requires that many detailed issues be addressed by examiners. Indeed, these details were given even greater specificity in 2011 legislative amendments.

Some examiners prefer that the report include subheadings addressing the defendant’s capacity both for rational understanding and ability to engage in reasoned choice. While, the standard for competency in art. 46B.003 has two prongs: (a) whether the defendant has a rational, as well as factual, knowledge of the proceedings against him or her, and (b) whether the person is able to consult with counsel with a reasonable degree of rational understanding – the examiner is required to “consider” a range of issues, identified in art. 46B.024:

(1) the capacity of the defendant during criminal proceedings to:

(A) rationally understand the charges against the defendant and the potential consequences of the pending criminal proceedings;

(B) disclose to counsel pertinent facts, events, and states of mind;
Locus of restoration treatment: Who goes for treatment and where?

If the subject of evaluation is opined not competent and is subsequently found not competent, commitment for restoration is mandatory unless the person is released on bond. If the defendant is charged with an aggravated offense, he/she will go to a maximum security facility for restoration treatment (unless released on bail, which is not likely). In the past, this has meant the North Texas State Hospital, Vernon Campus, but Rusk has also opened a small maximum security unit. If, on the other hand, the defendant is a misdemeanant, or charged with a non-violent felony, the person may be sent to any state facility having a restoration unit bed, as designated by the DSHS clearinghouse. An option is also a funded local restoration unit. Note, however, that commitment is mandatory upon a finding of incompetency, unless the defendant is released on bail, Id. 46B.071-.073. An exception is the circumstance in which the defendant has a medical condition which cannot easily be treated in a mental facility, such as kidney failure requiring dialysis, or chemotherapy treatment for cancer, etc. Moreover, a ruling by a district court in Travis County, in 2012, now requires the state to move a person declared incompetent to the appropriate treatment facility within at least 21 days.

A legal exception, about which more will be said, applies to defendants who are opined not competent, but unlikely to regain competency in the foreseeable future – which means, within the time frame available to the court (60 days for misdemeanants, 120 days for felony cases, with a possible 60 day extension applicable to both). In these cases the person may not be committed for restoration by statute (46B.071(b)) and examiners should be prepared to tailor treatment options based upon that statute.

Limitations on appeal from restoration: You can’t!

See Tex. Code Crim. Proc. art. 46B.011. “Neither the state nor the defendant is entitled to make an interlocutory appeal relating to a determination or ruling under Article 46B.005.” See also, Queen v. State, 212 S.W.3d 619 (Tex. App. – Austin 2006). The consent of the defendant is not required for such commitments as they are in the class of commitments which are involuntary.

Time frames: For how long may a defendant be committed?

As suggested above, this issue has implications for psychologist examiners; for while misdemeanor cases are subject to commitment for sixty (60) days with a possible sixty-day extension at the request of the facility and felony cases for one hundred twenty days (120) days with a possible sixty-day extension, psychologists are asked to opine on the issue whether a defendant is likely to be restored “in the foreseeable future.” In this circumstance, “foreseeable future” means the period of time available to the court in connection with the present case. Thus, for misdemeanants this means not more than 120 days or three months; and for felony cases, not more than 180 days, or six months of treatment.
Know where to find the rules:
The attorney will ask!

It is probably wiser not to presume that counsel will know the applicable rules – which are largely found in Tex. Code Crim. Proc. art. 46B – and available on-line.

Be aware of forced med rules and circumstances of application

It is not uncommon for persons who are so ill as to be adjudicated incompetent to also be unable to provide effective consent for the psychoactive medications necessary for restoration. And, absent valid consent, emergency situations, or rare circumstances in which the defendant has a guardian who can provide such consent, court intervention is required. Unfortunately, the forced medication statutes in Texas are convoluted and seeking a forced medication order for a defendant adjudicated incompetent is a cumbersome process – more so in counties with statutory probate courts, as the requisite two-step process involves both a civil and a criminal court. The first step invokes Tex. Health & Safety Code §574.106 and a court having mental-health jurisdiction in which a petition to authorize administration of psychoactive medication must be filed – by the physician treating the person. The standard is either dangerousness to self or others, or incapacity and best interest if the person has been subject to court-ordered mental health services in the six months preceding a hearing under this section. Only if such an order is denied by the civil court under this proceeding will 46B.086 apply – now in criminal court. Art. 46B.086 relies on the Sell standard. See Sell v. United States, 539 U.S. 166 (2003). The statute then requires two medical certificates; there must be a compelling state interest; the medication must be medically appropriate and in the best medical interest of the person; there is no lesser means of effectuating competency; and the person’s rights will not otherwise be compromised. But see State ex rel E.H., 214 S.W.3d 780 (Tex. App. – Tyler 2007, no pet) (declining to find a compelling state interest when the pending charge was a Class B misdemeanor).

Be prepared to opine on the likelihood of restoration and advise viz. unrestored defendants.

Persons having previously been found incompetent to stand trial, or incompetent probationers, or persons unlikely to be restored, all constitute special populations.

And, because, as noted, persons who, having been opined not competent not likely to be restored, and found so by the court, cannot be committed for restoration treatment under Tex. Code Crim. Proc. art. 46B.073, then examiners have a special duty to advise the court as to treatment options which, in this case are limited, as the court must proceed under Subchapters E or F (see 46B.071(b)). These subchapters offer options for civil commitment either with charges pending or charges dismissed. This means you must know both the options and the procedures – which are those of Tex. Health & Safety Code relating to civil commitments. Important is that you – in your capacity as a psychologist -- may not execute a medical certificate in support of such a commitment. Medical certificates may only be executed by physicians, though only one need be by a psychiatrist, if there is a psychiatrist available in the county. Comically, a proctologist and psychiatrist could execute certificates. In some counties, two family practice physicians could so do, because there is no psychiatrist in the county.

Relevant for Tex. Code Crim. Proc. art. 46B.102 commitments, i.e. civil commitments by the criminal court with charges pending, is that these commitments have both a duration on their own terms (either 90 days or one year, both renewable) but will terminate upon the defendant having reached that maximum period of confinement for which he/she could have been confined had they been convicted on day one of their arrest. This is most likely applicable when the charges are of a misdemeanor nature as that period could be for six months or one year, maximum, since the commitment could expire earlier than the date on its face.

Be aware of the effects of a prior unvacated incompetency

If a psychologist happens to see a defendant who was found incompetent in their most recent case and not restored, (an “unvacated adjudication of incompetency”) then the evaluation takes on a different tone. First, the defendant is now presumed to be incompetent rather than the reverse. And second, the state has the burden to prove that the defendant is competent – beyond a reasonable doubt. Id.

The burden shift described above results in an examination to a different standard. As the defendant is now presumed to be incompetent, the examiner must ascertain if he/she is competent and must offer an opinion to a very high standard indeed, i.e. opine “beyond a reasonable doubt” that the defendant has now regained competency. It would be wise to know this rule and describe for the court how it affects your opinion.

Summary

Psychologists are often involved in competency to stand trial proceedings as court-appointed examiners. It may be helpful to know what lawyers are being told concerning the legal standards, examiner qualifications, as well as what should be in reports – as these standards will be applied to the psychologist who performs such evaluations for the court. This presentation has focused less on the minutiae of how to conduct competency examination than on the procedural processes and rules which oft prove problematic for examiners.

Floyd L. Jennings, JD, Ph.D., ABPP 713 551-9604

References for this article can be found at: http://texaspsyc.org/associations/246/files/Competency%20Article%20References.pdf
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Rollin McCraty, PhD Director of Research at the Heartmath Institute
Karen Newel & Eben Alexander, MD Developers of Sacred Acoustics

INVITED PRESENTATIONS

Roger Jahnke, OMD Qi-Gong Master
Wendy Ann McCarty, PhD Leader in Pre-Perinatal Psychology
Gregory Nicosia, PhD Past President of ACEP
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The recent TPA convention was a celebration of legislative accomplishments (extender rule, exemption clause, etc.), but there are other developments in the regulatory world that psychologists should understand. Darrel Spinks, the executive director of the Texas State Board of Examiners of Psychologists graciously provided an overview of recent developments and current concerns. We have included a summary of the high points here.

**Rules That Have Changed**

**465.18**—Recommendations for child visitation/parental access: the rules are expanded to specifically clarify that such recommendations must only be made in the context of a thorough forensic evaluation. Thus, these recommendations should meet the standards of any forensic assessment (e.g. to the standards of a custody evaluation).

**465.15**—Collection agencies shall not be used unless the client has been given 30 days warning.

**465.22**—Records. Records now need only be retained for 7 years past the final date of service or 3 years past the age of majority, whichever is greater. In addition the standards for withholding records have been brought into conformity with HIPAA regulations.

**463.11 & 463.31**—Use of title by LPAs. Psychological Associates may use their title during formal and informal years of supervision and during practicum experiences (e.g. as part of doctoral level training).

**461.11**, Professional Development (CE). 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:

- 3 hours must be in the areas of ethics, Board rules, or professional responsibility
- 3 hours must be in the area of cultural diversity; and
- At least 10 hours 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.

**Pending Litigation Involoving the term “DIAGNOSIS”**

There are three court cases that may have implications for the practice of psychology. Basically, the medical profession is attempting to curtail the ability of allied health professions to use the term “diagnosis” by arguing that this is a medical practice. If successful with LMFTs or Chiropractors, it is likely that other professions will be attacked. The TSBEP is not a party to these actions, but both TSBEP and TPA are watching these developments with concern. The cases are:

- Cause No. 03-13-00077-CV, TX State Bd. of Marriage and Family Therapists, et al v. Texas Medical Association, et al, 3rd COA, Austin, Texas
- Cause No. 03-10-00673-CV, TX State Bd. of Chiropractic Examiners, et al v. Texas Medical Association, et al, 3rd COA, Austin, Texas (case has been remanded to 250th Dist. Ct. of Travis County, TX in Cause No. D-1-GN-06-003451)
- Cause No. D-1-GN-11-000326, Texas Medical Association v. TX State Bd. of Chiropractic Examiners, et al, 353rd Dist. Ct. of Travis County, TX (Cause No. 03-12-00151-CV, 3rd COA)
Rules in the Wind:

The big issue confronting the board is the need to revise supervision rules. There was a time when supervision was well defined and operationalized by the Board: for each client the supervisor must have at least two sources of data (assessment data, audio/video recording, face-to-face contact, direct observation). This rule was relaxed in the 1990s, and the nature of supervision was left to the supervisor's discretion, with the understanding that the supervisor would be responsible to demonstrate that his/her procedures were adequate. Developments in the regulatory world (need to make standards more precise and enforceable, need to define minimal thresholds for different levels of training, etc.) push the pendulum back toward more operationalized rules. At the same time, the knowledge base regarding supervision has mushroomed, the profession is developing expectations for supervisory competence and documentation of the supervisory relationship, and a previously nonexistent empirical basis for supervision has emerged.

In the context of all these developments, the TSBEP will be upgrading its rules, while attempting to balance the protection of the public with the need for flexible rules that can be applied to practicum students, career LPAs and other extenders, provisionally licensed psychologists, and so forth. Look for these to be discussed in meetings over the next few months.

Several Other Rules Are Under Discussion:

The legislature has required that all boards find ways to give credit toward licensure for relevant activities conducted in the context of military service and the Board must find a way to comply. There is talk of not putting degree information on the license. Instead of Jane Dow, PhD, one would simply be Jane Dow. The impetus for this seems to come from IT concerns about limitations on the number of fields in the database.

NOTICE

Changes to 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, 3 hours must be in the areas of ethics, Board rules, or professional responsibility, and 3 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.
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