Key Professional Liability Insurance Protection Throughout Your Career

Insurance coverage is key to your peace of mind. Along with your training, experience, and expertise, Trust Sponsored Professional Liability Insurance* gives you the confidence to provide psychological services in a host of settings – across your entire career. Even if you have coverage through your institution or employer, it pays to have your own priority protection through The Trust.

Unlock essential benefits. Along with reliable insurance coverage, The Trust policy includes useful benefits focusing on psychologists – free Advocate 800 consultations, exclusive discounts on continuing education and insurance premiums, and more. See why so many of your colleagues rely on The Trust for their insurance and risk management needs.

Key features you may not find in other policies:

- Insurance premium discounts including CE, early career, part time, group, and more.
- Broad affordable occurrence & claims-made coverage rated A++ by A.M. Best.
- Unlimited confidential consultations with independent risk management experts.
- No sublimit for defense of sexual misconduct allegations and a free extended reporting period or “tail” to insureds upon retirement.
- Case review process for adverse claim decision by insurance carrier.
- Through TrustPARMA, reduced registration fees for continuing education workshops and webinars.

* Insurance provided by ACE American Insurance Company, Philadelphia, PA and its U.S.-based Chubb underwriting company affiliates. Program administered by Trust Risk Management Services, Inc. The product information above is a summary only. The insurance policy actually issued contains the terms and conditions of the contract. All products may not be available in all states. Chubb is the marketing name used to refer to subsidiaries of Chubb Limited providing insurance and related services. For a list of these subsidiaries, please visit new.chubb.com. Chubb Limited, the parent company of Chubb, is listed on the New York Stock Exchange (NYSE: CB) and is a component of the S&P 500 index.
In this issue

2
The Changing Landscape
Carol A. Grothues, Ph.D.

4
Disaster Response Psychologists
David White, CAE

5
A Note from the Editor
Jennifer Rockett, Ph.D.

6
From TPF Board President: What Can We Improve?
Jo Vendl, Psy.D.

7 Multicultural Diversity
Combating Violence against Transgender and Gender NonConforming Individuals
Kimber Shelton, Ph.D.

9 Ethics
Developing a Social Media Policy for Your Independent Practice
Casey Christian, M.A., LPC;
Mary Madison Eagle, Ph.D.;
Sally H. Falwell, Psy. D.

11 Forensic Issues
To Test or Not to Test, That is the Question
Mary Alice Conroy, Ph.D., ABPP

14 Student & Early Career
Psychometrist: A Noteworthy Vocational Option
Anna E. Pineda, M.S.

16 Prescription Privileges for Specially Trained Psychologists in Texas
Cheryl L. Hall, Ph.D., M.S. Psy.Pharm.
This year has been a whirlwind of proposed changes in our profession – some we have managed to stop, but likely only temporarily. The mental health landscape is changing and this change is necessary in order to address the needs of our population. While we may not like some of these changes, we need to be actively involved in this process and step up to lead them.

**Changes in training guidelines**

The American Psychological Association took steps years ago (2010) to change training guidelines that they believe will increase timeliness of licensure for psychologists without sacrificing competency – which include eliminating oral exam requirements and modifying the post-doctoral training requirement (a modification that does not decrease required hours, but allows flexibility in obtaining these hours at the pre-doctoral level). The Sunset Commission recommended that TSBEP adopt these changes this year, and will likely recommend them again in 2019. TPA fought hard to hold on to these requirements in Texas, as they are part of the high standards of practice we feel are essential to the practice of psychology. Even though we were successful legislatively, our state board (TSBEP) are facing even more logistical barriers to implementing the oral exam and were able to find a way that would allow them to propose rule changes to eliminate this requirement without legislative change. Although they did try to find alternative ways to implement the exam, they were strongly swayed by national associations (APA and ASPPB) who do not support the use of the exam. It is part of the overall change in removing barriers to licensure because of the need for more psychologists. In addition, APA is also moving forward on finding a place for master's level practitioners in psychology – which likely will include some level of independent practice.

As you know, the entire country is facing severe mental health workforce shortages, and Texas is struggling as well. Only four of the 254 counties in Texas have enough psychiatrists, with psychologist availability not far behind. Only 39% of people in need of mental health care receive treatment in our state. We want to be part of the solution for this shortage problem, while still maintaining standards of training. As we prepare for the next Sunset process, we want to be sure that we are ensuring that quality training for psychologists continue and that we work with TSBEP to improve efficiency in licensing as well as addressing the reported concerns of agency size and anti-trust issues without compromising effective regulation.

One of the solutions to the workforce shortage on the table is to allow Licensed Psychological Associates (LPAs) to practice independently. While this has often been a push by TAPA (Texas Association of Psychological Associates), this door was opened even wider by the 2015 Supreme Court's decision in the North Caroline Board of Dentistry/Federal Trade Commission case. One outcome of this case was that all state agencies were required to review their rules to identify potential anti-trust issues and the required lifetime supervision for LPAs was identified as such an issue. This differs from physician assistants (PAs) because their supervised status was not determined by board rule, but by legislative statute. The restricted scope for LPAs is solely determined by board rule, which allows it to be questioned as an anti-competitive issue. Unfortunately, we cannot assert that the legislature's failure to pass a statute granting LPAs independent practice this past session meant that they support a supervised scope of practice for LPAs. TSBEP was left with the clear message that they need to address this issue and thus they have proposed rule changes allowing LPAs to practice independently with increased education and training hours (commensurate with LPCs). TPA continues to assert that there is a difference between the practice of psychology and that of counseling, clinical social work, and marriage and family therapy. While there is overlap, the differences are important and it is up to us to distinguish psychologists from other mental health professionals.

It is the role of a state board to establish guidelines for independent practice; however, some of the members of our state board believe that restricting master's level practitioners is anti-competitive given the provision of services in other mental health fields, which are primarily master's level professions.

The burden is on us to clearly delineate this difference and find the right restrictions in practice. Since the 1960s, it has been drilled into us that doctoral training was the minimal training necessary for the independent practice of psychology. It will be very difficult to identify which parts can be performed safely and effectively with less training, but that is the task at hand.
Another major change we must be prepared for is the change in state agencies in Texas, and likely, nationwide. Even though we have had a highly efficient and well-functioning state board, TSBEP believes they need to be consolidated in order to maintain their efficiency and regulatory strength. Without some additional level of state oversight, TSBEP believes it is too vulnerable and its authority would be under constant question, as well as possibly making each board member personally liable in anti-trust lawsuits. In addition, key legislators argued that small agencies, such as TSBEP, have the potential to be crippled by loss of employees and that increasing agency size through consolidation protects against this vulnerability – and may also be less costly to the state. While both of these issues are highly debatable and most of our time during the last session was spent debating them successfully, we must be better prepared in 2019, when these issues will re-emerge. We cannot simply argue that we do not want change; we need to offer a solution to these concerns, or provide clear evidence that these vulnerabilities are not valid.

How are we preparing for these changes in landscape?

The TPA Board of Trustees recently voted to make extensive changes to the TPA staff. Significant budget changes were approved to increase TPAs priority to legislative and governmental agency issues. We unfortunately lost our Public Relations staff member, Lauren Witt, in May, who moved on to become more involved in her non-profit interests. Lauren was an incredible asset to TPA and contributed extensively to many areas of TPAs functioning. Her expertise in marketing and public relations cannot easily be replaced; however, we believe that the extraordinary skills of our Executive Director and Co-Executive Director, David White and Sherry Reisman, with help from Sarah Bann, will be enough to manage those tasks (hopefully), and we can take the chance to allocate the PR salary, as well as eliminate another part-time position and re-allocate other budgeted items to hire a full-time government relations staff member. While we sincerely appreciate the double-time David White has played in being both TPA Executive Director and our TPA lobbyist, the TPA Board wants to take the next step in improving our legislative presence, sophistication, and expertise. There will no doubt be some growing pains in this transition, but I am excited about the potential growth for our association and the positive impact we will have adding more expertise to our growing active legislative involvement of our membership.

We also have a Sunset Strategy Task Force led by Dr. Cheryl Hall who are already meeting biweekly to prepare for the 2019 Sunset. Several of our members who live in Austin and who were actively involved in both legislative sessions this year, Drs. Bonny Gardner, Fran Douglas, and Elisabeth Middleton, have already been involved in discussions with Senator Kirk Watson, who will be the only returning senator to serve on the 2019 Sunset Committee. We are also hoping to work with TSBEP to find answers to their concerns and options for consolidation, LPA rule changes, and changes to the training/licensing standards for psychologists. We still are prepared to fight legally against allowing LPAs to have the full scope of independent practice privileges, as we firmly believe that is not in the best interest of the public or the profession.

TPA represents you. We are actively working every day to educate the public about psychology, increase reimbursement, protect high standards of training, and do what we can to increase effective regulation of the practice of psychology in Texas. I am proud to be a psychologist and have enjoyed the privilege of working this year to promote and protect psychology in Texas as your president.

I hope to see all of you in Houston this November. My very best to all those affected by Hurricane Harvey and my sincere thanks to our dedicated Disaster Response Committee co-chairs, Drs. Rebecca Hamlin and Judith Andrews, who were on top of dealing with this tragedy in our state. Many members have volunteered to offer free services to victims of Harvey and this is just one additional example of the good we do. Check out the TPA website if you missed this opportunity and still want to be involved. Let’s continue to grow psychology and TPA!

Submit an article

The Texas Psychologist is seeking submissions for its upcoming 2018 issues.

We are seeking content in the following areas: Independent Practice; Ethics; Multicultural Diversity; Forensic Issues; and Student and Early Career.

Collaborations with students are encouraged. 1000-2000 word count; APA Style.

Send to drjenniferrockett@gmail.com.
What type of work do you do as a psychologist? Are you an IO psychologist, school psychologist, neuropsychologist, or a psychologist who focuses on children, adults, couples, or the elderly? Over the last couple of months, a lesser known type of psychologist has risen to the forefront of your profession. These are the psychologists who assist in the midst or aftermath of a disaster – disaster response psychologists. Disaster response psychologists are trained to help when a disaster of any kind occurs in their communities, even when they are personally affected by the disaster itself. In late August, if you lived along the Texas Gulf Coast or Southeast Texas, you experienced the most devastating natural disaster ever experienced in the U.S. If you did not live in these areas, you experienced and felt the gut-wrenching rescues by watching or listening to media. Hurricane Harvey, which hit the Texas coast as a category 5 hurricane, is estimated to have dropped 27 trillion gallons of water in Texas and Louisiana with a record of 51 inches of rain in some places. Both Hobby Airport and Houston Intercontinental Airport (the 10th largest airport in North America) shut down in the wake of the storm. School districts were forced to cancel school for extended periods. More than 75,000 people were rescued in the Houston area alone. Some estimates of the economic impact of Hurricane Harvey is $190 billion, which will make this storm the costliest natural disaster on record.

As we were all carrying on our daily activities or even taking some needed down time, disaster response psychologists were gearing up. For a disaster response psychologist, the call to action is paramount to what is happening in your personal life. As a result, a European holiday and some nice relaxing time in San Antonio were cut short for TPA's Disaster Resource Committee Co-Chairs, Drs. Beckie Hamlin and Judith Andrews. They immediately returned home to storm-ravaged Houston and began to engage their resources. One of their first calls was to TPA's Assistant Executive Director, Sherry Reisman, who immediately sent out messages to TPA members about self-care and Red Cross resources as well as Red Cross calls for volunteers.

It was in the early stages of this disaster when I reached out to Dr. Hamlin. She shared her experiences:

The Red Cross regional lead for the Gulf Coast is very new and also reported a recent family loss. Dr. Andrews and I quickly assessed that we would need to support the Red Cross leaders to the extent possible. We communicated with the MH Chief and Managers and Dr. Andrews actually went to Red Cross headquarters to help with organization and communication. Dr. Lisa Garmezy, one of our Disaster Resource Committee members will make herself available to the George R Brown shelter as well as other shelters over the next several weeks. I was “stuck” in North Houston, literally surrounded by water. As soon as possible, I began to travel among many of the shelters (Red Cross and independent) to offer MH support. Red Cross was having trouble getting people into the city and, even when here, could not travel to this area in the first days. I have several images: the first was the immediate hugs I received from volunteers who were overwhelmed when I said I was MH; the second was seeing teenagers who were volunteering at some of the shelters set up in schools – so great to see our youth as volunteers; I recall the frustrations of volunteers and clients having to move from one shelter to another; In many cases, MH providers just “showed up” at shelters to help – not ideal but such a testimony to the helping profession as a whole – in some cases, I was giving crash courses in how to respond in disasters.

It's hard to explain the devastation of such a storm and fully comprehend her experiences without seeing it first-hand. Therefore, I extended an invitation to Dr. Tony Puente, President of the American Psychological Association, to visit Houston. Along with Drs. Hamlin and Andrews, we visited the Red Cross Headquarters as well as the George R Brown Convention Center shelter. The experiences of that day shed new light on what it means to be a disaster response psychologist. This disaster, like any other disaster, is a life changing experience. In many cases, the life altering changes happen quickly and often linger. I applaud the Red Cross for all they do in times like this. We
Happy Fall, everyone!

Wow, it is hot outside and what better way to welcome a Texas Fall than a jam-packed Texas Psychologist in your mailbox. I want to personally thank the many of you who submitted articles this time around; you certainly stepped up to the plate! And for your words of encouragement and positive feedback on the changes we have made to the Texas Psychologist – thank-you!

I trust readers will be excited by the content in this issue, as we have an amazing array of timely topics for your reading pleasure. The Diversity Column features a piece on Trans-women by Dr. Shelton. For those of you working in the field of forensic psychology, Dr. Conroy provides a review of the appropriateness of testing in forensic cases in the Forensic Column. Students and early career psychologists will enjoy the piece in their column by Dr. Pineda on the career path of a psychometrist. Finally, those of us in private practice will appreciate the discussion by Drs. Christian, Eagle, and Falwell on the development of a social media policy, in the Ethics Column. We also have an update from our President, Dr. Grothues.

I am looking forward to seeing everyone at Convention in November!

Jennifer Rockett, Ph.D.
Independent Practice
College Station, Texas

FROM THE EDITOR’S DESK

Notes on the Fall Issue

quickly realized that TPA needed to support the affected citizens of Texas who were touched by this storm.

As a result, Drs. Hamlin and Andrews envisioned a short-term, three-session, pro bono brief therapy search service for Texans impacted by Hurricane Harvey. With their vision, Sherry's talents, and nearly 200 volunteer psychologists, TPA has been able to realize this vision and make it a reality for Texans in need. Early on, once the service was in place with approximately 100 volunteer psychologists, TPA and the Andrews Foundation launched a media campaign and distributed a press release announcing the free service. The response was even better than we anticipated. The Associated Press picked up our release which led to a call from a FEMA contractor as well as stories being reported in The Houston Chronicle, Fort Worth Star Telegram, News 4 San Antonio, NPR, KLTV 7 in Tyler, CBS Austin, Fort Bend Herald, Fox San Antonio, CBS DFW, KTSA to mention a few! Following the media coverage, the Harvey Psychologist Finder Resource had the most traffic of any page on our website for nearly a week.

Our Disaster Resource Committee Co-Chairs and the pro bono service providers are true champions and shine a light on all that is good about psychology. TPA is ecstatic that we have been able to let Texans know more about psychologists and the good that you do. They are the backbone and they are setting the example of how psychologists play vital roles in the midst of disasters.

The initial disaster is over but the positive impact of our Disaster Resource Committee Co-Chairs, committee members, and volunteers remains. If you are interested in getting involved with the TPA Disaster Resource Committee, please send an email to Sarah Bann at admin@texaspsyc.org, we would love to have you.

Jennifer Rockett, Ph.D.
Independent Practice
College Station, Texas
What Can We Improve?

This is the time of year when we look back and reflect on the quick pace of the year and wonder where the time has gone. We are coming up on our biggest event of the year, the annual convention, and are looking forward to seeing old and new faces. As our field grows and changes, so does the Foundation as we adjust to the needs of students in our shifting world. Our board has been wondering how we can best serve students in the field of psychology, and the bigger community of psychologists in our mission to further the profession. We will be continuing with our traditional fundraising and poster judging activities, and are exploring new areas of growth to reach and support even more students and professionals.

At the annual convention, we are excited to be judging the poster presentations at the Friday night poster session and reception. We will be offering 1st, 2nd and 3rd place prizes for the most impressive research topics, design, methods, and presentation. Students will be encouraged to engage their visiting professionals in discussion about their projects and findings thus far.

Alongside the convention we will be hosting a fundraising event to continue supporting the future of psychology through awards and grants we give out annually. Please check our Facebook page, Twitter feed and websites for up-to-the-minute information about this event. Details coming soon!

Now we wish to ask of you, our readers and audience, what can we be doing to better support students and professionals in the great field of psychology? How can we be in better communication with students, recent graduates, early career and expert psychologists? What resources do you need? What topics need discussion and exploration? How do we better connect the professionals with the academics and students? We as a philanthropic organization would like to grow with the changing tides of our profession, and would like to know how best to serve you. Send all comments through our social media pages or directly to the board by emailing me at jo@drjovendl.com.

See you all next month!
This year started as the deadliest year on record for transgender women. In February, over the course of one week, four transwomen were murdered (Morlin, 2017), totaling seven confirmed deaths of transgender and gender nonconforming (TGNC) individuals by February’s end. All were Women of Color. The Anti-Violence Project, a program that tracks crimes against transgender individuals, recorded 23 deaths of TGNC individuals in 2016. With already 22 confirmed deaths of TGNC individuals (Human Rights Campaign, 2017) the 2017 death rate will surpass that of 2016.

Experiences of hate, violence and harassment against TGNC individuals are well documented. The National Transgender Discrimination Survey (James, Herman, Rankin, Keisling, Mottet, & Anafi, 2016) showed TGNC individuals experienced pervasive mistreatment and violence at school and work, and severe economic hardship and financial instability, resulting in harmful mental and physical effects. Key findings from the study included:

- 40% of TGNC respondents reported attempting suicide in their lifetime (Nine times greater than the 4.6% attempted suicide rate in the U.S. population).
- 77% of those who were out or perceived as transgender at some point between kindergarten and grade 12 experienced some form of mistreatment (i.e., verbal or physical assault, harsh discipline).
- In the past year, 9% of respondents were denied access to a restroom, 12% were verbally harassed, 1% was physically attacked and 1% was sexually assaulted while in the restroom.
- Across all categories, TGNC individuals of color experienced the greatest rates of discrimination, abuse and mistreatment:
  - TGNC people of color were up to three times as likely as the U.S. population (14%) to be living in poverty
  - 50% of TGNC undocumented respondents had experienced homelessness in their lifetime

Texas maintains the country’s second largest transgender population. According to the Williams Institute, more than 125,000 individuals in Texas identify as TGNC (Flores, Herman, Gates, & Brown, 2016). Proposed legislation such as, Senate Bill 6 (SB 6) “The Bathroom Bill”, threatens to override nondiscrimination ordinances that prohibit discrimination based on gender identity in public facilities. SB 6 requires individuals to use public restrooms based on biological sex, rather than identified gender. SB 6 and other bills like it, create undue stress on Texan TGNC individuals. For example, instead of creating the most efficient means for completing required courses, I have worked with TGNC college students who created their course schedules around where there was access to a single stall restroom to use in-between classes. This is an unnecessary burden placed on the educational attainment and success of TGNC students.

Amidst controversial issues such as SB 6 and 23 other anti-LGBT bills (Jervis, 2017), as many pro-LGBT bills have been filed to the Texas legislature this year. This includes House Bill 569, which penalizes mental health professionals who engage in sexual orientation or gender identity change efforts (i.e., conversion or reparative therapies). Furthermore, Texas continues to push for greater support and access to care for TGNC individuals. One example being Central Texas’ Health Action Kind Clinic’s recent opening of a free transgender clinic. The Kind Clinic’s website reports that the facility provides “…access to high-quality gender care and sexual health services, regardless of insurance, immigration status, or identity (Kind Clinic, 2017).” There is also increased visibility of TGNC individuals, including Texas’ first openly out Trans mayor, Jess Herbst, Town of New Hope Mayor.

At the international and national level, psychological organizations have advocated for the rights of TGNC communities. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2015) advocated for the end of conversion therapy with TGNC youth and 16 major psychological associations in the UK.
signed a Memorandum of Understanding citing conversion therapies as unethical (British Association for Counselling and Psychotherapy, et al., 2015). Both the American Psychological Association (APA) and Texas Psychological Association (TPA) have worked to create greater inclusivity for TGNC psychologists. All Gender Restrooms were accessible at the two most recent APA National Conventions and consolidated meetings, and were available for the first time at the TPA Annual Convention in Austin. I acknowledge feeling discomfort during my first use of an All Gender restroom. My discomfort came from a history of socialization in sex-segregated restrooms, thus having had little experience sharing a restroom with all genders. The next time I used an All Gender restroom, my discomfort had abated. Others may feel discomfort with All Gender Restrooms based on fear; however, there are no documented cases of TGNC individuals harming anyone while in the restroom; while, nearly 15% of TGNC individuals reported being the targets of abuse and harassment in the restroom (James, et al., 2016).

There is much Texas Psychologists can do to better support and advocate for TGNC Texans:

Utilize TGNC Affirmative Practice Guidelines. The APA Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (2015) provides 16 guidelines, which are appropriate for psychologists engaged in clinical practice, research or education with TGNC individuals and allies.

Donate Resources. Donate your time and money to TGNC-affirming resources. Volunteering at local community agencies and providing sliding scales or pro bono services are ways psychologists can better support TGNC individuals within their community. Psychologists can also provide monetary donations to organizations that support and advocate for TGNC communities.

Identify Local Resources. Expand your community and assist TGNC Texans connect with local TGNC-affirming resources such as physicians, psychologists and counselors, agencies, and support groups. Co-founded by Texas Psychologist Colt Keo-Meier, The Gender Infinity Map, https://resource.genderinfinity.org/, serves as a location source for transgender affirming providers.

Engage Politically. Increase your awareness of legislation affecting the well-being of TGNC individuals. Contact government agencies to advocate for TGNC individuals. The Human Rights Campaign (HRC) provides a number of resources for contacting governmental agencies at www.hrc.org/take-action.

Educate Yourself and Your Agency. Psychologists specializing in TGNC-issues, such as Houston-based psychologist, Kaden J. Stanley, www.emergepsych.com, can help establish your organization as a leader in trans-affirmative care. Invite TGNC experts to your practice, organization or hospital to educate staff around issues related to pronoun use, hormone replace therapies, inpatient housing and care, resiliency, and creating safe and inclusive spaces. Explore trans-affirming speakers through the TPA Speakers Bureau, earn PD hours watching LGBTQ Ally Development: Four Steps for Building Competence workshop from the 2016 TPA Annual Convention, or attend local and national workshops on affirmative Trans care.

Recognize the Unique Challenges Faced by Transwomen of Color. In 2015 and 2016 transwomen of color were the primary targets of violence and murder. 2017 has started as the most brutal year for transwomen of color. Psychologists can work to disrupt systems that dehumanize and devalue the intersecting identities transwomen of color hold. This can begin with recognizing the lives of these victims -#sayhername: The 18 transwomen of color we have lost to violence this year are:

» Mesha Caldwell, age 41
» Jamie Lee Wounded Arrow, age 28
» JoJo Striker, age 23
» Tiara Richmond, age 24
» Jaquarius Holland, age 18
» Chyna Doll Dupree, age 31
» Ciara McElveen, age 21
» Alphonza Watson, 38
» Chay Reed, 28
» Sherrrell Faulkner, 46

» Kenne McFadden, 27
» Kendra Marie Adams (aka Josie Berrios), 28
» Ava Le-Ray Barrin, 17
» Ebony Morgan, 28
» TeeTee Dangerfield, 32
» Kiwi Herring, 30
» Derricka Banner, 26
» Jaylow MC, 29

References


Ethics

Developing a Social Media Policy for Your Independent Practice

Casey Christian, M.A., LPC, Independent Practice, Dallas, Texas
Mary Madison Eagle, Ph.D., Independent Practice, Dallas, Texas
Sally H. Falwell, Psy. D., Independent Practice, Dallas, Texas

The use of social media websites and applications has rapidly increased in recent years and become highly prevalent across generations. According to the Pew Research Center (2017) 69% of Americans engage in at least one social media outlet, a notable increase from the five percent of adults who used at least one social media platform in 2005. Despite wide-spread use by the general population, little clarity exists regarding policies for the use of social media platforms by psychologists in independent practice.

If used properly, social media offers psychologists the opportunity to connect with clients with whom they may not have been previously able to connect without the reach of social media. Establishing oneself as knowledgeable in a particular area of psychology through social media can be beneficial for the therapist looking to grow his or her independent practice, as well as for the client looking to begin therapy with a clinician who has a particular specialty. Beyond focused marketing efforts, social media is oftentimes used in other formats in clinical practice to offer and obtain resources from other professionals, organizations, and the general public through blogging, discussion boards, or consultation.

Despite the valuable, and often crucial, component of integrating social media into a successful independent practice, its use can create ethical dilemmas that psychologists have not previously had to address. Due to the integration of social media into independent practice in the last decade, many clinical training programs have not incorporated instruction on ethical social media use for psychologists into their curriculum. As such, many may find themselves trying to navigate the oftentimes complicated relationship between engaging in mediums such as Twitter® or Facebook®, and maintaining adherence to ethical principles as psychologists (Kolmes, 2012). Yet, it must be done.

With regard to implementing a social media policy for your practice, it is critical to consider the ways in which social media engagement has the potential to harm the client, specifically through potential confidentiality breaches, possible blurred boundaries, and confusion in relationship roles (Kolmes, Nagel, & Anthony, 2011). Any connection a client has to you as a therapist on the Internet could compromise his or her confidentiality. The possible increase for a compromise to occur with a “connection” on social media must be considered (Kolmes and Taube, 2014) as well as the possibility of this “connection” to blur the boundaries of the professional relationship. A few of the ways these breaches could occur in the therapist-client relationship include a client “liking” or following your professional page on Facebook, connecting with you on Twitter, following you on Instagram, “checking-in” to your practice using location-based services, or writing a review about you on the Internet (Kolmes, Nagel, & Anthony, 2011).

An additional difficulty that psychologists will face is the possibility that their personal or private online activity may overlap with their professional competence and professional role. Online self-disclosures may “represent the intersection where dilemmas surrounding personal and professional roles meet — in some cases signaling the start of boundary violations” (Lannin and Scott, 2014). Kaslow, Patterson and Gottlieb (2011) note that with self-disclosure online client’s perceptions of the client-therapist relationship may alter in ways that could possibly impact the therapeutic outcome.

Consideration should further be given to implementing a social media policy for mental health professionals employed by a group practice. This may augment current policies on conduct already in place within the practice in order to draw attention to the importance and risk associated with this particular communication outlet. Implementing such a policy can be a delicate issue, as it involves protecting the organization and its employees from risky online behavior and commentary while not attempting to limit employees’ rights to engage in social networking activity.

This policy may include basic tenets such as: requiring that the employee make clear that his or her statements and opinions on his or her personal social media profiles are his or hers alone – not that of the group practice or his or her supervisors; requiring that the employee respects the privacy of others in what he or she chooses to publish; and emphasizing a specific policy to govern online statements that may affect the group
practice regardless if the commentary is “official” or “unofficial.”

Whether establishing or updating a social media policy, there are a few steps psychologists can take to stay current and in line with American Psychological Association (APA) and Texas State Board of Examiners of Psychologists (2016). Three guiding commitments to support the development and implementation of a policy are awareness, management and practice.

**Awareness**

Gathering information from the Internet about a practitioner, or a client, is not unheard of, and is actually becoming more of a common practice. Knowing this, psychologists must integrate awareness of best practices and how to implement safeguards both personally and professionally. Practitioners need to be aware of relevant and commonly used programs such as Facebook®, LinkedIn®, Snapchat®, and Instagram®. Additionally, clinicians need to know how not addressing the presence of social media can impact their practice, and how they are representing themselves online (Kolmes, 2012). A few possible ways to pursue awareness in these areas are:

1. **Do an online search.** Google yourself and see what comes up. What can you find from your interactions on blogs, community sites, or friends’ posts? If you do not like the idea of searching yourself, you could start by having a colleague or friend search as if they were a current or potential client and report their findings to you.

2. **Review sample Social Media Policies, then compose, edit and integrate your own** (Kolmes, 2010). Review a number of samples for what might be most applicable to your practice and corresponds to your online presence. An added recommendation includes vigilance over copyright issues and appropriate citation. Two examples include:

   » http://www.drkkolmes.com/docs/socmed.pdf
   » http://lisajohnsonlmft.com/forms/Electronic_Resources_and_Social_Media_Acknowledgement.pdf

3. **Maintain a working knowledge of research regarding changes to the professional landscape of this field.** For example, relevant research shows us that internet searches by potential and current clients are common, and many times are not addressed or revealed in session (Kolmes and Taube, 2016). This reflects the need for professionals to acknowledge how the Internet impacts the therapeutic relationship. Develop a social media policy, and guide clients through how you choose to handle online interactions and requests.

4. **Be aware of pitfalls.** A few pitfalls to consider are: a) deciding that Internet and social media searches are uncommon and do not impact you or your practice, b) deciding that clients cannot easily find your customer service complaints, friend groups, social outings, political views, community involvements, religious beliefs, favorite foods, pets names, etc. through your LinkedIn® profile, Twitter® interactions, Instagram® photos, posts on your favorite blogs, or tags by friends, c) assuming that clients will respect your privacy and, d) maintaining high levels of suspicion about reasons a client looks you up. Curiosity and connection are the most common reasons clients pursue information about their providers online (Kolmes and Taube, 2016).

**Management**

After maintaining awareness and avoiding pitfalls, manage your professional approach to social media by:

1. **Making necessary changes to your privacy settings and talking with family and friends about their posts that include you.**

2. **Connecting with a few colleagues to help encourage professional insight and practice regarding designing and implementing your own social media policy.** Supportive professional connections help encourage awareness and professionalism and foster ideas for best practices (Knapp, Gottlieb & Handelsman, 2017).

3. **Checking that your social media policy addresses topics such as: status updates, communication, reviews on sites such as Yelp® or Facebook®, testimonials, likes, icons or emojis that reflect an emotional response to content, and how you prefer to handle personal questions and client curiosity.**

**Practice**

Protect your own practice by specifically addressing how the Internet, social media, and cultural norms can impact the therapeutic relationship. Two ways to implement a new or updated social media policy are:

1. **Ask questions, repeatedly.** Addressing the topic of online searches and conduct helps to normalize the conversation for both client and professional and set expectations when addressed during informed consent. However, clients might forget that you initially discussed limits and guidelines; do not hesitate to follow up or inquire as the therapeutic relationship develops.

2. **Be ready to engage.** Construct a response to a connection, follow or friend request and then address with the client in person. This helps to normalize the topic as therapeutically appropriate, and invites conversation around the client seeking both personal and professional information about their providers online.

Whatever you decide regarding the specific details of your social media policy for your independent practice, taking time to carefully consider the various implications of integrating social media into clinical practice is part of maintaining a current, ethically sound practice. Once the policy has been established or updated, one of the most critical steps in implementing the policy is communicating with clients through informed consent and clearly reviewing the policy, discussing expectations, answering questions and continuing to update both the policy and communication as necessary as time and technology advance.

**References**

In the field of forensic assessment for the criminal courts, there is great variability among evaluators regarding the use of traditional psychological testing. Some psychologists do almost no testing in the forensic context, others tailor test use to the specific case, and still others give extensive batteries as part of any forensic evaluation. The Specialty Guidelines for Forensic Psychologists (SGFP) remind clinicians that testing applied in the forensic context should be quite different from a basic clinical evaluation (APA, 10.02). There can be advantages to the use of psychometric instruments, but there can also be serious drawbacks. I am going to suggest that before deciding on the use of test instruments in the criminal forensic context, five questions should be seriously considered:

» Is it the standard of practice in the field?
» Is it going to tell me something I need to know regarding the psycholegal question?
» Is it appropriate to the population being examined?
» Is it appropriate to the single individual being examined?
» Is it providing the best possible service to the court?

### Standard of Practice

The standard of practice (as opposed to the standard of care, which is a legal matter) refers to the typical way in which something is done in a particular field. In other words, the “industry standard” or what is considered by most practitioners to be “best practice.” I have heard it alleged that formal psychological testing is the standard of practice for any psychological evaluation. However, surveys of active forensic evaluators would suggest this may not be, in fact, the case (Archer et al., 2006; Lally, 2003). These surveys indicate that very few specific instruments are used by evaluators in more than 50% of their evaluations. Only a few instruments are recommended by more than 60% of the evaluators surveyed. Unstructured/projective techniques were rated unacceptable by the majority of forensic evaluators. That is not to say that many forensic clinicians do not use test instruments.
regularly—they do. And, many of these instruments have significant empirical support for what they are designed to do (Archer, Wheeler, & Vauter, 2016). However, if asked the question: "Isn’t it true that the standard of practice in the field is to include psychological test instruments in any good psychological evaluation?", I would answer "No." The data simply does not support that conclusion.

## Relevance to the Psycholegal Question

Forensic evaluations are much more focused than a general clinical evaluation. SGFP 10.01 specially encourages evaluators to provide data most relevant to the legal issue at hand. Melton, Petrila, Poythress, and Slobogin (2007), in their widely used forensic text, indicate that the appropriate justification for any testing is “...the degree to which test results will inform the judgment that has to be made.” Is it going to tell me something I would not otherwise know? Most forensic questions raised by the criminal courts involve directly examining an individual’s functional capabilities. It is challenging to explain what a general personality inventory can tell one about the examinee’s factual or rational understanding of the charges or the ability to consult with one’s attorney or what the person’s mental capacity may have been at some distant time. No particular IQ score may have great relevance if the individual is able to demonstrate the necessary functional capacities required by law.

An issue frequently raised in defense of formal testing is that of diagnosis. However, some in our field have seriously questioned the value of very specific diagnostic opinions in forensic work (Greenberg, Shuman, & Meyer, 2004). The SGFP specifically caution evaluators to beware of the problems with clinical diagnoses (SGFP, 10.01). In criminal forensic work, evaluators are generally dealing with a very small number of diagnoses that might render someone legally incompetent, insane, or at high risk for violence. Often a particular symptom, not a general diagnosis, is the target of concern. Nonetheless, Texas statutes (e.g., 46B) require the evaluator to specify why, for example, is the individual incompetent. Some recognized diagnosis is generally expected in this regard. But then the question becomes, is psychological testing a necessary element when history, collateral sources, and forensic interviews are available?

## Acknowledging Diverse Populations

The APA Code of Conduct makes it clear that psychologists are to use testing instruments that are appropriate to the population and for the purpose for which they were intended. I have had the unfortunate experience of seeing numerous forensic reports that would seem to violate this principle. For example, an evaluator was asked to opine as to whether a particular individual would be dangerous to the staff and patients if transferred from a prison to a psychiatric hospital for two to three weeks. In establishing that opinion, the evaluator relied on the Violence Risk Appraisal Guide (VRAG), a well-researched and respected instrument. However, that instrument was designed to assess potential for violence in the community over several years’ time. What would a VRAG score tell us about someone’s violence potential in a structured psychiatric hospital over two to three weeks? NOTHING!! When asked about why the measure was used, the clinician said it was simply the closest scientific instrument that was well researched and available. “Close” is a dangerous concept when presenting scientific-sounding data to a trier of fact that may be very misleading.

Another example I see commonly occurring is in the context of Atkins evaluations—the only criminal forensic issue where the diagnosis is the answer. Adaptive behavior is a critical element in the conceptualization of Intellectual Disability (ID). Yet an examination of the typically used standardized measures makes clear that they are most appropriate for middle class urban Americans with pro-social attitudes. I have had contact with a number of cultural groups who, for various reasons, do not engage in the behaviors specified in the adaptive behavior measures. Then, of course, there are individuals who come from a distinctly criminal subculture, for whom what mainstream culture identifies as maladaptive behavior is really very adaptive. At least one study found that individuals who score higher on psychopathy also score significantly lower on adaptive behavior even when IQ is accounted for (Young, Boccaccini, & Simpler, 2012).

A final example, commonly encountered, is the scoring of risk assessment instruments that are designed to be structured professional judgment devices. This occurs with some frequency even when manuals specifically decry the practice—think HCR-20. This is an arena in which one single overwhelming factor may override everything else. Yet a number, based upon a complex algorithm, may appear to a trier of fact as very scientific and persuasive. The list of common examples could go on.

## The Single Individual

I think most of us would agree that any testing instrument used in criminal forensic evaluations must have strong empirical support for its validity and reliability. However, by its very nature, that empirical support is going to be based upon group data. A typical criminal forensic evaluation is not asking about a population; rather, it is asking about a single individual who is the subject of the particular evaluation. These are unique individuals each existing in a particular context. Hart and Cooke (2013) make a rather sophisticated statistical argument suggesting that violence risk assessment, for example, applied to an individual might be even less precise than often acknowledged. Specifically, they note that group probability estimates have significant margins of error, but margins of error applied to individuals are much larger. Meta-analysis is often considered a much more sophisticated methodology. However, as Boccaccini (2017) noted, a large amount of variability generally exists in effect sizes across studies and, at the present time, there are not enough studies to explain the reasons for this variation. In particular, there is a dearth of actual field studies regarding many of these instruments. Boccaccini concludes that meta-analyses often inform us more in regard to what we do not know then what we do.

## Service to the Court

Forensic psychologists work in service to the courts. We function primarily to provide data, and sometimes opinions, to assist the court in coming to a legal ruling. The more test data that is included, the longer and more complex a report will be. A reasonable question is whether we are actually presenting to the courts something a judge or jury could realistically comprehend. Testing also adds costs in terms of time spent
by the practitioner. Are we actually charging for services that provide incremental validity? Then, one can question whether an extensive battery, or even a broad general test, is providing more information than is wanted. People involved in death penalty work often experience defense attorneys who are very clearly opposed to extensive testing. The general reason given is that such testing provides information that is not actually probative, but rather seriously prejudicial and unnecessary to the psycholegal issue at hand. I find this to be a very persuasive argument against extensive testing in competence for execution evaluations. Clinicians have argued that, with such high stakes, evaluations should be extremely thorough—often to the point of revisiting mitigation. However, the two prongs of the Texas statute are actually very straightforward functional issues. I know of no instrument that directly addresses either one of them.

Conclusions
The point of this article is certainly NOT to decry the use of all psychological testing in the context of criminal forensic evaluations. If an instrument will provide important information to address the psycholegal question, is appropriate to the population and to the individual being assessed, by all means use it. You would be remiss not to do so. However, it is also important to recognize the use of instruments as a choice not an obligation. Careful consideration should be given to decide if formal psychological testing is going to best serve judicial clientele and, of so, what instruments should be applied.

References
Trying to navigate the future of psychology can be a cumbersome task, much more given the current political and social climate. Being a leader and supervisor poses heavy responsibilities for those that have psychology graduate and undergraduate students. Suggestions for further areas of study or professional tracks are of utmost importance to students who are also trying to balance academic interests and the reality of economic pressures. Psychology graduates often have high levels of debt and are often eager to veer their interests to a specialty or field that promises a continued supply of positions. One area of promise is the field of neuropsychology; and for undergraduates or terminal master’s degree students is a position as a psychometrist.

In fact, many misnomers unfortunately exist for the title “psychometrist” (i.e., psychometrician, neuropsychometrician, psychological assistant, psychology technician). The main role of a psychometrist is to administer and score various psychological and neuropsychological assessments under the supervision of a psychologist (National Association of Psychometrists, 2016). Psychometrists also gather behavioral data during the evaluation and may perform clerical duties such as maintaining supplies of assessments, scheduling patients, and data entry. Psychometrists work in a variety of areas from private practice, hospitals, clinics, research centers and within the government sector. It is an enticing job for students with bachelor’s degrees in psychology that would like to use their knowledge as usually less than 5% obtain positions in the field (Martin, 2009).

Many students and recent graduates are unaware this position exists. Nationwide there is confusion as the title is not recognized in the United States classification system for occupations: O*NET. Since “psychometrist” or a similar title does not yet exist in the O*NET database, the vocational outlook is not truly known. However, we can look to fields that regularly employ psychometrists, such as a clinical psychology and neuropsychology for clues to the future. Neuropsychologists and clinical psychologists are job titles that have been labeled as “bright outlook” occupations, which are areas that are going to grow rapidly and have large numbers of job openings nationally (National Center for O*NET Development, 2017). In Texas, clinical psychologists will have a 21% increase from 2014 to 2024 in available positions (Career One Stop, 2017).

The promise of a job position such as a psychometrist dates back to the historical accounts that listed the need for such personnel in the early 20th century. This need continued to show a strong utilization for such professionals until the early 21st century in the fields of clinical psychology and neuropsychology (Malek-Ahmadi, Erickson, Puente, Pliskin, & Rock, 2012). Additionally, recent information about the utilization of psychometrists shows 64.6% of neuropsychologists use psychometrists to gather assessment data (Sweet, Benson, Nelson, & Moberg, 2015). Benefits to have psychometrists assist in assessment collection are to potentially allow for a less biased view of results and to allow the psychologist to have more productive time. To further establish the vocation as a viable one, several organizations have advocated for the model. Position papers from various psychological and neuropsychological organizations regarding the use of psychometrists outline important topics such as training, supervision and job duties (Division 40, 1991; NAN Policy Planning Committee, 2000; Puente et al., 2006). Texas allows the employment of such individuals in this capacity since they gather data and score tests (Tex. Admin. Code Title 22 Part 21 Chap 456 §465.4, (b) 2).

The educational requirement for being a psychometrist is to have a minimum of a Bachelor’s degree in psychology (or a similar field) by an accredited college or university with relevant coursework. Additionally, psychometrists are supervised under the psychologist or neuropsychologist in assessment administration and scoring. Experience for Bachelor’s level psychometrists is usually learned on-site during training. One can assume that Master’s level psychometrists have more clinical experience from their graduate studies and courses in assessment. Currently there are no strong preference guidelines regarding educational level of the psychometrist and assessment tools. Survey data has not yet addressed this topic directly from neuropsychologists’ perspective. Test publishers dictate that a
professional should have adequate education and training before administering an assessment. Some assessments are not given by the psychometrist, such as the Vineland Adaptive Behavior Scales Interview or the Autism Diagnostic Observation Schedule which require more clinical experience and/or specialized training. The National Association of Psychometrists (NAP) had surveyed their members in 2015 for salary information, employer preferences, and other related information. The respondents indicated that regarding employers, 54.3% prefer a Masters, 35.3% prefer a Bachelors, 0.9% prefer a doctorate, and 9.5% reported their employer had no stated preference (NAP, 2017).

If a student or recent graduate would like to know more about becoming a psychometrist, NAP is the organization they should contact. Students are able to become members at a discounted rate. Additionally, the organization holds yearly conferences about topics pertinent to associated fields such as patient populations, information about upcoming standardized test, and ethics. If an employer or supervisor currently uses a technician to gather test data, they could support their professional by suggesting they join the organization. A psychometrist could also be a certified specialist in psychometry (CSP) by the Board of Certified Psychometrists. This board holds examinations at least twice a year. Results from the 2015 survey indicated that only 17.5% of respondents stated this certification as a preference while 58.8% stated their employer had no preference or requirement (NAP, 2017).

Data from the National Association of Psychometrists reports that the hourly wage nationwide is $23.00. There was no significant difference for hourly rate among education levels, although years of experience had the greatest impact. However, psychometrists surveyed with more than 10 years of experience had the greatest impact. If employers want to ensure the quality of the psychometrist’s work, they can offer incentives for the psychometrist to become a member of an organization or become certified. In addition, providing partial reimbursement for conference costs could entice professionals to obtain continuing education.

If an undergraduate student is considering graduate studies but is indecisive, choosing to work as a psychometrist may be a wise decision. Becoming a psychologist comes with a price that possibly not all can afford. The average debt for bachelor’s degrees was $26,600 and those with PsyD had a median debt of $120,000 (Novotney, 2013). Therefore, working as a psychometrist may potentially serve as a method to gain experience and hone preferences while earning income. Working as a psychometrist allows a professional to still use their degree to its highest potential. It could be a direction to steer students towards and hopefully increase the number of psychology undergraduates that have position within the field that we hold dear.

References


When I embarked on psychopharmacology training in February of 1999, I had been a licensed psychologist for only four years. I entered the CSPP/Alliant/Texas A & M post-doctoral program to deepen my knowledge of psychotropic medications and how they impacted the patient, along with how they interacted with other health conditions and medications. I had a keen interest in this area after working in settings that relied heavily on medications, along with other interventions, to help ameliorate mental illness in patients; a state school for adults with developmental disabilities, and a residential treatment program for children. The previous year I had entered full-time private practice and my need to know burgeoned exponentially. When the opportunity presented itself, I did not hesitate long to enroll, make a payment plan, and begin spending a full weekend twice a month with psychologists across the state learning biochemistry, anatomy and physiology, psychophysiology, neuroanatomy and clinical psychopharmacology, just to name a few of the courses. My goals were to become a more informed psychologist for my patients, to be able to consult with medical professionals on behalf of my patients, and to, eventually, prescribe psychotropic medications. I wanted to offer all possible interventions to help patients, and that included medication.

During our last months in the program, many of us pledged two years of monthly payments to assist in the legislative efforts that a newly hired lobbyist would be launching to achieve this goal. Our intrepid and passionate leader, Dr. Deanna "Dee" Yates sparked our enthusiasm, brought us together with unity of purpose and inspired us to make economic commitments. We were fired up! As I reflect back to that time, I don't regret any of our passion or investment to improve mental health care in Texas. We introduced Prescription Privileges (RxP) legislation in 2003 but it did not go anywhere. We didn't know what we didn't know; that grassroots relationships must be the backbone of any legislative initiative to have any hope of a bill passing through all the hoops to become a law. Many good laws do not pass until those relationships are solid. Now, seventeen years later, I realize how exceedingly naïve I was about how difficult the road to prescription privileges would be. I greatly underestimated how long it would take.

The military and Indian Health Services had prescribing psychologists already and soon, New Mexico joined them as the first state to pass the law in 2002. Louisiana followed in 2009 and then Illinois passed their bill in 2012. Iowa passed their law in 2016 and Idaho was on their heels, passing their bill in 2017. The state medical associations fight this initiative every step of the way. All of these battles have been hard-fought, but ultimately they prevailed because they did not give up. There is momentum across the country given the scarcity of well-trained mental health prescribers and Texas is no different. In 2014 the Department of State Health Services published the Mental Health Workforce Shortage report and highlighted that 206 out of 254 counties in Texas have been identified as mental health prescriber shortage areas. A Mental Health Select committee formed prior to the 2017 legislative session to research and address the mental health shortages in our state.

So let’s go back to that psychopharm class that finished in 2001 if you will. After several years of meetings, financial commitments, lobbyists and valiant attempts to establish and maintain a grassroots network by pioneers of this movement (to which I am eternally grateful), the efforts for RxP specifically dwindled. However, the extremely effective grassroots network we have today is a later iteration of our original network which was started by RxP psychologists, toward the aim of RxP of course, but also for the benefit of all issues important to TPA’s legislative agenda. After a few years of dormancy, the RxP movement was revived again in 2013. As the Psychopharm division chair I was asked to lead an RxP Task Force. With help from several task force members, a white paper was created detailing strategies to achieve passage of an RxP bill in Texas. Presentations were made to the TPA Board of Trustees asking that RxP be placed on the legislative
agenda. The vote in November 2014 was successful and during the 2015 legislative session we hastily presented talking points and a potential bill to legislators. There was clear interest in our bill, but it was too late in the process for a legislator to pick up the bill and file it. We continued to talk RxP to anyone who would listen, knowing that passing an RxP bill is a marathon and we were only at the starting line, planning ahead for the long run.

At the risk of repeating myself for some readers, I think it’s important to summarize our rationale and talking points for those of you who may be new to the RxP movement. Why is this important for the citizens of Texas and for psychology as a profession? The first and most important answer is to increase access to prescribers with expertise in mental health; the wait is long for psychiatrists and most psychotropics are prescribed by primary care physicians or other health prescribers with little to no mental health expertise. Those that need care the most are low income, rural, children and minorities. Second, it makes sense that the professional with the MOST mental health training would also prescribe for those conditions. RxP trained psychologists have a Ph.D. in clinical or counseling psychology plus the equivalent of another Master’s degree in biomedical sciences, an additional year of preceptorship prescribing under supervision and have to pass a nationally accredited Psychopharmacology Examination for Psychologists. Third, prescribing psychologists in the military, Indian Health services, New Mexico and Louisiana have a spotless safety record. There is no outcome data to suggest that going to medical school leads to better outcomes. There have been no board complaints. RxP psychologists are prescribing safely and effectively. RxP psychologists are unprescribing as well and using other tools to treat patients including behavioral, cognitive and psychosocial interventions. They spend more time with patients than a med check and consult with primary care physicians as part of their standard of care. It provides a free market solution to consumers to have choices in providers and what about the economic aspects? Patients have one appointment away from work and one copay instead of two. This cost savings would be more far-reaching if consulting psychiatrists that work on contract for the state were replaced by prescribing psychologists who already work in those settings.

So where are we now? We worked during the interim prior to the 2017 session to obtain sponsors for an RxP bill and found a bill sponsor, Rep. Dustin Burrows (R) from Lubbock who filed the bill early in the session. One co-sponsor signed on in the House, Gary VanDeaver (R) from Paris and Senator Jose Rodriguez (D) from El Paso filed the bill in the Senate. We were thrilled to have sponsors in the House AND the Senate, progress that was unprecedented in Texas! TPA had more media coverage on HB 593/SB 1240 than any other legislative bill ever with psychologists around the state giving radio, TV and newspaper interviews. Rep. Burrows championed the need for mental health providers in Texas prisons and jails, in addition to advocating for general public access. One psychologist relayed the story that there was a two year wait for a psychiatrist to see a child with Medicaid in an urban area, another discussed the dilemma in treating a newly diagnosed child with schizophrenia who lived in an extremely rural area and yet another shared the story a young mother who was depressed and had suffered functional limitations for over 18 months, while being seen repeatedly by her rural physician and prescribed a sub-therapeutic dosage of a common anti-depressant. Evocative stories of real people from around the state vividly illustrated scarcities in care and treatment that was provided in good faith by providers who were not skilled in treating mental health disorders.

Our next step was to get a hearing in the House Public Health committee so that the bill could be discussed and hopefully passed out of committee to the House floor. We were not successful. Nevertheless, we will not give up and as we go forward into the next legislative cycle, our progress in 2017 will buoy us as we move even further along the legislative trail. We know that as more states pass RxP bills there will be more momentum. We know that as we deal with assaults on every side regarding the profession of psychology, prescription privileges can provide economic stability, reduce overuse on medications and improve access to skilled evaluation for mental health medications. Now, more than ever, we must distinguish ourselves from other mental health providers, as providing therapy alone appears to be going the way of Master’s level practitioners. Specialty areas like forensic and neuropsychological evaluation, behavioral medicine and psychopharmacology are part of that survival landscape.

I don’t know where exactly the finish line will be for the prescriptive privileges marathon, but I do know that it’s worth running. I’ve learned a lot about the legislative process since those early years fresh out of psychopharm training. The legislative process is daunting to say the least. We have an edge though as experts in relationships, which is at the heart of how bills get passed. RxP is the road less traveled because prescription privileges are not for everyone, and that’s completely fine. One of the best parts of being a psychologist is that we have so many diverse and specialized areas of practice and we can support each other even when it’s an area outside our interests. I hope that many of you who ARE interested in this area will call or write, go to our website (TexasRxP.com), donate money, join the division and/or task force or simply support and cheer on the sidelines for those of us that have passion and determination for RxP in Texas!

Please direct comments to: Dr. Cheryl L. Hall, Ph.D., MS PsyPharm, 7021 Kewanee Ave, 7101, Lubbock, TX 79424, challphd@yahoo.com, 1-806-763-0173
TherapyNotes™
Online Practice Management Software for Behavioral Health

Scheduling & To-Do Lists
Track clinician schedules, patient appointments, notes, and billing. Appointments and other tasks are automatically added to your personal To-Do List. Sync your calendar to your smart phone to view your schedule on the go.

Patient Notes & EMR
Complete your notes quickly and easily. Our note templates have been uniquely designed for mental and behavioral health. Go paperless by uploading your patient files into TherapyNotes. All of your data is secure and encrypted.

Electronic Billing
Streamline your billing with seamlessly integrated electronic insurance claims, ERA payment posting, credit card processing, and more. Submit insurance claims with a single click. Easily generate patient statements, superbills, revenue reports, and more.

...AND MANY MORE FEATURES!

Automatic Reminders
Automatic text, phone, and email reminders to reduce no-shows and decrease expenses

Custom Client Portal
TherapyPortal, your own custom client portal for appointment requests

Unlimited Support
Superior, unlimited phone and email support included with every TherapyNotes account

Special Offer!
Just for Texas Psychologist Readers!
Sign Up and Receive Your First 2 Months FREE!
Use Promo Code: TPAFL17
Offer Expires 1/1/2018

My experience with TherapyNotes has been fantastic!

Firstly, the system is easy to navigate, thorough, flexible, and extremely clinically intuitive. Secondly, technical and customer support has been efficient, fast, and very personal. I am leaving another EHR system for TherapyNotes...gladly. I’m very happy that you’ve created such a quality product. Thank you!

Dr. Christina Zampitella, FT, Licensed Clinical Psychologist

Many more stories on TherapyNotes.com!