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TEXAS

# psychologist

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## FROM THE PRESIDENT

# We Are Ready For You, 2018!!!



**CHERYL HALL, PH.D.,  
M.S. PSY.PHARM.**  
Independent Practice  
Lubbock, Texas

I know you will join me in thanking Dr. Carol Grothues for leading us during a year that was unprecedented with challenges both from the legislature and from our regulatory board. Her theme of growing psychology was put to the test as others tried to shrink psychology, water it down, and carve it up. However, as I reflect on the year's theme, I truly believe we have been growing: professionally into specialty areas like integrated care and RxP, politically in fundraising efforts through an active and enthusiastic Political Action Committee (PAC), and legislatively as our grassroots network continues to expand and flourish every day. I hope that TPA members become more active in response to the threat of unwelcome changes, and that these challenges become the catalyst for activism and for fierce defense of our psychology profession. Some of these developments have to do with the needs of Texans and national trends, and we may not be able to stop them completely. In that case, though, it's important to stay engaged, have input, and even lead some of these changes.

### Sunset 2019

During the 2018 interim year we will be preparing for the Sunset review in 2019. As the chair of the Sunset Strategy Task Force, I can report that we are working diligently to achieve our goals of ensuring the stability of the doctoral standard, and of maintaining both our independent agency and independent regulatory board. We are advocating to continue the postdoctoral supervision year, as long as it meets reciprocity criteria. This will significantly increase reciprocity with other states. We are also open to added flexibility when those hours are earned. Finally, we continue to promote the utility of the oral exam

and the inclusion of PSYPACT, which will allow psychologists to practice across state lines. We submitted a formal report in October, and Dr. Grothues, David White, our Executive Director, and I met with the chair of the Sunset Committee, Mr. Robert Romig, to brainstorm how we might work together to achieve our goals, while satisfying their concerns for the vulnerability of a small agency and their problem of other mental health groups who are not operating efficiently. Mr. Romig assured us that if we were consolidated administratively with other mental health boards, staff resources would increase. While we clearly prefer to maintain an independent agency, we will be exploring the viability of this option. We also met with Mr. Darrel Spinks, executive director of TSBE, to discuss his concerns about the possibility of an anti-trust lawsuit that could be brought against the board members if there is not adequate oversight by individuals who are not market participants. We left both meetings feeling they were constructive, where viable solutions were discussed and we felt heard. Now some critical work begins: most 2019 Sunset Committee member Senators and Representatives are appointed and we will begin talking to them about our objectives prior to the Sunset hearings in March. Stay tuned for alerts that may ask for your help in talking to key legislators and/or coming to Austin to testify during the hearing.

### Government Relations Consultants

I'm happy to announce that TPA has recently contracted with two government relations experts, Mr. Jerry Phillips and Mr. Kevin Stewart, both attorney-lobbyists, to provide expertise, experience, and consistent legislative presence during both the interim and the legislative session. They

will assist us with a successful Sunset process and continue to help us strategize other legislative priorities like our bill to protect against civil liability for the duty to warn, prescription privileges for appropriately trained psychologists, and the determination of wards, just to name a few. During the interim there are hearings, stakeholder meetings, and many other opportunities to work on our objectives so that much is done in advance of the legislative session. We are also planning a legislative day at the Capitol to meet with staffers to discuss our issues during a less hectic time. Everything we do during the interim is aimed at making the legislative session more successful. You make a difference when you call, email, or write your legislator, and we will let you know how and when to do so while they are in their home districts and have more time to listen to and exchange ideas.

### Texas State Board of Examiners of Psychologists (TSBEP)

On another front, in November 2017, our regulatory board, TSBEP, passed a rule allowing Licensed Psychological Associates (LPAs) to practice independently. Thank you to everyone who wrote in and testified at the TSBEP meeting to protest this rule. This was, in our opinion, an example of TSBEP operating beyond their purview. We believe such a decision should be made legislatively. However, TSBEP forged ahead and passed this rule citing the workforce shortage as a rationale. Members of TSBEP also believe restricting master's level practitioners is anti-competitive given that services provided in other mental health fields are primarily master's level professions. Again, we believe there is a difference between psychology and counseling, social work, and marriage and family therapy. TSBEP did concede



that in specialty areas there may need to be competency guidelines defined and they have created a workgroup to do so. Our own Pete Stavinovha agreed to serve in that capacity as a TPA representative. It's important to be a part of this process even though we don't know if the rule will withstand the lawsuit that TPA has filed. The filing of this lawsuit was a well-thought-out decision and certainly not something we wanted to do. We hope it will be successful in halting this process and maintaining that doctoral training is the minimum training necessary for the independent practice of psychology. LPAs practicing independently is not in the best interest of the profession or the public.

### Resiliency for 2018

In 2018, I will promote the Resiliency of Psychology as we face the challenges ahead. Resiliency is the ability to recover from setbacks, thrive in difficult conditions, adapt well to change, and keep going in the face of adversity. We teach our patients to be more resilient, and we observe resiliency within tragedies like Hurricane Harvey and the Sutherland Springs shooting. Our resiliency as a profession is being tested, but I believe we CAN epitomize the concept of resiliency in fighting changes that we don't think are constructive for psychology or for our patients. We can also be resilient in adapting to changes that may occur anyway, in spite of our best efforts. We can be further resilient by defining additional areas, such as prescription privileges and determination

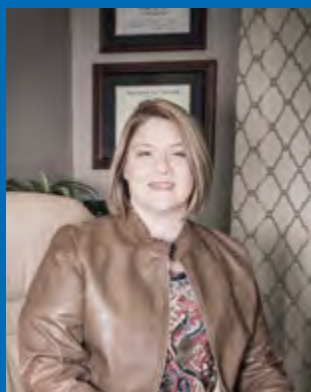
of guardianship, where psychologists can practice at the ceiling of our training. This is a time for persistence, creativity, improvisation, and growth and I am grateful that each and every one of you are a part of it.

Thank you for being a member of TPA! TPA is the only organization that works to address crucial issues regarding the survivability of our profession and that works to ensure the provision of effective, quality care for patients. If you have colleagues that are not members, encourage them to join. It costs \$7.50 a week to support your profession. TPA's efforts benefit ALL Texas psychologists.

I'm looking forward to a year of accomplishments for TPA, and I wish you all a happy 2018! ■



**JENNIFER ROCKETT, PH.D.**  
Private Practice  
Bryan, Texas



## FROM THE EDITOR'S DESK

# Notes on the Winter Issue

**G**reetings and happy new year, colleagues. I hope you each have good health in this new year, as Texas finds itself in the midst of a nasty flu outbreak, to which some of us fell hard. Brace yourself for this new year: even as psychology is growing in its resiliency, we have several large fights ahead. We open this year's first issue of the *Texas Psychologist* (TP) with a message from our new TPA president, Dr. Cheryl Hall. Please join me in wishing Dr. Hall a splendid presidency!

We also welcome our new Texas Psychology Foundation president, Dr. Heyward Green. In Dr. Green's column, he presents his vision for TPF. And in the spirit of that vision, the Winter TP is well-represented by student-led articles. See, for example, Ms. McGeehan and Dr. Palomares-Fernandez'

clinical assessment case study highlighting the importance of placing the client's needs above external demands and clinician/assessor-internal pressures. And, Ms. Bailey and Galicia in collaboration with Dr. Venta address the growing need for services among immigrant youth. These authors provide a broad overview of the challenges facing immigrant youths and give us specific guidance on clinical activities like being culturally competent in our work, obtaining informed consent, building rapport, and considering the use of translators and engaging with youths in their primary language. In keeping with this issue's focus on student authors and resilience in our profession, Drs. Kennard, Foxwell, Robinson, and Korman discuss a growing trend in the field, that of integrated training models and

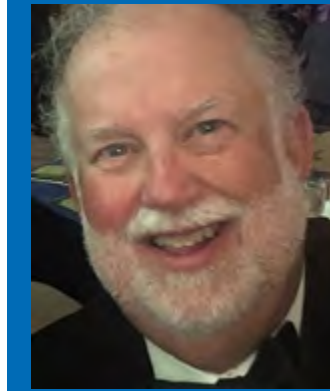
the use of internships that are exclusive to specific doctoral programs, referred to as "exclusively affiliated internships." We also feature an article submitted by predoctoral interns, Drs. Werry, Wood, Anastasiades, Grosse, and Fierro from the University of Texas Science Center at Tyler, that discusses the Integrated Behavioral Health movement and our role in the implementation of services in rural integrated health settings. Finally, in this issue's forensic column, the father-daughter duo of Drs. Harris gives us an overview of the assessment of civil competency among elders, a growing forensic psychology practice area.

As always, thank you to all the authors who submitted work for the Winter TP. Please keep the articles coming! ■



## A NOTE FROM THE FOUNDATION

# Looking Ahead With TPF



HEYWARD GREEN, PSY.D.  
Texas A&M Health Science  
Center and Baylor Scott &  
White Health

**A** long-standing convention claims the month of January is named for the Roman deity Janus. In Roman religion and mythology, Janus is the god of beginnings and endings, passages and transitions, and even doorways and gates. Usually he is depicted with two faces, one looking back and the other forward—or in a more symbolic sense, one viewing the past and the other looking toward the future. As I move into my new role as president of the Texas Psychological Foundation (TPF), the dual perspective of Janus seems especially appropriate.

In its history, TPF admittedly has waxed and waned in visibility. It has benefitted from a core of dedicated psychologists whose vision and support have sustained its mission to stimulate interest in and knowledge of psychology in Texas. At times in the past TPF was highly visible at the Texas Psychological Association annual convention, and at other times it was barely a footnote to the rank-and-file membership and attendees. Over the past several years, TPF arguably has grown more visible with more popular activities at conventions. Still, based on comments and questions from some fellow convention attendees in November, its purpose remains obscure for some, if not many, members of TPA.

Compared with its more prominent sibling, the PAC, TPF has ambled along quietly to support our science and discipline through the poster session at convention and various research awards and grants. As I write, we are living in trying times in which there are threats and attacks on things many of us

have more or less taken for granted. Based on numerous situations over the years, we have come to recognize the various assaults on our license in Texas. In most instances, we have prevailed in keeping our professional identity alive and distinct, and in so doing have advanced the practice of psychology in Texas. Ironically, the latest threat to our status comes not from other professional entities, but from our own state board of examiners. TPA and the PAC are directing considerable effort and resources to address that problem and to restore appropriate standards for our profession that will secure our status for the future.

While the PAC addresses the more visible and tangible aspects of professional psychology in Texas, it occurs to me that we face a subtler, but perhaps equally lethal threat to psychology. Caught in winds of political discourse, science itself has increasingly come under attack. In a world where the natural or so-called hard sciences are targeted with suspicion and doubt, the status of psychology and other social or soft sciences becomes even more vulnerable to the pernicious effect of challenges based on lack of knowledge or understanding.

As scientists, we know our standards and embrace our methods in our efforts to achieve an accurate understanding of behavior. We attempt to set aside biases and certain kinds of beliefs in a quest for truth. We also challenge and critique the work of each other in an exercise of discerning potential flaws in methodology and design that could threaten the validity of research findings. That scrutiny is at times brutal, but

it has served to winnow out the chaff as we build a stronger body of knowledge about behavior.

The purview of our corner of science makes us especially vulnerable to doubt and derision coming from some quarters. We use constructs, mathematical models, and statistics instead of measuring tangibles. We explore issues that question the uniqueness of humans in the natural world. We ask questions and propose answers for issues that stir unease such as sexuality, gender, criminal behavior, aggression, substance abuse, and other addictions, relationships and so much more. Our findings based on demonstrable evidence sometimes challenge or refute existing beliefs and attitudes. Typically, our investigations are not intended to uproot a long-standing belief, and in fact sometimes lend support to those ideas. But when findings run against convention, these findings can be rejected, mocked, or ridiculed. Data from public opinion polls—sometimes themselves clearly biased—are compiled as attempts to refute the validity of a scientific finding. It is suggested that when poll results disagree with the finding, it must not be valid. From there it gets worse when pseudoscience gleans obscure pieces of data from questionable sources to disprove the results of well-designed, replicated studies. Our entire discipline can be attacked as we become like the proverbial messenger of unwanted news.

Science is not legislated, so the PAC funds and associated efforts do not really accomplish much in swaying opinions and beliefs among the general public about



the body of knowledge we call science. We know that the body of knowledge in psychology has expanded rapidly in the past two decades. Public understanding lags, and where the vacuum of unawareness exists, plenty of inaccurate information and beliefs rush in to fill the void. That is where we—all of us in this field—come in. We have an opportunity to promote knowledge and understanding based on our science. We do not have to do this singly. Few of us have the will or talent to be commanding spokespersons. We can, however, join effort to expand awareness and understanding of what we know about behavior and what we do to help others through our evidence based practices. One avenue for that support is through backing research and the progress of students who are pursuing careers in psychology.

TPF is organized exclusively for charitable, educational, and scientific purposes. Funds received by TPF are intended to:

- » stimulate interest in and knowledge of psychology amongst the public;
- » recognize excellence and achievement in graduate training by granting awards, scholarships, and fellowships;
- » encourage the design and development of novel techniques and innovative programs for providing effective psychological services in schools, institutions, industries, and in the community-at-large;
- » promote or fund basic and/or applied research programs in psychology;
- » encourage and support scholarship and publication in the field of psychology; and

- » develop materials and programs for the advancement of professional education in psychology.

As we consider the past and look toward the future, I invite you to join me in demonstrating real and tangible support for TPF along with the PAC. Doing so will help preserve the progress achieved during the course of our own lifetimes regarding both our professional standards and the expansion of our understanding of behavior. Perhaps more importantly, we have the opportunity to create a legacy for future psychologists by strengthening the foundation of practice and knowledge.

A \$100 contribution establishes you as a Friend of TPF. ■

## Why your Foundation gift matters

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## *Ethics and Independent Practice: Keeping the Client First*

*Brittany McGeehan, B.A.  
Ronald Palomares-Fernandez, Ph.D.  
Texas Woman's University*

**W**hen conducting an assessment, there may be times when the practitioner loses track of the client as they focus on obtaining the results. This article is designed to remind practitioners how important it is to keep the client in the forefront throughout the assessment process. It also serves as a reminder of how easy it is to place the practitioner's own needs before those of the client's.

As a graduate student approaching the end of my program, I was assigned an end-of-program project, through which I was to demonstrate my best work on a psycho-educational assessment. As an eager student, I embarked on this assessment with a 9-year-old boy, referred for evaluation by his mother because of emotional and academic concerns. (Various details from the actual case have been changed to protect client confidentiality.) This young boy had a prior diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and Juvenile Myoclonic Epilepsy and at the time of the evaluation, he was on stimulant medication to treat his ADHD symptoms. His mother reported that three months prior to the evaluation, his neurologist had provided her with a choice as to whether to treat his attention-related symptoms or his seizures with medication. His mother was not provided with guidance or information as to the effects that removing his current antiepileptic medication would have on him; she was simply asked to make a decision. Although he had been treated with medication for

his attention-related symptoms, his mother felt that she needed further professional guidance regarding his treatment planning.

The young boy, Tom, was pleasant to work with and open to sharing his experiences with me, which made it easy as the evaluator to quickly build a large assessment battery that I felt would answer the referral question and allow me to demonstrate my assessment skills. As we moved through the assessment I began to notice a wide variation in Tom's assessment results, especially his difficulty when trying to decipher a pattern. During the second assessment session, while completing an attention-related task, I noticed that Tom was staring off into space and not responding to the question that was just asked, despite having been engaged in the task only moments before. This was when it dawned on me that he was potentially having an absence seizure. Tom did not display the typical eye flutter that I was accustomed to observing with absence seizures, which is why I had not picked up on it before. When asked what was the last thing he remembered me saying was, his answer reflected the previous question. Tom had no memory of me asking the present question, further supporting my hypothesis that he may have experienced an absence seizure while the question was being asked.

Initially, I simply made a note of the suspected seizure and continued the test to keep inline with the standardization process. Although I was concerned, I knew that I had to turn in my best work for my graduate project and really wanted to gather the most

complete assessment picture of Tom. So, I began to add more subtests from a variety of tests to get the most thorough profile of this child that I could. Although I offered him breaks more frequently and we stopped testing to have a snack on several occasions, I saw that Tom had become noticeably more fatigued and so, after just a few hours of testing, I decided it was best to cut the session short for that day and continue where we left off at the next scheduled session.

That evening, as I scored the various tests I had administered that day and began writing my report, I found I had a wide range of discrepant scores from Tom's cognitive, academic achievement, social-emotional, and brief neuropsychological measures, none displaying a discernible pattern. As I sat and planned out what areas I still needed to assess to get a better picture of Tom, as well as to demonstrate my skills best, it dawned on me that I was placing the focus of my concern on my needs (which was to provide a thorough assessment for my graduate program) rather than the needs of this child. What Tom needed from me as a practitioner was to help educate and advocate for him with his mother so that she could make an informed decision for her son. While a thorough report might provide this information, the majority of the results would be convoluted by the suspicion that Tom was having seizures throughout the assessment. As I worked on my recommendations I already knew that I would be referring the family for a second



opinion from a neurologist to seek treatment for the seizures and then potentially reevaluating the situation in a few months. Therefore, the more I continued testing Tom and obtaining questionable scores, the more I was potentially taking away assessment options from a future evaluator. In addition, the longer that the recommendation was delayed, the longer Tom would be having seizures, leading to further brain damage and long-term effects. Furthermore, I understood from my neuropsychological training that Juvenile Myoclonic Epilepsy should be controlled with medication and that the typical prognosis indicated that seizures would not improve until approximately the fourth decade of life. To keep this information from Tom's mother would be breaking the first APA principle of Beneficence and Nonmaleficence (APA, 2017).

This realization led to one of the most difficult predicaments I had faced thus far in my training. I had to decide if I would forego this assessment and immediately refer the child out to a neurologist (and have to find another case for my project) or if I would complete my assessment, thus postponing the referral. Although I knew a referral was in Tom's best interest, no matter the results I gathered from that point on, I did not want to stop my assessment while it was still incomplete. While those reading this article may easily see the clearly ethical answer to this dilemma, I struggled because my doctoral candidacy was on the line with this project. I knew that I was expected to show

my best assessment abilities and therefore wanted to give a comprehensive assessment. In addition, I was also working under the deadline of internship applications. If I did not pass this project, I would be unable to go on my predoctoral internship, delaying my professional career by adding a year to my studies. As a graduate student, not only did I face these personal pressures, but I also struggled with what would be expected from my program's faculty and direct supervisor. These pressures can make it easy to forget that the child on the other side of the numbers is in crisis and depending on you for help. Tom's life at home and school were in shambles. Tom was being passed along at school, despite failing his assignments, and internalizing this perceived failure so much that he had begun displaying depressive behaviors both at home and at school. For him, my candidacy, internship, and faculty's opinions were irrelevant because he needed help immediately, not after the report was approved several months later.

That is when it became clear to me: I had to place Tom first and find a way to advocate for him immediately, rather than placing my own needs first. Suddenly, APA's ethical standards "Do no harm" came to mind (APA, 2017). When I realized this, it hit me—this is what I have been trained to do, place my client first! So, sorting through my results I decided the best course of action would be to provide the family with the results, knowing that they are mostly irrelevant because Tom appeared to be having minor seizures or some other

disruption, and share my observations immediately. My recommendation to Tom's mother was to seek a second neurologist's opinion to control his seizures. If the same needs were still present after the Juvenile Myoclonic Epilepsy treatment plan had been in effect for several months, then I recommended for Tom to be reevaluated at that time.

This article is being brought forth as a reminder to psychologists to never lose sight of their client, keeping them first throughout their work. Although this "client-first" focus may seem straightforward and something one feels they may not ever forget, external pressures, including demands from others or limited time, may make it harder to remember that our client should always come first. Our ethics course may have been a few months or years ago, but we have to keep foremost in mind the client's well being, as stated so clearly throughout APA's ethical standards of practice (APA, 2017). If we are to go into this field with the purpose of doing no harm and serving our clients to the best of our abilities, this lesson is well taken and one we will have to continually remind ourselves of. ■

## References

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## Call for submissions

The *Texas Psychologist* is seeking submissions for its upcoming 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](mailto:drjenniferrockett@gmail.com) by February 28 for the spring issue.

## *Using Integrated Behavioral Health to Extend Services to Diverse Rural Population*

*Amy E. Werry – Pacific University, School of Graduate Psychology*

*Ashley E. Wood – Willams James College, Clinical Psychology Department*

*Maria H. Anastasiades – Mercer University, Clinical Medical Psychology Program*

*Chase V. Grosse – Mercer University, Clinical Medical Psychology Program*

*Leigh Ann Fierro – University of Texas at Tyler, Department of Psychology and Counseling*

### **Authors' Note**

*This article is submitted by predoctoral interns (2017–2018) training at the University of Texas Health Science Center at Tyler, an APA-accredited Psychology Internship Program with a focus in Integrated Behavioral Health, as well as a master's level student from the University of Texas at Tyler.*

*Correspondence concerning this article should be addressed to Kathryn Wortz, Ph.D., Training Director, Department of Psychiatry and Behavioral Medicine, University of Texas Health Science Center at Tyler, Tyler, TX 75708. Email: kathryn.wortz@uthct.edu*

**I**ntegrated behavioral health (IBH) is a collaborative model for providing behavioral health and mental health treatment to patients receiving medical care within a primary care setting. Providers working within this model work hand-in-hand with primary care providers to ensure that the biopsychosocial needs of the patient are being addressed by the treatment plan (Hunter, Goodie, Oordt, & Dobmeyer, 2009). This model is efficacious in treating mental health and behavioral health conditions and reduces the cost of treating medical conditions (Cummings, O'Donohue, & Cummings, 2009). Rural Texas has an immense need for mental health and behavioral health services (Rural Health Information Hub, 2017) and providers working within the integrated behavioral

health model can meet these needs. Billing codes are available for providers working within this model (apapracticentral.org), and training requirements and competency guidelines exist (McDaniel et al., 2014). This paper will demonstrate the benefit of implementing integrated behavioral health and provide an overview for providers hoping to gain a basic understanding of this model.

IBH works to meet the need for simultaneous medical and psychological care. The pattern of rural people seeking mental health care from their primary physicians allows for seamless integration of behavioral health in rural primary care settings (Leichter & Slama 2016). Barriers to receiving medical and mental health services in rural areas are many and impact a large number of Texans. According to census data, rural areas encompass 96.65% of Texas land and 3.8 million Texans (U.S. Census Bureau, 2010). Systemic issues that impact access to health services for rural Texans include a shortage of providers and limited funding. Of all the states, Texas spends the least money per capita on mental health services and the sixth lowest amount on health care overall (National Center for Policy Analysis, 2013).

Rural IBH psychologists can work to ameliorate the impact of limited resources. For example, IBH providers can target health risk behaviors that contribute to chronic illness. In Texas, health risk behaviors are

associated with five of the six highest causes of death (Texas Department of State Health Services, 2014). Mental health providers are more prevalent per capita in urban areas compared to rural areas despite the fact that prevalence rates of mental health diagnoses are similar (Rural Health Information Hub, 2017). This likely impacts the poorest among rural Texans the most, as the cost to drive long distances to multiple appointments interferes with access for clients of lower economic brackets. Culturally, many rural Texans live in close-knit communities and are deterred from receiving services because they fear that they cannot actually receive confidential care (Gamm, Stone, & Pittman, 2010). If patients are able to see a physician and a psychologist at the same time, one less trip needs to be funded and the patient is allowed an extra layer of anonymity because nobody in the waiting room will know whether they are seeking treatment for a less stigmatized illness such as the flu or for a psychological condition.

Treating mental health conditions through an integrated health model allows for effective treatment of up to 80% of mental health care cases and only the most chronic cases require further specialty care (Cummings, O'Donohue, & Cummings, 2009). Not only does IBH increase efficiency; it can also reduce cost. An individual who has a chronic illness as well as a mental illness tends to overutilize medical services, so much so that the cost of care may double

(Anton, 2015). One study showed that such patients who received behavioral health care reduced medical utilization by 15.7%. Meanwhile, costs rose an additional 12.3% for a matched group that did not receive those services (Leichter & Slama 2016). Additional studies have shown that IBH can decrease the cost of medical care by 20-30% on top of eliminating the cost of treating the mental health condition (Cummings, O'Donohue, & Cummings, 2009).

IBH can not only cut costs and overutilization, but it can also improve medical care. Incorporating behavioral health interventions for chronic health conditions such as diabetes, asthma, and cardiovascular disease, has demonstrated better medical outcomes (Anton, 2015). Behavioral interventions have been shown to improve compliance with medically necessary lifestyle changes and prescribed medical regimens (Cummings, O'Donohue, & Cummings, 2009). In sum, there is both medical and psychological evidence to support the use of IBH with diverse rural populations. Integrated health care models allow various health professionals to provide treatment for both medical illnesses and mental health disorders (Kwan & Nease 2013), increase access, and reduce cost.

IBH models are sustained by Medicare. In January of 2002, Medicare recognized six Health and Behavior Current Procedural Terminology® (CPT) codes as a result of the development of and advocacy for such codes by the American Psychological Association's (APA) Practice Directorate. Health and Behavior CPT codes are now known as H&B or HABI codes. These codes allow psychologists working within an integrated behavior health model to bill for services provided (American Psychological Association Practice Organization, 2012). The H&B codes are billed in 15-minute increments. Because of this, psychologists are able to integrate behavioral health services into the pace and practice structure of primary care offices. Importantly, these codes can only be used on a diagnosed physical health problem when the focus is on psychological, behavioral, and emotional factors that impact that health problem (Centers for Medicaid and Medicare Services, 2010). The H&B codes cannot be used for focusing on mental health concerns,

and patients must have a diagnosed, underlying physical illness with a physician-documented need for health behavior services. Patients who have a mental health diagnosis can be treated using these codes, but the focus of the visit must be on treating the biopsychosocial issues that directly interfere with a diagnosed physical health problem. Since these codes are used in 15-minute units, service should be rounded up or down to the nearest increment, including only face-to-face patient contact (Mork, 2009). There are no billing codes per se that allow for the sole treatment of mental health disorders under an integrated behavioral health model, despite the evidence that this model improves outcomes and decreases costs (Cummings, O'Donohue, & Cummings, 2009). Instead, traditional psychological codes may be used, as appropriate.

Examples of appropriate uses of H&B codes include:

- » Pre-surgical evaluation for spinal cord stimulator
- » Providing coping skills for a child with diabetes and her parents to reduce the stress of daily injections
- » Providing a smoking cessation group for patients with secondary physical health problems, such as chronic obstructive pulmonary disease
- » Providing mindfulness-based stress reduction skills for a patient with obesity who engages in overeating of high-calorie foods to cope with emotions

Billable CPT codes and 2012 Medicare reimbursement rates per 15-minute unit include:

- » Initial assessment of the patient to determine the biological, psychological, and social factors affecting the patient's physical health and any treatment problems (96150; \$20.42).
- » Re-assessment of the patient to evaluate the patient's condition and determine the need for further treatment. A re-assessment may be performed by a clinician other than the one who conducted the patient's initial assessment (96151; \$19.74).

- » Intervention service provided to an individual to modify the psychological, behavioral, cognitive, and social factors affecting the patient's physical health and well-being. Examples include increasing the patient's awareness about his or her disease and using cognitive and behavioral approaches to initiate physician prescribed diet and exercise regimens (96152; \$18.38).
- » Intervention service provided to a group. An example is a smoking cessation program that includes educational information, cognitive-behavioral treatment, and social support. Group sessions typically last for 90 minutes and involve 8 to 10 patients (96153; \$4.42 per person).
- » Intervention service provided to a family with the patient present. For example, a psychologist could use relaxation techniques with both a diabetic child and his or her parents to reduce the child's fear of receiving injections and the parents' tension when administering the injections (96154; \$18.38).

A psychologist working within an IBH model provides services within appointments that last between 15 and 30 minutes. In this model, the behavioral health provider fits into the flow of the clinic without interrupting services. Proper pacing should be utilized to cover the referral question, assess the patient, deliver an intervention, and plan for follow-up or referral to the community. After the service is provided to the patient, the psychologist consults with and provides feedback to the referring provider (Society for Health Psychology, 2016). An IBH psychologist can expect to address concerns ranging from mental health issues to medical diagnoses that respond to psychological intervention (Society for Health Psychology, 2016). Generally, assessment should be focused to recognize red flags that could indicate a medical condition, mental health concerns, side-effects of medications, or other factors that could be impacting the presentation or referral question. While initially difficult due to traditional training models and a desire to be thorough, it is necessary to streamline questioning and



deliver a targeted intervention. With practice this may be accomplished while still being comprehensive.

An IBH provider's toolbox may be filled with many resources for common concerns to facilitate intervention. Those tools may include patient handouts (mindfulness scripts, local AA meeting directory, sleep hygiene psychoeducation), suggestions for smartphone apps, coping strategies (brief mindfulness/stress reduction exercises), clinical skills (motivational interviewing), and information about community resources (Society for Health Psychology, 2016). In addition, brief screening measures delivered at check-in are valuable tools to alert the integrated team to ensure delivery of psychological services, as well as to assist in patient assessment.

Training requirements and competency models have been developed to ensure that psychologists providing these services are well-trained and working within their area of competency. Integrated Primary Care training by the Society for Health Psychology utilizes the six core competencies as proposed by McDaniel et al (2014). The six domain clusters include Science, Systems, Professionalism, Relationships, Application, and Education. McDaniel et al. (2014) organize each of the six competencies by providing a description of the essential competency component, a behavioral anchor, and a practical example of each competency. It should be noted that there are other proposed integrated primary care (IPC) competencies that include the Air Force Primary Behavioral Health Care competencies (Air Force Medical Operations Agency, 2011), Substance Abuse and Mental Health Services Administration (Hoge, Morris, Laraia, Pomerantz, & Farley, 2014), the Interprofessional Collaborative Practice Model, and recently the Core Competencies for Behavioral Health Providers Working in Primary Care presented by the Farley Health Policy Center (Interprofessional Education Collaborative Expert Panel, 2011; Miller et al., 2016).

The IPC training proposes a training arc for each of the competencies proposed by McDaniel et al. (2014) that span from practicum training to postdoctoral training. Each level of advanced training builds upon the foundation of exposure and learning

during practicum. Interns build confidence and practice independently while being closely supervised. Residents are expected to practice with minimal supervision and grow in leadership ability. While one may consider a traditional course of training that begins in graduate school and extends through internship and residency, continuing education and re-specialization programs are also available (Society for Health Psychology, 2016).

Implementation of IBH can meet the need for mental health and behavioral health in rural Texas, while simultaneously reducing the cost of medical care. Providers working within this model are integrated into the primary care setting and seamlessly provide care within the flow of the primary care clinic. Providers can bill for services provided for mental health and behavioral health concerns that are directly related to a medical condition. Those who are interested in learning more about the implementation of IBH can turn to the training requirements and competency guidelines. In conclusion, IBH is a cost-effective, efficient, and efficacious way to provide services to individuals where they are already receiving medical care and is essential to meeting the needs of rural Texas. ■

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## Working with Unauthorized Immigrant Minors

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An estimated 11 million unauthorized immigrants live in the United States (U.S.), 1,470,000 of whom reside in Texas, making it the state with the second largest number of unauthorized immigrants in the U.S. (Migration Policy Institute, 2014a). Of the nearly 1.5 million unauthorized individuals, 90% are of Central American origin (Migration Policy Institute, 2014b). Although the stereotype of an unauthorized immigrant as portrayed by the media has continued to be a single adult searching for economic opportunity, statistics suggest otherwise. Customs and Border Patrol (2016) reported an 8% increase from 2015 to 2016 in the overall number of individuals (i.e., single adults) immigrating to the U.S. at the southern border. Yet, this number pales in comparison to the 72% increase in the number of unaccompanied children and

families immigrating to the U.S., suggesting that the demographic of unauthorized immigrants is changing.

As regional violence runs rampant in Central America (Hiskey, Córdoba, Orcés, & Malone, 2016), unauthorized immigrants continue to seek refuge in the U.S. (Customs and Border Patrol, 2016), despite current attempts to increase immigration enforcement and change enforcement priorities driven by the Trump administration. Such changes have increased the number of arrests of removable immigrants by 32.6% (Migration Policy Institute, 2017), putting immigrants in more frequent contact with specialized services, such as legal and psychological aid. As the number of unauthorized immigrants rises and the demand for psychological services grows, our need to understand this population increases proportionately. Given the rapid increase of unauthorized immigrant minors in the U.S. in recent years, the broad aim of this article is to provide considerations when working with this population.

### Unauthorized Immigrant Minors: What We Know

Immigrant minors and family members migrate to the U.S. for many reasons, most notably to escape violence in society, abuse in the home, persecution, or deprivation (United Nations High Commissioner for Refugees, n.d.), or to unite with a family member (Adelman & Taylor, 2015). Indeed, more than 90% of minors have a family member, such as a parent, in the U.S. already (E. Kennedy, personal communication, n.d.). Research shows minors who are separated from their parents for a long period of time are at risk of developing anxiety and depressive symptoms (Suarez-Orozco, Bang, & Kim, 2010). While it might seem that reunification is a better option, the process of reunification is not easy. Minors may be ambivalent about leaving family and friends in their home country to reunite with family members whom they may not have seen in a long time and who may feel like strangers (Suarez-Orozco et al., 2010).



Of most concern are the immigrant minors who migrate to the U.S. to escape violence. Kennedy (personal communication, n.d.) interviewed 322 unaccompanied minors who had been sent back to El Salvador from the U.S. and found that more than half lived in neighborhoods with gang presence, and a third reported the presence of gangs inside their schools. Approximately 34% reported being threatened to join a gang or were given death threats (E. Kennedy, personal communication, n.d.). Despite knowing the journey to the U.S. includes dangers such as rape, kidnappings, and physical violence, many children report that they feel this path is less risky than staying at home (E. Kennedy, personal communication, n.d.). Kirmayer et al. (2011) reports there is empirical evidence suggesting that individuals seeking refuge are at a significantly higher risk of developing a psychiatric disorder than the general population, including post-traumatic stress disorder, depression, and other bodily and somatic complaints. These symptomatic presentations appear to be related to these individuals' exposure to war, violence, and the experience of migration (Kirmayer et al., 2011). Indeed, refugee immigrant youth may experience higher rates of traumatic grief, dissociative symptoms, and other symptoms of distress (Betancourt, Newnham, Birman, Lee, Ellis, & Layne, 2017).

Moreover, immigrant children in the U.S. have the highest rate of poverty at 26% (Fortuny, Chaudry, & Jargowsky, 2010), placing these minors at risk of having unstable sources of food and housing, along with medical and mental health problems (Pereira et al., 2012). Researchers have also found significantly lower rates of health-service utilization among immigrant youth as reported by caregivers (Bridges, de Arellano, Rheingold, Danielson, & Silcott, 2010). In sum, immigrant minors leave their home country to escape the turmoil and seek better opportunities in America, though past trauma may place them at risk for developing psychopathological symptoms.

### **Fear of Deportation**

Deportation fear affects the everyday lives of unauthorized immigrants, including turning everyday activities into illicit acts (Coutin, 2000), forcing individuals into hiding

(Coutin, 2000; Hagan, 1994; Rouse, 1991), and fomenting stress and worry (Viruell-Fuentes, 2007) with correlated reduction in reported health (Cavazos-Rehg, Zayas, & Spitznagel, 2007). Undocumented immigrant youth have evidenced reductions in school enrollment (Jefferies, 2014), increases in school absences (Capps, Castañeda, Chaudry, & Santos, 2007), dissociation from their cultural heritage (Dreby, 2012), and prodromal indicators of internalizing and externalizing mental health issues (Capps et al., 2007). This fear of deportation is not unreasonable given that minors face being uprooted from their lives and returning to violent, unsafe environments (Hiskey et al., 2016).

Not only does deportation fear affect the daily lives of unauthorized immigrants, it affects our ability as psychologists to understand this population (Gusmano, 2012). Indeed, a majority of the research we have on immigrants consists of data from documented immigrants or small samples of unauthorized immigrants (e.g., Lui, 2015; Viruell-Fuentes, 2007), as many unauthorized immigrants are fearful to participate in research. This gap in our understanding is further compounded by the scant number of bilingual psychologists, linguistically appropriate research tools, and culturally sensitive measures available for use in this population (Fernandez, Boccaccini, & Noland, 2007; Guilman, 2015). Indeed, the majority of unauthorized immigrants speak little to no English (Migration Policy Institute, 2014b).

Although researchers have begun developing culturally and linguistically sensitive measures to research unauthorized immigrants (e.g., Intolerance of Unpreparedness for Immigration Court Scale [IUPS], Perceived Preparedness for Immigration Court Scale [PPICS]; Bailey, Venta, Crosby, Varela, & Boccaccini, unpublished manuscript; Migration Experiences Interview; Venta, unpublished manuscript), these measures barely scratch the surface of what is needed to more fully understand this population. Thus, following are a list of considerations to take when clinically evaluating unauthorized immigrant minors. Specifically, we are more likely to come into contact with unauthorized immigrant youth from Central America

due to our geographic location (Customs and Border Patrol, 2016) and the additional forms of relief afforded to immigrant youth (Catholic Legal Immigration Network, Inc., 2015).

### **The Evaluation Process: Key Considerations**

#### ***Getting Informed Consent for Evaluations with Unauthorized Immigrant Minors***

Although receiving informed consent is standard protocol in the U.S., Weiss and Rosenfeld (2012) explain that non-Western individuals may have little knowledge about what the informed consent process entails, such as understanding confidentiality, privilege, and the right to not answer any question. Weiss and Rosenfeld (2012) recommend carefully and thoroughly explaining the informed consent process to the examinee. As can be observed in other fields, such as in medicine, youth and even parents have a substandard understanding of the informed consent process (Jubbal, Chun, Chang, Zhang, Terrones, & Huang, 2015). Given the possibility that immigrant minors may also be unfamiliar with the informed consent process, Weiss and Rosenfeld's (2012) recommendation should be incorporated into the beginning of every evaluation to ensure that immigrant minors and their guardian(s) understand both the informed consent process and its limits. Moreover, the minor's developmental level and ability to comprehend the informed consent process should be considered as well, as is typically required for research purposes (Office of Human Research Protections, n.d.). Considering these factors provides an opportunity for the minor to willingly participate in the evaluation, rather than just complying with instructions (Office of Human Research Protections, n.d.).

#### ***Building Rapport During the Evaluation: Addressing the Fear of Deportation***

Building rapport with unauthorized minors has a unique element with this population; the evaluator must assuage any immediate fears of deportation that may interfere with the evaluation process. For example, unauthorized immigrants' fear of deportation is such that some wait "until health issues were critical to seek services because of concerns of being reported to



authorities” (Hacker, Anies, Folb, & Zallman, 2015, p. 178). Therefore, it is understandable for unauthorized minors to have a ubiquitous fear of seeking mental health care and of working with mental health care providers. Given this fear, psychologists and other professionals may need to assure immigrant examinees that they do not work for the U.S. Immigration and Customs Enforcement (ICE) department or any other governmental entity that has the power to deport or report individuals for deportation (Capps et al., 2016; Zayas & Heffron, 2016). Such an assurance may further provide the groundwork for building rapport throughout the evaluation.

### **During the Evaluation**

Although precise statistics are currently unavailable, many immigrants, such as unaccompanied children, are not proficient in English, meaning they possess limited command of the language (Pierce, 2015; Wiltz, 2015). Estimates in 2015 reported that there were 25.9 million individuals in the U.S. ages five and older who were considered “Limited English Proficient” individuals (Zong & Batalova, 2017). Therefore, evaluators must carefully consider the potential for language barriers. When possible, evaluators should consider doing the evaluation in the examinee’s primary language—without the use of a translator. Using a translator has the potential for losses in translation or the cultural context, i.e. when the examinee uses colloquialisms to describe an event or emotion (see Weiss & Rosenfeld, 2012 for a full review on using translators).

Additionally, the American Psychological Association recommends (APA; 2013), taking into consideration the immigrant minor’s culture to prevent over-diagnosing and overlooking the influence of resilience. To gain a holistic understanding of the minor’s mental health, evaluators “may benefit by using multiple sources of evidence ... and identifying culture-specific expressions of well-being and distress” (APA, 2013, p. 6). Evaluators should also be aware of the sociopolitical context, including understanding the living condition and current psychological state of the immigrant minor. For example, some youth who have been apprehended by immigration officers

are held in detention centers, while others are awaiting release to family in a shelter, or are already living with a family.

Further, many immigrant youths in the U.S. are still exposed to discrimination, gangs, immigration raids, separation from family members, racial profiling, and other significant stressors. (Parra-Cardona, Bullock, Imig, Villaruel, & Gold, 2006; Passel & Cohn, 2009). Such exposure can lead to distress and negative emotional and behavioral outcomes, such as anxiety, fear, or depression (Chaudry et al., 2010). For example, children whose parents were taken by immigration raids displayed internalizing and externalizing changes, including changes in mood and eating and sleeping habits; these changes persisted over time, even nine months post-arrest (Chaudry et al., 2010). Undoubtedly, immigrant minors experience a myriad of troubling exposures to potentially traumatizing events and these should be carefully assessed during an evaluation. Evaluators should strive to have an adequate level of cultural competence in order to understand how culture affects how immigrant minors understand symptoms, problems, and illnesses (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; DSM-5; American Psychiatric Association, 2013).

### **Conclusion**

The present article briefly illustrates the complexities of an immigrant minor’s life before and after arrival to the U.S. and provides information on key elements to consider during an evaluation. Working with unauthorized immigrant minors presents a unique clinical experience for psychologists given the challenges many minors have faced at such a young age. In order to provide quality care and services, psychologists should have a thorough understanding of cultural factors that may affect the evaluation process for immigrant minors. We recommend seeking an adequate level of cultural competence in order to better serve this population. Cultural competence in our field is necessary but not sufficient, and should be considered only a stepping stone on the road to competence, which is never-ending. Indeed, clinicians and researchers must strive to continually build upon their foundation of information. ■

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## Forensic Issues

### *Assessing Elder Civil Competency*

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As the legal system increasingly understands and appreciates the knowledge and skills of forensic psychologists, more opportunities arise for us to contribute in this area (Moye, Marson, & Edelstein, 2013). One place where forensic psychologists are becoming more valued is in providing information to the courts regarding civil legal competency. Issues of civil competency often arise in elder populations where there may be some reason to question their capacity to make decisions in medical, financial, or testamentary matters. Documenting their abilities or deficits can limit subsequent difficulties, such as litigation. There are a number of specific factors to consider when evaluating competency in this context.

Competency is actually a legal determination made by the court based on a global assessment of functioning. What a forensic psychologist does is more accurately termed a functional assessment to determine if an

individual possesses the capacity to make a specific decision in an explicit area addressed by the law (Moye & Marson, 2007). Ethically, it is important to keep in mind that adults are, and should be, presumed competent unless their competence is called into question based on a particular concern (Moye, Marson, & Edelstein, 2013). Self-determination is a foundational concept in this society. Persons have the right to make decisions in their own interest, generally limited only by potential significant harm to themselves or others (American Bar Association & American Psychological Association, 2008). When considering the issue of competency, especially when working with an elder population, the focus should not necessarily be on whether the person makes the “best” choice, but rather should focus on the reasonableness and consistency of the person’s decision-making process.

At a general level, competence can be defined as the capacity to make reasonable decisions. The most common factors that

that may affect an individual’s decision making skills include dementia, depression, delirium (the three Ds), as well as psychosis and memory loss (often part of Alzheimer’s disease). As individuals live increasingly longer lives, the likelihood of experiencing a loss of capacity in a given area due to one of these factors also increases (Karel, Gatz, & Smyer, 2012). Often, the individual will be generally competent but may have certain specific deficits that are relevant to the legal question (Jaworski, 1963).

Bearing in mind the ethical considerations of self-determination, respect, and dignity, there is an established sequence to conducting a civil competency evaluation. If the question concerns medical issues, the issue of competency is most likely to be raised when the person’s decision involves refusal of treatment, or a Do Not Resuscitate order. In financial affairs, the contested decision often involves large purchases, donations, or changing investments. For testamentary matters, Texas law (Texas



Estates Code 251.001) states that a person must be of “sound mind” to make a last will and testament. While often retrospective, with the issue of competence raised after the individual’s death, assessment can, and should, be done proactively. By conducting a civil competency evaluation at the time a person finalizes their last will and testament, the probability increases that a disgruntled family member will be unsuccessful in any attempt to later contest its validity.

It is worth noting that it is preferable for the forensic psychologist to be appointed by the attorney of the family or examinee, rather than be engaged directly by the family or examinee. This helps ensure that the psychologist is properly focused on the legal questions involved and will provide the information needed for a court to make the competency determination. Additionally, it reduces the appearance of bias or improper relationships with the involved parties.

Once appointed to the case by the attorney, the psychologist’s first step is to clearly formulate the question being addressed. What area of competence is being explored, and what information will you need to answer this question? For example, “Does the person possess the capacity to make reasonable decisions regarding the distribution of his or her property?” In this case, there are four important considerations: (1) Does the person have an understanding of the nature of a will? (2) Can they recollect the nature and situation of his or her property? (3) Do they have knowledge of their heirs? (4) Do they know the manner in which they want their property to be distributed (Jaworski, 1963)?

The second step is to conduct a thorough interview of the individual. Generally there are five standards to assess: 1) Expression of a preference: Does the client individual express a clear preference? This may be expressed verbally, written, or nonverbally communicated. Determine if the preference is being expressed consistently. 2) Understanding: Does the client appear to have a satisfactory understanding of the issue at hand? Can they appropriately convey their understanding to you and to others? 3) Appreciation: Appreciation adds affective meaning to the concept of understanding. It elevates the concept of

understanding by adding in the abstract dimension of applicability to oneself. 4) Reasonable Decision-making Process: Does their thought process address the understanding and appreciation necessary to arrive at the decision they have made? 5) Reasonable Outcome: After the decision-making process has been evaluated, look at the actual decision. Could this decision be considered reasonable, given the person’s circumstances? Be prepared to document why or why not.

In addition to a clinical interview with the individual, a collateral interview should always be conducted, if at all possible. The collateral informant may be a close friend or family member, a caregiver, or even a trusted neighbor, who has ongoing knowledge of the examinee’s ability to function in their daily life. Ideally, this person should not have potential gain related to the outcome of the evaluation. Ask the collateral informant to provide you with information that will either confirm or oppose what the examinee has shared with you. The role of the forensic psychologist will be to weigh the sources of information—which should also include a review of all available medical, or other relevant records—and create a realistic portrait of the examinee.

The third step is to conduct any needed supplementary testing, such as on memory, language, cognitive, or suggestibility. Allow the interview to be the guide for choosing areas to be tested or instruments. Are there general cognitive concerns? Do you see indications of language deficits, memory loss, or coercion by others? Of course, because you are working in a legal context you should be aware of the psychometric properties of any tests you use. Always use instruments that are valid, reliable, and up-to-date, especially within forensic settings.

Writing a report of your findings is fairly straightforward. Be clear about the legal question or questions you are addressing. Document your method and findings. Be sure to explain how the findings, including test results, relate to any specific capacity you are assessing and how that capacity relates to the legal question. Do not forget that competency is a legal concept and is decided by the court, not by you. You may state that you have found the person to have (or not

have) the capacities or abilities that appear to meet the legal criteria, but you cannot make the final determination of competency.

As the population of this country ages, there are increasing opportunities for forensic psychologists to provide competency assessments of older adults. Moreover, this is an area in which psychologists can showcase their doctoral-level, specialized training. To provide these services properly there are a few guidelines to keep in mind. Always clearly specify the question, or questions, to be answered. Competence should not be used as a general term. The task is to assess an individual’s capacity to meet legal criteria. Then gather information to answer the five important questions in the interview portion of the evaluation. Collateral interviews are very important for providing confirmatory or conflicting information. Review medical and other relevant records as available. Use supplementary instrumentation only as needed. Remember the importance of dignity, respect, and the right to self-determination. Proceed cautiously and in the best interest of your client. ■

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## *Integrated Training Model: A Doctoral Program in Clinical Psychology with an Exclusively Affiliated Internship Program*

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The doctoral internship is an integral part of doctoral training in psychology and often serves as the capstone of any graduate student's experience (McCutcheon, 2011). Graduate students typically acquire an internship through the Association of Psychology Postdoctoral and Internship Centers (APPIC) match system. The system allows students to apply for available internships, be selected for an interview, and participate in the match process to obtain an internship. Although this process is well structured and systematized, the process can be stressful, expensive, and time-consuming (Parent et al, 2016). In addition, there can be a discrepancy between the number of applicants and the number of available APA-accredited internship positions.

The number of available positions has varied over the years, indicating a lack of stability in the internship process. Furthermore, there has been an increasing number of applicants who registered in APPIC, exceeding the number of available positions by 522 in 1999 and by 1,105 in 2013 (APPIC, 2014). Candidates for internship outweighed the number of spots as early as 1976 (Stedman, 2006). Relatively recently, from 1999 to 2013, the overall APPIC match rate dropped from 84% to 76% and the APA/CPA-accredited internships went from 61% to

56% (APPIC, 2015). Although the match rate has recently improved to 95%, 13.0% of applicants matched to a non-accredited position (APPIC, 2017). These numbers represent an improvement over prior years; however, the 5% of applicants that did not match equates to 169 graduate students in one year (APPIC, 2017). Furthermore, the 13.0% in unaccredited internships equates to 367 graduate students. This leaves a large number of students in a difficult position as they try to work toward completing the requirements for their doctoral degree and licensure. Without an internship to complete their training, students are forced to spend additional time enrolled in their program and lose both time and monetary resources (Wells et al., 2014). In addition, these students will have to use additional time and resources (an average of \$1,812 in 2011) to apply for internship the following year (APPIC, 2011a).

Furthermore, not matching for internship often causes additional stress on the students. In a 2011 poll conducted by APPIC, students mentioned feelings of defeat, anger, and increased anxiety and stress (APPIC, 2011b; Parent, et al, 2016). Matching into an unaccredited internship can also result in difficulty obtaining employment—many employers require an APA or Canadian Psychological Association

(CPA) accredited internship—and some states require the completion of an APA-accredited internship for licensure, potentially lengthening the process of acquiring licensure (Bailey, 2004).

Given the numbers of unmatched interns or interns matched to unaccredited programs, the consideration of other training models is warranted. An exclusively affiliated internship is defined as “an accredited internship that only admits interns who are students from a specific accredited doctoral program” while a partially affiliated internship is defined as “an accredited internship in which a portion of the interns admitted are students from a specific accredited doctoral program” (C-16 D; American Psychological Association Commission on Accreditation, Standards of Accreditation, 2017). The use of an affiliated doctoral internship is an approach that is gaining popularity. In 2015, APPIC identified 11 exclusively affiliated internship programs (Doran and Cimbor, 2016) and that number increased to 19 in 2017.

Of the 19 internships that report being fully affiliated with a graduate program, only five of the graduate programs listed as their affiliate have a 100% internship match rate. Furthermore, time to degree completion of these programs varies from 4.0 years to 6.8, with a mean of 5.7 years. Thus, shorter time

to completion of the Ph.D. program does not seem to be a consistent benefit of the affiliated internship.

In this paper, we will present an integrated model for an APA-accredited doctoral program and exclusively affiliated APA-accredited internship. We will provide a program description, training outcomes, and program satisfaction data.

## Method

**Program description:** The exclusively affiliated internship program described here began in 1953 in the department of psychiatry in a large, urban, academic medical center (Michael, 1997). The integration with the graduate program occurred in 1963, upon the establishment of a doctoral program in clinical psychology. Developing an integrated doctoral and internship program was a natural fit in a large academic medical center where coursework, research, and clinical care can be experienced concurrently. Approval by the American Psychological Association was not sought until the mid-1980s, and obtained in 1986 on its first evaluation (Gluck, 1990).

The doctoral program and exclusively affiliated APA-accredited internship are located within the Department of Psychiatry and the Graduate School of Biomedical Sciences at the academic medical center. The program is a structured and sequenced four-year program that includes a two-year, part-time internship that is completed concurrently with the third and fourth year of the Ph.D. program (see Table 1). The doctoral program and internship run year-round, rather than a typical nine-month school year.

Students begin their training by taking relevant courses in their first year. During the summer of their first year and through their second year in the program, they begin their practicum experience (20 hours per week) as well as training in our outpatient psychotherapy training clinic (two to three hours per week). Students have two hours of individual supervision, in addition to group supervision and didactics. Students are placed in community clinics, hospital settings, and forensic settings for their practicum clinical training.

The Internship Program provides interns with broad exposure to diverse patient populations, ethnic and cultural groups, and multidisciplinary approaches to patient care. The Internship Program is a two-year, half-time program that takes place in the third and fourth year of the interns' doctoral study. Interns rotate through clinical rotations (typically two primary rotations, 12 months each). Settings include university-affiliated hospitals, psychological services on and off campus, affiliated community mental health centers, university counseling centers, and rehabilitation clinics. Interns are required to attend weekly didactics that cover the nine content areas described by the Standards of Accreditation (APA CoA, 2015). Simultaneously, students formally begin their dissertation projects (although some students begin working on their projects in their first year), which is done half-time and in parallel with the internship.

In addition to the internship placement site, interns are provided with ongoing outpatient psychotherapy experience, treating patients (minimum of two to three) referred through our psychotherapy training clinic. This service provides interns with an opportunity to carry long-term, as well as short-term, outpatient psychotherapy cases which are supervised by an assigned licensed psychologist. Interns also have an opportunity to facilitate a DBT skills group in the clinic. In the first year of their internship, interns rotate through a shared rotation schedule of the County Hospital Emergency Room for six months, which provides an opportunity to learn psychiatric emergency treatment and crisis intervention procedures. More recently, we have added a peer mentorship program (Foxwell et al., 2017) to strengthen experiential training in supervision and promote the development of supervision competencies to our interns. Interns are paired with practicum students and provided with administrative and clinical guidance during their practicum year.

Although interns rotate through two different clinical sites during their internship, the evaluation of interns is standardized across sites and reviewed by the internship's clinical training committee three times a year. Thus, comparison among interns and across cohorts allow for the assessment of

minimal levels of achievements across a wide array of training experiences and systematic quality improvement efforts.

## Clinical sites and contracting for services:

All interns are funded for the two years of their part-time internship experience. We have direct contracts with clinical rotation sites that provide the stipend funds to the internship program. The internship has been consistently funded since its inception through a combination of long-standing, institutional training sites and external agencies. This not only provides consistent funding but also flexibility with regard to training experiences. For instance, both a large county hospital and a nonprofit pediatric hospital have been training sites for decades. However, other sites, such as a newly formed clinic to treat veterans and their families and an autism spectrum disorder treatment clinic, have recently been added and allow for training in these growing areas. This diverse array of training sites allows the internship to meet the individual training needs of students and mitigates the concerns for lost funding if a training site can no longer accept interns. The location of our program and internship within an academic medical center setting provides the benefit of partnerships with diverse training sites, access to a large number of faculty (more than 100) within the medical center and community, and funding for interns.

**Intern selection:** During the admissions process, applicants to the integrated Doctoral Program and Internship are carefully screened for interests, aptitudes, and academic preparation that are appropriate for both the Doctoral Program's and Internship's goals and objectives. Ordinarily, we admit 10 doctoral students per year, who will matriculate into the internship program during their third year of the doctoral program. Prior to entering the internship, all graduate students must have completed approximately 15 months of supervised practicum training (20 hours per week, and 2-3 additional hours through the outpatient psychotherapy clinic) in the doctoral program, achieved a satisfactory performance grades on four semesters of practicum, and passed a qualifying exam.



**Table 1. Integrated Model of Doctoral Program and Exclusively Affiliated Internship Structure.**

	Fall Semester	Spring Semester	Summer Semester	
Year 1	Coursework (17 credit hours)	Coursework (16 credit hours)	Coursework (6 credit hours)	Begin Practicum Rotation (20 hours/week)
Year 2	Coursework (9 credit hours)	Coursework (9 credit hours)	Coursework (6 credit hours)	
	Practicum Rotation (20 hours/week)			
	Psychotherapy Training Clinic (4-5 hours/week)			
Year 3	Coursework (3 credit hours)	Coursework (3 credit hours)	Coursework (2 credit hours)	
Year 1 in Internship	Research/Dissertation (16 hours/week)			
	Internship Clinical Rotation (20 hours/week) + Internship Program Sponsored Didactics (10 required per semester)			
	Psychotherapy Training Clinic (4-5 hours/week)			
	County Hospital Psychiatric Emergency Room Rotation (80 hours in 6 months)			
Year 4	Research/Dissertation (20hours/week)			
Year 2 in Internship	Internship Clinical Rotation (20 hours/week) + Internship Program Sponsored Didactics (10 required per semester)			
	Psychotherapy Training Clinic (4-5 hours/week)			

Once these criteria are met students are admitted to their internship and given the title “psychology intern.”

**Internship match process:** As we have an exclusively affiliated internship, we are able to achieve a 100% match rate to an accredited internship. As reported earlier, we are aware of only four other programs that report a 100% match rate with an affiliated internship. Our match process includes the following: a) an internship placement committee consisting of the program director, internship director, assistant director, and chair of admissions; b) an internship fair, where students have an opportunity to meet with representatives from all available clinical sites, c) an opportunity for students to provide their training goals, clinical interests, and placement preferences for interviews; d) the internship committee reviewing the preferences of these internship applicants and recommending interviews (two interviews are typically recommended, but for students vying for heavily requested sites, three interviews were recommended); and e) based on internship site and student preferences, students being matched to an internship site.

## Results

**Program outcomes:** Satisfaction with internship clinical sites is measured yearly by the interns at the completion of their rotations. Over the last five years, our interns rated their training at internship sites an 8.8 (10=highest satisfaction). Over the last eight years, the average time to complete the Ph.D. degree in our program was 4.1 years, which includes the completion of the internship. Over this same time period, our attrition rate was 4.5%. Other outcomes include an EPPP pass rate for graduates of the doctoral program of 100% for the years 2015-2017. Our licensure rate (from 2007-2017) is high, with 94.0% of our graduates having obtained a license (calculation based on compliance with American Psychological Association Standards of Accreditation, IR C-26 D). Additionally, 100% of graduates who sought employment obtained it upon graduation. The majority of our graduates go on to formal postdoctoral fellowships (80%, with 53% going to APA-accredited postdocs).

Graduate student satisfaction is also high. We routinely request feedback from alumni during their postdoctoral fellowship year on the training in clinical practice (assessment, intervention), research, ethical and professional conduct, and ability to

work with diverse populations. Results of our Alumni Postdoctoral Survey (N=53; graduates 2010 to 2015) suggest that the majority of alumni are satisfied with the overall training, rating the doctoral program and internship as satisfactory (18.4%) or very well prepared (79.6%); a small percent (2%) reported being “fairly” satisfied with their training.

## Discussion

Training in an academic medical center allows for the ability to combine doctoral training with internship training into an integrated model. Simultaneously completing an internship and a research apprenticeship provides an excellent environment for training in a clinician researcher model.

**Limitations:** Although there are many strengths to the integrated training model presented above, we are aware that there are some limitations. First, receiving all graduate training at one site can be viewed as undesirable. Additionally, the program is structured, sequenced, and year-round, which leads to less flexibility in our curriculum. The training is rigorous, time intensive, and can be stressful at times; however, the program and internship



provide the students/interns with resources, mentorship, and support as they complete their training. This is typically provided through faculty and student advisory systems that meet several times a year, student/intern/faculty meetings, a fall social for students and faculty, and several student organizations mentored by faculty members. In addition, the academic medical center houses a medical school, graduate school of biomedical sciences, and school of health professions. Thus, there are a large number of institution-wide resources for our graduate students and interns. These include a wellness center, student wellness and counseling services, student academic support, career development services, a large number of student organizations, and library and research resources and services.

Typically, our graduate students matriculate into the internship in their third year of the graduate program, which could be criticized as having inadequate preparation for internship. However, because our practicum is 15 months long (20 hours per week in addition to 2-3 hours per week in our outpatient therapy training clinic), this allows for multiple opportunities for corrective feedback (four evaluation points) and closely supervised clinical experience. Finally, we understand that this model may not be feasible for all doctoral programs as it requires access to multiple resources including access to diverse patient populations, contractual partnerships with training sites, large number of on campus faculty, and large numbers of clinical/volunteer faculty.

The exclusively affiliated internship model has many benefits including reducing time to degree, yet providing rich and diverse clinical and research training, reducing the stress and expense of matching to an internship site, and offsetting the cost of graduate stipends. Developing long-term relationships with training sites provides for a beneficial collaboration where the service needs of the site and the training needs of the student and university are both met. The

model is feasible and acceptable, and has good professional outcomes (licensure and employment). ■

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# Their need for care doesn't stop when they leave your office.



MEDICAL



DENTAL



BEHAVIORAL  
HEALTH



SCHOOL  
SERVICES



SOCIAL  
SERVICES

Case managers help patients navigate the health system by coordinating access to care related to their health conditions.



*Texas Health Steps is health care for children birth through age 20 who have Medicaid. Case Management can help families of children with special needs find and get services.*

When your patients need extra support for their health conditions, refer them to case management services, a Medicaid benefit for children birth through age 20 and high-risk pregnant women.



CASE  
MANAGEMENT

Children enrolled in Medicaid (Traditional Fee-for-Service, STAR, and STAR Health) may be eligible. Patients enrolled in STAR Kids should first be referred to their health plan.

To refer your patient,  
call Texas Health Steps

**1-877-THSteps**

or visit

[dshs.texas.gov/caseman](https://dshs.texas.gov/caseman)



**TEXAS**  
Health and Human  
Services

*Case Management for Children  
and Pregnant Women*



# 2018 Annual Convention

## RESILIENCY: BUILDING INDIVIDUAL, PROFESSIONAL AND ORGANIZATIONAL STRENGTHS

### Call for Proposals

will be distributed/posted  
in February–March 2018  
with an April deadline of receipt.

### Location

Embassy Suites & Conference Center  
7600 John Q. Hammons Drive, Ste. 401  
Frisco, Texas 75034

### Keynote Speaker

Alan L. Peterson, Ph.D., ABPP

### Watch for Details

at [texaspsyc.org](http://texaspsyc.org)